

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000			
F 279 SS=D	Correction Date: <u>4-4-17</u> The deficiency relates to the complaint investigation #66041-I and #64686. Complaint #64686 was not substantiated, Complaint #66041 is substantiated. See code of Federal Regulations (42CFR) Part 482, Subpart B-C. 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 279			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kau Sent

TITLE

Administrator

(X6) DATE

4-11-17

04/05/2017

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.

OK Kasper 4/12/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews and review of manufacturer's operational manual, the facility failed to develop a comprehensive Care Plan with approaches to direct staff of mechanical lift assistive devices to use in order to prevent injury (Resident #5). The sample consisted of 5 residents and the facility reported a census of 85 residents.	F 279			

F000

Please accept this plan of correction and this facility's credible allegation of compliance.
All deficiencies were corrected on 4-4-2017

The preparation and/or execution of this plan of correction do not constitute and should not be interpreted as an admission or an agreement by the facility of the truth of the facts in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because of provisions of state and federal law requires it.

F279

Our facility only uses one accessory strap with the EZ stand lift- the seat strap. In the future we will call it the seat strap.

The therapy rec stated "use strap under buttocks for transfers." Our care plan read "stand lift for all transfers with assist of 2 and strap under buttocks."

Both therapy and MDS coordinators have been educated on using the correct terminology.

Care plans are reviewed quarterly as well as daily if needed.

This will be monitored by the MDS coordinator and Director of Nursing.

F323

The 2 CNA's were coached regarding following the therapy rec which was to use the buttocks strap with transfers of resident. This resident's transfers was immediately changed to mechanical sling lift after the incident.

On 3-22-17 lift training was held for nursing staff which included the use of the seat strap.

On 3-29-17 nursing staff were educated regarding following the care plan and therapy recs and where to find the information.

Our protocol if a transfer is difficult is to notify the nurse immediately. We may increase assistance and monitor and have therapy do a screen.

Therapy recommendations are reviewed daily at QA.

This will be monitored by Director of Nursing and Nurse Managers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017	
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 12 Record), identified medication given as needed for pain. The resident requested Ibuprofen 600 milligrams on the following dates and times: 1/21/17 at 9:00 p.m., 1/24/17 at 8:50 p.m., 1/27/17 at 3:30 p.m., 1/27/17 at 1:30 a.m., 1/29/17 at 8:20 a.m., 1/29/17 at 5:45 p.m., 2/1/17 at 6:15 p.m., and 2/26/17 at 11:30 p.m. for left arm and shoulder pain.			F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 2 Findings include: 1. Resident #5 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 12/29/16. The MDS indicated the resident scored a BIMS (Brief Interview for Mental Status) of 15. A score of 15 represented the resident had no cognitive problems. The MDS identified Resident #5 had diagnoses including high blood pressure, diabetes, stroke, anxiety, seizure disorder, and depression. The MDS indicated the resident required extensive assistance of two staff members for bed mobility, transfers, and toilet use. The MDS indicated the resident had an impairment of one side of the body, both upper and lower extremities. The Care Plan with the goal dates of 1/13/17 identified the resident at risk for falls due to left sided hemiplegia (paralysis), and a seizure disorder. The Care Plan identified a problem with the resident at risk for injury related to seizure disorder, hemiplegia and a fractured left tibia. The approaches directed 2 staff members to use a mechanical EZ stand for transfers. A form titled, Physical Therapy Recommendation for Restorative/Functional Maintenance Program, dated 6/27/16, directed two staff members to use the stand lift with a strap under the [resident's] buttocks when transferring from the bed or wheelchair or traveling to and from the bathroom. A Physical Therapy Evaluation & Plan of Treatment, with a start of care dated 6/27/17, documented that the resident had flaccid muscle tone to the left extremity. The evaluation indicated the resident had poor standing balance, and	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 3 unable to shift weight. The Physical Therapy Evaluation impression indicated the resident presented with difficulty in stand lift transfers due to fatigue intermittently; this date the resident stood excellent, however benefits from the caregiver training could improve safety with transfer consistency. The manufacturer's operator's instructions titled, The EZ Way Stand Operator's Instructions, revised on 3/11/09, directed the following: On page 7, additional accessories are available as a seat trap, and stand support strap. The operator's instructions documented the seat strap to be used for additional lower body support, and can be used for transferring or ambulation. The directions indicated the stand support strap is used for additional lower body support and effective in helping patients stand in an upright position. The resident's Care Plan lacked description of which strap should be used. The Incident/Accident/Unusual Occurrences Form dated 1/21/17 at 7:30 p.m. indicated a Certified Nurse's Aide (CNA) reported Resident#5 had difficulty with transfers in the stand lift. The form documented the resident had difficulty with weight bearing and gripping of the handle during a transfer. The form indicated the resident complained of left shoulder pain on a scale of 10 out of 10 with movement, but no pain with palpation. The form documented absence of redness, warmth or swelling to the left upper extremity. On 3/21/17 at 10:30 a.m. Resident#5 was interviewed and stated the CNAs transferred her on 1/21/17, like they always did with the EZ stand,	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 4 strap under my arms. Resident#5 reported that his/her arms just started to hurt, she yelled, and a nurse came in and told the CNAs to stop. Resident#5 reported no problems with transfer before. During an interview on 3/21/17 at 12:26 p.m. Staff B, CNA reported the resident sat on the toilet and Staff A, CNA assisted with the transfer. Staff B stated Staff A, CNA assisted with the transfer and the resident had straps around the legs and under the arms and hung onto the lift with one hand. Staff B stated the resident had a stroke with paralysis of the left arm and could not hang onto the lift. Staff B stated the resident was up in the lift and out the bathroom door, when the resident reported his/her arm hurting. Staff B reported that she and Staff A put the resident in a chair outside of the bathroom door and then Staff A left to get the nurse. Staff B stated Staff C, Registered Nurse, performed an assessment of the resident. Staff B stated the resident wanted to try and stand again, and the resident complained of pain again. Staff B stated she put the resident down and the resident wanted to try again. Staff B stated Staff C provided education to the resident why they should use the Hoyer (another type of lift) and the resident refused. Staff B stated they tried again and the resident made it to the bed. On 3/21/17 at 2:44 p.m. Staff A was interviewed and stated Staff A helped her transfer Resident #5 out of the bathroom. Staff A stated the resident went up in the lift, and complained of loss of strength, and said he/she couldn't stand well, so they put the resident in a chair. Staff A stated the nurse assessed the resident, and the resident refused to use the Hoyer lift. Staff A stated the resident voiced of hand hurting. Staff A reported	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 5 the resident wanted to use the EZ stand, and was able to get to the bed after two attempts. Staff A reported they use a Hoyer lift now with the resident. The resident wears an arm sling at all times now. On 3/21/17 at 11:10 a.m. Staff C, Registered Nurse, was interviewed and stated Staff A and Staff B were present when the resident could not grab onto the EZstand lift. Staff C stated the resident could not grab the lift with either hand very well and she told the CNAs to stop the transfer. Staff C stated the resident refused the Hoyer lift on 1/21/17. On 3/23/17 at 11:52 a.m. Staff C, Registered Nurse, was interviewed and stated the staff did not use a lift that went under the resident's buttocks. Staff C stated the facility does have buttock slings. On 3/23/17 at 11:56 a.m. Staff B, CNA was interviewed and stated they did not use a buttock sling on the resident when the resident fell, only the shoulder sling. Staff B stated the facility had two mechanical lift options [with the EZ stand] which is the buttock sling or the shoulder sling. Staff B stated the facility did have butt slings. On 3/23/17 at 12:06 p.m. Staff A, CNA reported that with the transfer of the resident they used a shoulder strap, leg strap, but not a strap that went under the buttocks [seat strap]. On 3/23/17 at 12:10 p.m. Staff D, CNA was interviewed and stated the facility has about four seat slings, and showed the surveyor three of them. The seat slings appeared to be new.	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 6 The Care Plan identified a problem with Self care Deficit. The goal indicated the resident would be well dressed and groomed each day and dated 4/12/17. The approaches directed the staff to use a stand lift for transfers with assistance of 2 [staff members] and a strap under the buttocks.	F 279			
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews and review of manufacturer's	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 7 operational manual, the facility failed to provide adequate supervision and use appropriate assistive devices when transferring a resident with a mechanical stand lift (Resident #5). The sample consisted of 5 residents and the facility reported a census of 85 residents. Findings include: 1. Resident #5 had a quarterly MDS (Minimum Data Set) assessment with a reference date of 12/29/16. The MDS indicated the resident scored a BIMS (Brief Interview for Mental Status) of 15. A score of 15 represented the resident had no cognitive problems. The MDS identified Resident #5 had diagnoses including high blood pressure, diabetes, stroke, anxiety, seizure disorder, and depression. The MDS indicated the resident required extensive assistance of two staff members for bed mobility, transfers, and toilet use. The MDS indicated the resident had an impairment of one side of the body, both upper and lower extremities. The Care Plan with the goal dates of 1/13/17 and 4/12/17 identified the resident at risk for falls due to left sided hemiplegia (paralysis), and a seizure disorder. The Care Plan directed two staff members to transfer the resident with the stand lift, and to use a strap under the resident's buttocks (4/12/17). The Care Plan identified a problem with the resident at risk for injury related to seizure disorder, hemiplegia and a fractured left tibia. The approaches directed 2 staff members to use a mechanical EZ stand for transfers. A form titled, Physical Therapy Recommendation	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 8 for Restorative/Functional Maintenance Program, dated 6/27/16, directed two staff members to use the stand lift with a strap under the [resident's] buttocks when transferring from the bed or wheelchair or traveling to and from the bathroom. A Physical Therapy Evaluation & Plan of Treatment, with a start of care dated 6/27/17, documented that the resident had flaccid muscle tone to the left extremity. The evaluation indicated the resident had poor standing balance, and unable to shift weight. The Physical Therapy Evaluation impression indicated the resident presented with difficulty in stand lift transfers due to fatigue intermittently; this date the resident stood excellent, however benefits from the caregiver training could improve safety with transfer consistency. The manufacturer's operator's instructions titled, The EZ Way Stand Operator's Instructions, revised on 3/11/09, directed the following: On page 7, additional accessories are available as a seat trap, and stand support strap. The operator's instructions documented the seat strap is to be used for additional lower body support, and can be used for transferring or ambulation. The directions indicated the stand support strap is used for additional lower body support and effective in helping patients stand in an upright position. The resident's Care Plan lacked description of which strap should be used. The Incident/Accident/Unusual Occurrences Form dated 1/21/17 at 7:30 p.m. indicated a Certified Nurse's Aide (CNA) reported Resident#5 had difficulty with transfers in the stand lift. The form documented the resident had difficulty with	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2017
---	---	--	--

NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 weight bearing and gripping of the handle during a transfer. The form indicated the resident complained of left shoulder pain on a scale of 10 out of 10 with movement, but no pain with palpation. The form documented absence of redness, warmth or swelling to the left upper extremity. Observation on 3/20/17 at 12:01 p.m. identified the resident's bed up against the window in the room. The approximate distance from the toilet to the bed measured 25 feet. On 3/21/17 at 10:30 a.m. Resident#5 was interviewed and stated the CNAs transferred her on 1/21/17, like they always did with the EZ stand, strap under my arms. Resident#5 reported that his/her arms just started to hurt, she yelled, and a nurse came in and told the CNAs to stop. Resident#5 reported no problems with transfer before. During an interview on 3/21/17 at 12:26 p.m. Staff B, CNA reported the resident sat on the toilet and Staff A, CNA assisted with the transfer. Staff B stated Staff A, CNA assisted with the transfer and the resident had straps around the legs and under the arms and hung onto the lift with one hand. Staff B stated the resident had a stroke with paralysis of the left arm and could not hang onto the lift. Staff B stated the resident was up in the lift and out the bathroom door, when the resident reported his/her arm hurting. Staff B reported that she and Staff A put the resident in a chair outside of the bathroom door and then Staff A left to get the nurse. Staff B stated Staff C, Registered Nurse, performed an assessment of the resident. Staff B stated the resident wanted to try and stand again, and the resident complained	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 10 of pain again. Staff B stated she put the resident down and the resident wanted to try again. Staff B stated Staff C provided education to the resident why they should use the Hoyer (another type of lift) and the resident refused. Staff B stated they tried again and the resident made it to the bed. On 3/21/17 at 2:44 p.m. Staff A was interviewed and stated Staff A helped her transfer Resident #5 out of the bathroom. Staff A stated the resident went up in the lift, and complained of loss of strength, and said he/she couldn't stand well, so they put the resident in a chair. Staff A stated the nurse assessed the resident, and the resident refused to use the Hoyer lift. Staff A stated the resident voiced of hand hurting. Staff A reported the resident wanted to use the EZ stand, and was able to get to the bed after two attempts. Staff A reported they use a Hoyer lift now with the resident. The resident wears an arm sling at all times now. On 3/21/17 at 11:10 a.m. Staff C, Registered Nurse, was interviewed and stated Staff A and Staff B were present when the resident could not grab onto the EZstand lift. Staff C stated the resident could not grab the lift with either hand very well and she told the CNAs to stop the transfer. Staff C stated the resident refused the Hoyer lift on 1/21/17. On 3/23/17 at 11:52 a.m. Staff C, Registered Nurse, was interviewed and stated the staff did not use a lift that went under the resident's buttocks. Staff C stated the facility does have buttock slings. On 3/23/17 at 11:56 a.m. Staff B, CNA was interviewed and stated they did not use a buttock sling on the resident when the resident fell, only the shoulder sling. Staff B stated the facility had	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/23/2017
NAME OF PROVIDER OR SUPPLIER LANTERN PARK SPECIALTY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 OAKDALE ROAD CORALVILLE, IA 52241		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 11 two mechanical lift options [with the EZ stand] which is the buttock sling (seat strap) or the shoulder sling. Staff B stated the facility did have seat straps. On 3/23/17 at 12:06 p.m. Staff A, CNA reported that with the transfer of the resident they used a shoulder strap, leg strap, but not a strap that went under the buttocks [seat strap]. On 3/23/17 at 12:10 p.m. Staff D, CNA was interviewed and stated the facility has about four seat slings, and showed the surveyor three of them. The seat slings appeared to be new. On 3/24/17 at 10:11 a.m. the resident's primary care physician was interviewed and stated the resident had a history of osteopenia (bone density), and experienced shoulder fractures in the past. The resident's primary care physician could not say if the use of the seat sling would have prevented the fracture. The x-ray report dated 1/21/17 identified a proximal humeral (upper arm) neck fracture with transverse orientation. The area showed minimal displacement and the clavicle (collar bone) appeared intact. The report documented osteopenia had been present. A Clinic Note dated 2/3/17 documented the physician evaluated the resident for a left proximal humerus fracture. The note documented the resident was given a sling but it had not been terribly comfortable. The note indicated the resident had taken Tylenol and ibuprofen for pain but neither had been helpful. Review of the MAR (Medication Administration	F 323			