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	165231	A. BUILDING _____ B. WING _____	C 10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY PARK NURSING & REHAB CENTER OF CARROLL	500 EAST VALLEY DRIVE CARROLL, IA 51401

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F 000	INITIAL COMMENTS	F 000		

V SB

Correction Date 11/20/20

A Focused COVID-19 infection control survey and the investigation of Complaint #84445-C, 85212-C and Facility Reported Incidents # 88568-I and 90160-I ending on 10/27/20 resulted in the following deficiencies.

Complaint # 84445-C was substantiated.
Complaint #85212-C was substantiated.
Facility Reported Incident #88568-I was substantiated.
Facility Reported Incident #90160-I was substantiated.

The facility was found in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.

Total residents: 30

See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.

F 658 SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) — F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — 11/17/2020 — (X6) DATE 11/10/2020

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.

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F 658	Continued From page 1	F 658		

interview the facility failed to provide services that met professional standards of quality when administering eye drops for 1 of 5 residents reviewed (Resident #5). The facility reported a census of 30 residents.

Findings include:

A Minimum Data Set (MDS) dated 9/29/20 assessed Resident #5 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 (severe cognitive impairment.) The MDS identified the resident as independent with transfers, ambulation and bed mobility and required set up assistance only for dressing and eating.

Physician's orders dated 3/1/20 revealed an order for artificial tears solution 0.4% instill 1 drop in both eyes 4 times a day

Observation showed on 10/19/20 at 11:50 AM Staff M, LPN (licensed practical nurse) removed the eye drops from the medication cart and took it into the room of Resident #5. She explained to the resident that she had her eye drops for her. With ungloved hands, she pulled down the bottom lid of the eye and placed one drop in each eye. She opened the drawer of the medication cart, touched the surface of the med cart and locked the drawer before using the hand sanitizer.

A review of the nursing notes revealed a note dated 10/23/20 at 7:29 PM indicated that the physician for Resident #5 had been called to inform him that the resident tested positive for Covid-19 and was placed into isolation.

On 10/27/20 at 1:30 PM the Director of Nursing

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F 658	Continued From page 2 stated she expects nurses to use gloves when administering eye drops. If they do not use gloves, she expects them to wash their hands immediately at contact with the resident.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, physician and staff interview, the facility failed to ensure that all residents received assessment and intervention in accordance with professional standards for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 30 residents. Findings include: The Minimum Data Set (MDS) dated 2/2/20, revealed Resident #2 admitted to the facility on 2/19/20. A Brief Interview for Mental Status (BIMS) test assessed the resident with a score of 8 (moderate cognitive deficit). The resident required extensive assistance of two staff for transfers, toileting, bed mobility, dressing and personal hygiene. A Care Plan initiated on 2/19/20, identified Resident #2 with a history of falls and admitted to	F 684		

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F 684	Continued From page 3	F 684		

the facility after a fracture of the right femur which resulted in impaired mobility, weakness and unsteady gait. The care plan indicated the resident required the assistance of 2 staff and a walker for transfers. On 3/10/20 a revision to the care plan identified the resident required the assistance of one staff. A note to staff dated 3/10/20 from the physical therapy (PT) department, identified a change in the resident's status to an assist of one with walker.

An incident report dated 3/20/20 at 7:30 a.m., Staff J, Certified Nursing Assistant (CNA) reported that she took Resident #2 to the bathroom and as the resident turned to position over the toilet, the resident started to fall. Staff J reported she held the gait belt that was around the resident and lowered her to the floor. She then pulled the call light in the bathroom to get help. She reported that the resident said her knee buckled.

An Incident Witness Statement dated 3/20/20 at 7:30 AM, revealed Staff I CNA responded to the bathroom call light, helped her pick the resident up off the floor and onto the toilet and then she went to get a nurse.
According to a nursing note dated 3/20/20 at 7:30 AM Staff C, Licensed Practicing Nurse (LPN) entered the room and observed the resident seated on the toilet.

On 10/20/20 at 1:45 PM, Staff C, LPN said she recalled when she entered the room she observed Resident #2 on the toilet with a gait belt around her. She said the resident was in pain and Staff C immediately observed swelling to the resident's right knee. Staff C said that Staff J told her she got the resident up off the floor and

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F 684	Continued From page 4	F 684		

placed her on the toilet. Staff C thought Staff J told her she heard a pop before the resident went down. When Staff C saw the swelling in the knee, she called 911 right away and the resident stayed on the toilet until the Emergency Medical Technicians (EMT) got there and transferred her to the hospital.

A hospital report dated 3/20/20 at 7:47 PM, the resident suffered a fracture of the right distal femur and transferred to Unity Point in Des Moines for orthopedic care. On 10/22/20 at 11:30 AM, Staff B, Assistant Director of Nursing (ADON) stated a major injury form was not completed for the fall because the resident transferred to a higher level of care to a Des Moines hospital to received care from an orthopedic specialist.

A nursing note dated 3/26/20 at 6:00 PM,revealed the resident returned from the hospital after surgery on 3/26/20 in a right leg cast that extended from the heal to the groin.

On 10/20/20 at 2:20, Staff J, CNA, stated when she arrived to work the evening of 3/20/20 she asked another CNA about transferring Resident #2 because Staff J worked mostly overnights, and hadn't transferred her before the time of the incident. Staff J stated another CNA informed her the resident transferred fine with one person. Staff J said that she did not receive a shift report at the start of her shift that night.

Staff J said she applied a gait belt on the resident and then assisted her from the bed to the bathroom. Staff J said when the resident fell, her right leg laid under her butt and the resident leaned against the bathroom door. She said that

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because of how the resident laid, she felt she should get the resident up so she put on the call light and Staff I, CNA came in and helped her get the resident off the floor and onto the toilet. She said that the resident wasn't bearing any weight at that time and she was in pain.

On 10/21/20 at 9:35 AM, Staff I stated she entered the resident's room on 3/20/20 to respond to the call light. She said that when she entered the room, the resident was on the toilet and Staff J was with her. Staff I said that she then went to get a nurse. Staff I said she transferred the resident many times before the fall and she did not feel comfortable transferring with just one person so she would always ask for help. She said the resident would often resist getting up and transferring, but before the fall did bear some weight.

On 10/26/20 at 2:45 PM, Staff I again stated that when she entered the room to answer the call light, the resident already sat on the toilet and she went to get the nurse. In her Incident Witness Statement dated 3/20/20 at 7:30 AM Staff I stated that the resident was on the floor when she came into the room.

On 10/26/20 at 2:40, Staff C reported she prepared a disciplinary action report for Staff I and Staff J because they both picked up the resident before a nurse assessed the resident for injuries.

According to the Employee Counseling/Disciplinary report, Staff J and Staff I received a written warning directing them to not pick up a resident after a fall and to wait for a nurse to assess the resident for injuries. Staff J

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F 684	Continued From page 6 signed she received the disciplinary report on 3/21/20, and Staff I received hers on 3/20/20. On 10/21/20 at 2:00 PM, Staff B the Assistant Director of Nursing (ADON) stated upon hire, CNAs are asked the question: what would you do if a resident falls? She said that if the CNA answered they would try to get the resident up, they would receive immediate correction and educate them to not move the resident until a nurse assesses the resident for injuries. On 10/20/20 at 1:45 PM, Staff C stated the facility educated staff education soon after the incident with Resident #2 in which they directed staff to wait for a nurse to assess after a resident fall. On 10/27/20 at 12:55 PM, Resident #2's physician stated it was not wise to move the resident after the fall but he did not believe moving the resident caused further injury. He said the movement would have caused the resident substantial pain but in his opinion, it probably did not change the outcome or follow up treatment needs.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

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F 689	Continued From page 7 Based on record review and staff interviews, the facility failed to provide adequate supervision to ensure resident safety with the use of mechanical lift for transferring for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 30 residents. Findings include: A Minimum Data Set (MDS) dated 1/21/20 assessed Resident #1 with a Brief Interview for Mental Status (BIMS) score of 8 (moderate cognitive impairment). The MDS documented the resident required extensive assistance with the help of two staff for bed mobility, transfers dressing and toileting. According to the MDS the resident had diagnosis that included: type 2 diabetes mellitus, diabetic retinopathy with macular edema, chronic obstructive pulmonary disease, and muscle weakness. A care plan updated on 11/12/19 identified Resident #1 with impaired mobility, a history of falls and an unsteady gait. The care plan directed staff to transfer the resident with a sit-to-stand lift with assistance of 2 staff. After 1/23/20 a care plan revision identified the resident used the Hoyer lift for all transfers. A Resident Incident Report dated 1/23/20 at 2:31 PM, revealed staff summoned Staff C, LPN (licensed practical nurse) to Resident #1's room because the resident fell. On 10/20/20 at 1:10, Staff C said when she entered the room she observed the resident still attached to the sit-to-stand mechanical lift. The resident held onto the sling that remained hooked up to the lift. The sling was fastened around the resident's chest and her feet were on the platform with the	F 689	Past noncompliance: no plan of correction required.	

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lower legs strapped to the machine. Staff C stated the resident wore gripper socks and no shoes but she could not remember if the resident was dangling or if her bottom rested on the floor. Staff C said the resident hollered with pain.

Staff C stated she moved the lift away from the bed and the brakes were not engaged. She stated she assisted staff to lower the resident enough to unhook the sling and they left the resident on the floor until the ambulance arrived. She said they took the resident's vitals while she laid on the floor, checked that her arms and legs were moving and another nurse came in and did the neurological assessment.

Staff C stated that Staff F, CNA (certified nurse aide), told her she hooked the resident up to the sit-to-stand and when she stepped out into the hallway to holler for help, the resident slid off of the bed. The resident complained of pain in her back and her right knee, and transferred to the hospital for examination.

On 10/22/20 at 11:30 AM, Staff B ADON (assistant director of nursing), remembered the incident occurred at the end of the day shift and she was asked for help with Resident #1. When she entered the room, the resident was holding onto the sling and her bottom touched the floor. She said the resident's feet rested on the platform of the mechanical lift and she yelled in pain. Staff B said that they did not get her off the floor. Staff left the resident lay there until paramedics arrived. Staff B stated they used a Hoyer lift to get her off the floor and onto a cot with the help of the paramedics. She remembered the resident seemed anxious and kept saying that it was her fault.

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On 10/21/20 at 10:30 AM Staff F, CNA initially said she couldn't remember anything about the circumstances that led up to the fall. After further consideration, she stated she did remember hooking the sling to the mechanical lift and around the resident, and that she followed procedure. She stated the resident sat on the side of her bed when she attached the sling and the resident slid off the bed onto the floor when her back was turned. Staff F did not remember if the breaks had been engaged when she turned away from the resident and stepped outside the door to call for help. Staff F remembered she didn't have her walkie-talkie with her at the time. When asked if it was procedure for just one person to hook the resident to the lift, she said that she probably should've had someone help with that step.

In a follow up interview on 10/26/20 at 10:40 AM, Staff F stated that she received education to not turn away from a resident when hooked up to a mechanical lift. She acknowledged when she stepped out into the hallway, she briefly turned her back on the resident. When asked why she did that, she stated she needed help and she forgot her walkie-talkie. She said she received a disciplinary action for not having her walkie-talkie and for stepping away from the resident. She acknowledged all staff are required to carry the walkie-talkies at all times and she could not remember why she didn't have hers that day.

Emergency Department (ED) physician documentation dated 1/23/20 revealed x-rays performed of the thoracic spine and knee. The ED documentation identified a new lumbar 1 compression fracture. The knee x-ray did not

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show fracture. The physician ordered the resident to return to the facility on bedrest with activity as tolerated. The resident should receive clear liquids for the 24 to 36 hours and increase as tolerated. The physician also ordered Bactrim DS (antibiotic) for a urinary tract infection twice a day and Tramadol 50 milligrams every 6 hours for pain. The resident returned to the facility on 1/23/20 at 5:30 PM.

The thoracic spine x-ray dated 1/23/20 identified a compression deformity near the thoracolumbar junction representing either a T12 or L1 fracture that appears new compared with lumbar spine films from 1/16/19.

A Major Injury Determination Form signed by the physician 1/24/20 at 9:00 AM, indicated that the injury sustained was not a major injury pursuant to 481 Iowa Administrative Code 50.7(1)(a)(3). The facility identified injuries of compression fractures to thoracic 12 and lumbar 1. The facility identified the circumstances causing the injury as: Resident hooked up to sit to stand and CNA went to check on help and the resident slid off the bed and landed on the floor.

On 10/20/20 at 1:10 PM Staff C stated after the incident with Resident #1, the facility provided staff education on always having two people with the sit to stand lift, even with the attaching of the sling and make sure the buckles are secure around the chest and on the legs, and never leave the resident unattended while attached to the mechanical lift.

On 10/22/20 at 12:55 PM Staff E, CNA said that if she needed help with a transfer she would always wait for another aide or nurse to arrive before

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attaching the sling to a mechanical lift. She said that other than the incident with Resident #1, she did not know of any time when staff left a resident alone in a lift. She said that if she were to have knowledge of that, she would go to the charge nurse on duty.

On 10/22/20 at 1:00 PM Staff L, CNA she said she always carried her walkie-talkie and called for assistance with lift transfers. She stated staff received education on use of lifts once a year in the skills competency. She said that other than the incident with Resident #1, she did not know of any situations where a resident was left alone while attached to the lift.

On 10/22/20 at 2:00 PM Staff G, CNA said that she received education on the importance of not leaving a resident when he/she is hooked up to a lift.

According to the operating manual for the sit to stand lift copyright 2014, staff were instructed to stay with the resident at all times when they are hooked up to the lift.

According to policy Safe Lifting and Movement of Residents, the facility would observe staff for competency in the use of mechanical lifts and observed periodically for adherence to policies and procedure regarding use of equipment and safe lifting techniques.

An employee counseling/disciplinary report dated 1/23/20 revealed Staff F received a written warning that contained the instruction to always carry the walkie-talkie while at work and to never leave a resident unattended in a lift.

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F 689	Continued From page 12 The facility corrected the "G" level deficiency by 1/28/20 after they retrained and educated all nursing staff and issued disciplinary action to the involved staff. This resulted in past noncompliance for the facility.	F 689		

Regency Park of Carroll Plan of Correction for survey exiting 10/27/2020

This serves as the credible allegation of compliance for Regency Park Nursing and Rehab Center of Carroll effective 11/20/2020. We assert that all correctives described on this plan of correction have been implemented. Regarding the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of actions. The staff of Regency Park Nursing and Rehab of Carroll is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit that Regency Park Nursing and Rehab of Carroll is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon resurvey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Regency Park Nursing and Rehab of Carroll has completed the following interventions as a result of the findings from survey exiting 10/27/2020. The facility will be in substantial compliance by 11/20/2020

F 658 SS=D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS-Regency Park Nursing and Rehabilitation Center of Carroll will ensure that each resident receives care and services that meet professional standards of quality. Staff M was re-educated during survey on October 19, 2020 regarding proper professional standards and use of gloves while instilling eye drops. All staff administering medications including eye drops were re-educated on October 19 and November 13, 2020 and will have proficiency testing completed. A copy of proficiency testing will be placed in the employee's personnel record. Random audits of medication pass will be completed by the DON (Director of Nursing) and/or ADON (Assistant Director of Nursing) to ensure ongoing compliance with infection control procedures and installation of eye drops per policy. Concerns identified will be reported and addressed in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 684 SS=D QUALITY OF CARE-Regency Park Nursing and Rehabilitation Center of Carroll will ensure that each resident receives care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents choices. Regency Park Nursing and Rehabilitation Center will ensure residents are assessed accordingly with appropriate intervention as needed. The direct care staff responsible for moving resident # 2 without an assessment by a nurse, following a fall were disciplined, and re-educated by the Director of Nursing on March 21, 2020. Direct care staff were re-educated by the Director of nursing on March 30, 2020 regarding the standard of practice in always having the nurse assess the resident prior to moving him/her. Residents will be re-assessed, and care planned to ensure the method and amount of assistance needed is accurate to prevent falls/injury. Proficiency testing of direct care staff will be completed by the DON/ADON observing transfers using a gait

belt and Hoyer lift to ensure safety. Education will also include that all falls warrant a full assessment by a nurse prior to moving the resident. Concerns identified will be addressed and reported in the facilities quality assurance compliance meetings for additional intervention as indicated.

F 689=G FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES- Determined to be past non-compliance no POC required.