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F 000	INITIAL COMMENTS Correction date 2-8-2021 On October 22 - December 3, 2020, a COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals in conjunction with the investigation of facility-reported incident # 93996-I and complaints # 93211-C, # 94129-C, # 93600-C, #93805-C, # 93959-C, # 94079-C, # 94417-C, and # 94427-C. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 89 Facility-reported incident # 93996-I and complaints # 93211-C and # 94129-C were substantiated. Complaints # 93600-C, #93805-C, # 93959-C, # 94079-C, # 94417-C, and # 94427-C were not substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, facility staff failed to provide routine oral care for one of five residents	F 677		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammy Burhoe LNHA — TITLE: Administrator — (X6) DATE: 2/18/2021 02/10/2021

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 677	Continued From page 1 reviewed for grooming and hygiene assistance (Resident #2). The facility identified a census of 89 current residents. Findings include: According to the Minimum Data Set (MDS) assessment of 8/10/20, Resident #2 had diagnoses that included end stage renal disease, diabetes mellitus, cerebrovascular accident, hemiplegia, traumatic brain injury, seizure disorder and cellulitis. The assessment documented Resident #2 possessed severe cognitive impairment. The resident required the assistance of one staff to meet his personal hygiene needs. The resident's Care Plan dated 8/6/20 documented he needed extensive assistance with personal hygiene. Observation on 11/2/20 at 11 am revealed Resident #2 lay in bed with dry lips and mouth. The observation revealed no oral care supplies on tables or counters for the resident's use. At 11:20 am, Staff A, LPN (Licensed Practical Nurse) completed wound and tracheotomy care for Resident #2 and did not provide oral care before leaving the resident's room. On 11/3/20 at 10 a.m., observation revealed Resident #2 laid on his left side in bed and his lips and tongue were dry and crusted. A clear chest in his room stored mouth swabs, all sealed and unused. No mouth swabs, water source or other forms of oral care were on counter or table surfaces for his use and his trash cans contained no swab wrappers indicating past use.	F 677		

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F 677	Continued From page 2 On 11/4/20 at 11:50 am, Resident #2 laid on his back in bed. His lips and tongue contained dried skin and scales on his tongue. Continued observation revealed no mouth swabs, water source or other forms of oral care on counter or table surfaces for his use and trash cans contained no swab wrappers indicating past use. The clear chest in his room continued to store sealed mouth swabs. On 11/5/20 at 10 am, Resident #2 laid on his back in bed. His lips and tongue contained dried skin and his tongue contained a larger area of scaling than observed on 11/4/20. Continued observation revealed no mouth swabs, water source or other forms of oral care on counter or table surfaces for his use and trash cans contained no swab wrappers indicating past use. The clear chest in his room continued to store sealed mouth swabs. During interview on 11/5/20 at 12 pm, the 4th Floor Unit Manager stated there would be no way Resident #2 could do oral care himself as he was fully dependent on staff for all cares.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

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necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility policy review and staff and primary care provider interviews, the facility failed to ensure two residents (#2 and #8) did not receive facility-acquired pressure ulcers. In addition, Resident #8 did not receive assessment and measurement of an ulcer when it was first discovered. The facility identified a census of 89 current residents and five residents were reviewed for pressure ulcer prevention and care.

Findings include:

The MDS (Minimum Data Set) assessment tool identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

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F 686	Continued From page 4 Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: Inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. According to the MDS dated 1/22/20, Resident #2 had diagnoses that included traumatic brain injury, stage 3 kidney disease, diabetes mellitus, aphasia, hemiplegia, seizure disorder and cellulitis. The assessment documented Resident #2 possessed severely impaired cognitive skills for daily decision-making. The MDS documented he had one unhealed pressure ulcer and the risk of developing further pressure ulcers. Staff documented his pressure ulcer as unstageable. Resident #2's Care Plan, initiated on 8/6/20, documented he had impaired skin integrity	F 686		

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related to incontinence, the inability to reposition himself, diabetes and peripheral vascular disease. The Care Plan documented his wounds were being followed by an ARNP (Advanced Registered Nurse Practitioner). The resident's clinical record showed Wound Treatment Plans documented by the Wound ARNP throughout 2020.

During a phone interview on 11/2/20 at 11:15 AM, the resident's Wound ARNP stated that in 3/20, when Resident #2 had his second toe removed, the first time she saw him afterwards, his dressing was tight. When they removed the dressing, new open areas appeared. The ARNP did not know if facility staff or hospital staff put the dressing on too tight. Also, with the open areas she saw in March, the open areas were located where the straps of a Prevalon (supportive) boot fell. She thought the straps of the boot could have caused the open areas. The ARNP tried to get the Prevalon boot discontinued but it kept re-appearing.

Review of the Treatment Administration Record of 3/20 revealed staff changed Resident #2's right foot dressing and covered the dressing with an ACE wrap every shift from 3/4 to 3/10/20.

The Wound Treatment Plan Note dated 3/4/20 documented Resident #2 underwent amputation of the second digit of his right foot at the hospital and just returned to the facility. The resident's surgeon managed the surgical site.

The Wound Treatment Plan note dated 3/11/20 documented several new areas of purple discoloration to the right foot that lined up with the straps on the Prevalon boot. The plan note

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documented the new areas were located as follows:
a. Lateral right foot, unstageable pressure ulcer, measuring 9.5 cm (centimeters) by 2.7 cm by 0.1, described as 5% stable eschar and 95% deep tissue injury.
b. Dorsal right foot, unstageable pressure ulcer, measuring 4.6 cm by 4.2 cm by 0.1 cm (3 linear areas.
c. Right foot hallus, PIP (proximal interphalangeal) joint, unstageable pressure ulcer, measuring 2 by 2 by 0.1 cm.
The note documented that all new deep tissue injury areas appeared to be secondary to the Prevalon boot. The distribution is linear and line up with straps of the boot. The ARNP ordered to discontinue the Prevalon boots.

The Wound Treatment Plan note dated 3/18/20 documented Resident #2 continued to require wound consultation. An Ankle Brachial Index test with arterial study completed the previous week showed some restriction in arterial blood flow and her wound inspection identified the etiology of his right foot ulcers as primarily related to pressure with a secondary cause as arterial.

The Wound Treatment Plan notes dated The Wound Treatment Plan note dated 3/25/20, 4/8/20 and 6/17/20 documented Resident #2 wore Prevalon boots during the ARNP's wound care visits. She documented removal of the boots from the resident's room on 4/8/20. The Wound Treatment Plan notes revealed the ARNP continued to see and treat Resident #2's wounds weekly with the most recent note dated 11/4/20.

During interview on 11/5/20 at 2:15, when asked the reason for placement of the Prevalon boot

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following it's order to be discontinued, the 4th floor Unit Manager (UM) stated stated that one night nurse kept putting the boot back on. The UM stated she talked to the staff member (Staff F) and told her of the resident's new open areas. Then the UM saw Resident #2 wear the boot again. The UM made a sign for the resident's room and talked to Staff F again when she saw the resident wearing the Prevalon boot; Staff F told the UM she forgot. The UM stated she finally removed the boot from the room and hid it.

During a phone interview on 11/16/20 at 7:48 am, Staff F, RN (Registered Nurse) recalled that Resident #2's Prevalon boot did cause skin issues, but orders for it's use went back and forth. Staff F did not recall any conversations with the UM regarding the Prevalon boot.

During an email dated 11/10/20 at 8:58 am, Resident #2's surgeon wrote that his only concern with the resident's wounds was that a dressing may have been applied too tightly causing development of wounds. Otherwise, the wound care had been appropriate.

The clinical protocol for Pressure Ulcers/Skin Breakdown, revised 4/18, instructed the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers and the physician would help identify causal or predisposing factors towards breakdown, clarify status of relevant medical issues and order pertinent wound treatments.

The facility provided an Independent Contractor Agreement for the Wound Care ARNP interviewed above to provide wound care and

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F 686	Continued From page 8 treatment for facility residents beginning 3/1/20. 2. Resident #8 entered the facility on 8/18/20, according to the Minimum Data Set (MDS) assessment of 8/22/20. The MDS documented he had diagnoses that included renal failure, diabetes mellitus, lumbar disc degeneration, muscle weakness, difficulty walking and high blood pressure. The MDS recorded he had moderate cognitive and memory impairment, as evidenced by a BIMS score of eight. Resident #8 required the assistance of one staff to move in bed, transfer, walk in his room, use the toilet and complete personal hygiene. The assessment identified a risk for pressure ulcer development and current moisture associated skin damage, with pressure relief to his bed and chair, application of creams and a turning schedule. Resident #8's hospital Discharge Summary dated 8/18/20 documented he entered the hospital on 8/11/20 after a prolonged stay in the lobby of his apartment building. Resident #8 informed hospital staff he went to the lobby in his electric wheelchair on 8/10/20 to watch the rain. The apartment had a power outage and the elevator did not work, so he could not return to his second floor apartment. After an overnight stay in the lobby, Resident #8 experienced incontinence and emergency medical services brought him to the hospital. The resident's Care Plan dated 8/18/20 identified his risk for impaired skin integrity and instructed staff to encourage him to frequently shift his weight, evaluate his skin integrity, to monitor for moisture and apply a barrier product as needed. The 8/20 Treatment Administration Record (TAR)	F 686		

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recorded staff applied Zinc Oxide paste to the resident's buttocks twice a day. His first documented skin assessment dated 8/18/20 at 3 pm documented he had intact skin.

A Progress Note dated 8/25/20 at 4:36 am documented Resident #8 had a superficial open area on his right buttock. The nurse, Staff G RN, cleansed the wound, patted it dry and applied his treatment: Zinc Oxide paste according to the 8/20 Treatment Administration Record (TAR). The TAR also documented twice a day skin checks beginning 8/18/20.

A Progress Note dated 8/28/20 at 12:33 pm documented Resident #8 had an unstageable area to his coccyx and the former wound nurse (author, Staff H, RN) was not notified. Staff H recorded an air mattress on order and starting the resident on weekly rounds. The note did not contain measurement or other description or assessment of the unstageable area.

A Progress Note dated 9/9/20 at 9:45 am documented the Wound care ARNP as unable to see Resident #8 as the paperwork and signed consent had not been received. The resident discharged from the facility on 9/9/20.

The resident's Care Plan contained no updated interventions following development of the open area on 8/18/20, the superficial area on 8/25/20 and unstageable area on 8/28/20.

A Weekly Wound Assessment form dated 9/2/20 at 1:30 pm and authored by Staff H documented Resident #8 had an unstageable pressure wound to and a his coccyx that measured 10 cm in length and 13.8 cm in width, with a 0.1

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unstageable depth, described as eschar. Staff documented the goal to keep the wound from opening and heal while closed, keep him off his back, encourage him to get out of bed and order of a pressure relief mattress. The assessment form documented notification to the resident's provider.

Resident #8's TAR of 8/20 documented staff staff placed Duoderm (a protective dressing) to his coccyx and the TAR of 9/20 documented removal on 9/1/20. A Verbal physician's order dated 9/2/20 at 1:38 pm instructed to apply a Mediderm border sacral dressing and change it every three days and prn. The 9/20 TAR documented the order as discontinued on 9/2/20. Duoderm at 8:32 am (a provider order could not be found for application). A Verbal physician's order dated 9/2/20 at 1:38 pm instructed to cleanse the resident's wound with a cleanser of choice, apply No Sting Skin Prep and a self-adhering foam dressing and change all every three days and prn. The 9/20 TAR documented staff implemented the dressing change on 9/3/20 at 8 am. On 9/2/20, the TAR recorded placement of a pressure relieving mattress on the resident's bed and directed to reposition Resident #8 side to side every two hours, to not position him on his back and to encourage him to get out of bed twice during the day (the MDS of 8/22/20 recorded Resident #8 received a turning schedule since on or before that date).

During a phone interview on 11/4/20 Staff H stated with regards to her Progress note of 8/28/20, she learned of Resident #8's coccyx wound on that date; it was black and started fairly small. Regarding assessment of wounds and Wound clinic referrals, Staff H stated she learned

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F 686	Continued From page 11 about resident wounds from any staff and thought the shower aide told her about his. Staff H then measured the wound, obtained treatment orders, and made a referral to the wound clinic. She remembered the Third Floor Unit Manager told her she would refer Resident #8 to the Wound clinic sometime between 9/2/20 and 9/9/20, but thought the 9/2/20 referral may have been missed. During a telephone interview on 11/5/20 at 7:40 am, Staff G stated she did not remember Resident #8 specifically but if she discovered an open area, she would pass the information to the oncoming shift, leave a note in the doctor's box to be seen and send a facsimile for treatment orders. If Staff H was not scheduled, she'd tell her in person. Staff G concluded that she would not have assessed the resident's wound upon discovery; Staff H assessed resident wounds then. On 11/5/20 at 11:47 pm, the Third floor Unit Manager stated after the 8/25/20 discovery of an open area, Resident #8 should have been added to hot charting related to the wound. Facility expectations include an assessment of a wound when it is first discovered. The Unit Manager denied referring Resident #8 to the Wound Clinic and referral would have come from the Staff H. The resident's air mattress overlay was placed on 8/26 (Progress Notes documented the air mattress ordered on 8/28/20 and the 9/20 TAR documented placement on 9/2/20). The Unit Manager provided shift-to-shift report sheets documenting an open area to Resident #8's buttocks beginning 8/25/20 and a pressure sore to his bottom beginning 8/29/20.	F 686		

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F 686	Continued From page 12 During interview on 11/5/20 at 12:30 pm, the Director of Nursing (DON) stated that upon discovery of a wound, staff are expected to notify the wound nurse and the physician for treatment orders. The DON would have expected wound measurements on 8/25 and 8/28/20. She did not think Resident #8 had a complicated wound on 8/25/20, so a Wound clinic referral would not have been done. By 9/2/20, Resident #8's wound appeared more complicated and should have been referred to the Wound clinic. The DON conducted resident wound assessments at present, Staff H left facility employment on 9/10/20.	F 686		
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: Based on clinical record review, observation, resident, staff and primary care provider interviews and review of staff training records and job descriptions, facility staff failed to provide a safe transfer for one of five residents reviewed for nursing supervision (Resident #3). The facility identified a census of 89 current residents. Findings include: According to the Minimum Data Set (MDS)	F 689		

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	165272	A. BUILDING _____ B. WING _____	C 12/03/2020

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UNIVERSITY PARK NURSING & REHABILITATION CENTER	233 UNIVERSITY AVENUE DES MOINES, IA 50314

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assessment dated 8/3/20, Resident #3 had diagnoses that included anxiety, post traumatic stress disorder, morbid obesity, lack of coordination, right knee pain and chronic lung disease. The assessment documented she had intact memory and cognitive skills, as evidenced by a brief interview for mental status score of 14. Resident #3 required the assistance of two staff during transfers and did not walk. She did not experience pain during the assessment period and had a scheduled pain medication regimen.

Resident #3's Care Plan, updated 7/30/20, identified Resident #3 as nonambulatory. The Care Plan instructed staff to transfer her with the assistance of two, using a 3 XL full body Hoyer sling, not the criss-cross style sling. The Care Plan also identified she had extensive chronic pain instructed to provide her medications as ordered.

The Order Summary Report dated 11/17/20 recorded Resident #3 received oxycodone 5 milligrams (mg) three times a day for chronic pain and gabapentin 400 mg three times a day for polyneuropathy, both medications beginning 2/29/20 .

The Fall Report dated 9/27/20 at 8:31 am documented Staff A, LPN (Licensed Practical Nurse) was summoned to Resident #3's room and observed the resident sitting on the floor with a CNA (certified nursing assistant) holding her in a sitting position. Staff A documented Resident #3's leg as internally rotated. While waiting for a return call from the resident's physician, Staff A interviewed the CNA's and learned the resident fell out of the sling to the floor as the leg straps of the lift sling were not crossed between the

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resident's thighs. When asked by Staff A of any pain, the resident was unable to give a definite description. Staff A documented after receiving orders for portable X-Ray, she assisted the CNA's to transfer Resident #3 from the floor to bed using the Hoyer lift and during the transfer, she taught the staff to properly position and secure the sling during a Hoyer transfer. Staff A noted Resident #3's ROM (range of motion) as in defined limits and she moved all extremities.

The X-Rays of Resident #3's right hip with pelvis on 9/27/20 revealed the impression as limited by body habitus with artifact (degraded imagery) on the right hip films. The X-Ray contained no evidence of a displaced fracture, no joint dislocation and her pubic rami appear intact.

Review of the resident's Progress Notes dated 9/27 - 10/6/20 revealed continued assessment following the fall. On 10/5/20 at 1:23 am documented Resident #3 complained of right knee pain and the area appeared swollen. Staff noted no increased warmth or discoloration, the resident reported the knee as painful to touch and she could not move it due to the pain. Resident #3 denied bumping the knee or any other trauma to the area. Staff sent a fax to her physician to report the change.

An X-Ray of Resident #3's right knee on 10/6/20 revealed a comminuted distal femoral fracture with fracture lines extended over a length of 10 cm (centimeters), surrounding soft tissue swelling and degenerative changes about the knee. The facility reported the incident to the Department of Inspections and Appeals on 10/6/20 and it's investigation documented Staff B and Staff C, Hospitality Aides as present during Resident #3's

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F 689	Continued From page 15 fall on 9/27/20. A Major Injury Determination Form signed by the resident's primary care provider on 10/7/20 documented Resident #3 did not sustain a major injury and would return to her previous functional status. During interview on 10/26/20 at 1:30 pm, Resident #3 stated that on 9/27/20, staff moved her with a lift. One staff put her in a sling and another staff cranked it up. They told her not to move during the transfer. Resident #3 stated she held on to the lift, told the staff she felt herself slipping, who then told her she would not fall. Resident #3 felt like she was falling and then did, landing on her hip. She experienced pain but could not state specifically where, and her leg went behind her. Resident #3 stated she would not have any other fall or incidents that could have caused injury. During interview at the facility on 10/26/20 at 2:41 pm, Staff A stated on 9/27/20, staff got Resident #3 up with a Hoyer lift. As Staff A passed medications, one of the staff reported Resident #3 fell. When Staff A entered the room, one of the staff held the resident's head and the resident sat on her right knee. Staff A observed the side straps of the sling were not criss-crossed and did a demonstration with both staff right after the fall. Staff A stated that both staff were new and said they did not know the straps needed to be crossed. During a phone interview on 10/26/20 at 4 pm, Staff B stated on 9/27/20, she moved to a new floor (4th) and did not know Resident #3 well. Staff B got a medium amputee sling and recalled	F 689		

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telling Staff A the sling looked wrong, who asked her to do what's needed to get the resident up. Staff B stated she was pretty new. Staff B and Staff C transferred the resident. Staff B stated she held sling and kept close to the resident during the transfer. Staff C moved, bumped the lift and Resident #3 fell. Staff B stated she slowed the resident's fall. feet first towards the floor and the resident's leg folded under her. Staff B stated she learned later the sling straps should have been criss-crossed and also where other lifts slings are stored. Staff B stated she worked eight hours a day since mid August, using a Hoyer lift at least seven times a day. Staff B stated her trainer taught Hoyer transfers using a full lift sling and she had never worked with an amputee Hoyer sling prior to 9/27/20.

During a phone interview on 10/26/20 at 6:36 pm, Staff C remembered 9/27/20 as a busy day. Staff C stated Staff B went to get the Hoyer sling and they worked together to place the sling under the resident, get her up and move her. Staff C stated the resident's wheelchair needed to be moved to seat the resident, so she had to turn it. As she turned the resident's wheelchair, Resident #3 slipped out of the sling. When the resident slipped, Staff B held on to the resident's sling to guide it to the wheelchair but Resident #3 never made it to the wheelchair. The resident landed with her legs bent under her buttocks. Staff C stated she had just completed training, had watched Hoyer lift transfers and she worked the lift controls. She did not remember Staff B mention concerns with the lift sling. Staff C stated she did not think either she or Staff B knew there was a difference between the types of lift slings.

During additional interview on 10/27/20 at 1:10

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pm, Staff A stated she did not remember talking with Staff B about any concerns with the appearance of the sling on 9/27/20.

Staff B's CNA Orientation Checklist dated 9/5/20 revealed she oriented to her position on 9/5 and 9/6/20 with the assistance of Staff D, CNA. Staff C's CNA Orientation Checklist dated 9/14/20 revealed she oriented to her position on 9/14/20 with the assistance of Staff E, CNA.
Both checklists documented the staff received training on the use of Hoyer lifts.

During a phone interview on 11/5/20 at 3:30 pm, Staff D stated when she trained new staff on Hoyer lift use, she had new staff observe the first couple of days so they can see how it is done. The next two days, she had the new staff run the lift while she supervised. Staff D stated she oriented new staff only on the full body lift sling. Staff D stated she had never seen or used an amputee sling and did not know the facility had them. Staff D also stated she used the CNA Orientation Checklist to orient new staff and had not received further training instruction from nursing staff.

During a phone interview on 11/9/20 at 11:50 am, Staff E stated when she oriented new staff, she normally ran the lift with another experienced aide while new staff watched. When they were both comfortable, she would have the new staff work the lift with her. Staff E normally used a full body lift sling to orient, but would use an amputee sling if a resident required one. Staff E used the CNA Orientation Checklist to train from.

On 10/28/20 at 10:12 am, tour with the 3rd floor Unit Manager revealed two Hoyer lift slings stored

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F 689	Continued From page 18 In the third floor linen room, 16 lift slings stored in the facility laundry room and six lift slings stored in the fourth floor linen room. All sizes were available for resident use. On 10/29/20 at 12:10 pm, the Administrator stated the job description for a Hospitality Aide would be the same as the job description for a CNA. The undated Position Description for the facility's CNA's documented one essential function of the job would be to assist with lifting, positioning and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc., in keeping with specific resident safety needs. On 11/10/20 at 1:40 pm, the Director of Nursing (DON) stated that CNA's who train new staff use the CNA Orientation Checklist as a guide and they would validate the training CNAs had the skills to train others, like for transfers and incontinence care. During phone interview on 11/16/20 at 10:30 am, Resident #3's Advanced Registered Nurse Practitioner (ARNP) stated it's not uncommon to have no fracture seen on portable X-Rays only to have a fracture seen on hospital films and that happens all the time. The ARNP stated Resident #3 had no other diagnoses she knew of that contributed to the fracture and it was possible her routine pain medications masked her pain.	F 689		

University Park Plan of correction for survey ending 12/03/2020

This serves as the credible allegation of compliance for University Park Nursing and Rehabilitation Center. We assert that all correctives described in 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 University Park Nursing and Rehabilitation Center 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 University Park Nursing and Rehabilitation Center is in substantial compliance as set forth below. We are confident that we will be found in substantial compliance upon re-survey.

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. University Park Nursing and Rehabilitation Center has completed the following interventions as a result of the findings from survey exiting 12/3/2020. The facility was in substantial compliance as of 2/8/2021.

F 677 SS D ADL CARE PROVIDED FOR DEPENDENT RESIDENTS:

University Park Nursing and Rehabilitation Center will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident # 2 has received a specialized toothbrush as he/she often refuses oral care and bites, clamps down related to his/her disease process. Documentation of oral care and refusals will be documented on this residents TAR (Treatment Administration Record) Staff were re-educated as to the importance of completing oral care on residents as part of their daily ADL (Activities of Daily Living routine) by the Director of Nursing on 2/16/2021. Random audits of resident's oral hygiene will be completed by the Director of Nursing and Assistant Director of Nursing to ensure ongoing compliance. Concerns identified will be reported and addressed in the facilities quality assurance compliance meetings as indicated. The facility will be in substantial compliance regarding this deficiency on 2/16/2021.

F 686 SS G TREATMENT SERVICES TO PREVENT/HEAL PRESSURE ULCER:

University Park Nursing and Rehabilitation Center will ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident # 2 has had his/her Prevalon boot removed and discontinued. Resident # 8 has been discharged from the facility. The facility hired a wound

nurse on 11/2/2020 to assist with management of wounds. Weekly skin assessments are documented in PCC (Point Click Care-the facilities EMR system). Measurements of those residents with wounds are also located in Point Click Care. Residents with wounds have been audited to ensure all preventative measures are in place. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as directed.

F 689 SS G FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES:

University Park Nursing and Rehabilitation Center will ensure that the residents environment remains as free of accident hazards as possible. The facility will ensure safe transfers of residents. All amputee slings were removed from inventory during survey. Staff were re-educated by the Director of Nursing on 9/28/2020 regarding safe transfers of residents utilizing Hoyer lifts. Random Hoyer lift transfer audits will be completed by the DON/ADON to ensure ongoing safety in transfers. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated.

Jimmy Bradley, LNHA