STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165261	A. BUILDING _____ B. WING _____	09/28/2021

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F 000	INITIAL COMMENTS Correction Date 9.29.21 The following deficiency is related to the recertification survey and investigation of incident #92307-I completed September 20-28, 2021. Incident #92307 was substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Total residents: 53	F 000	On behalf of Mill Pond, I respectfully submit our Plan of Correction for your approval. This Plan of Correction should constitute our credible allegation of compliance and we trust you will find it adequate and acceptable. This Plan of Corrections is submitted as required under State and Federal Law. The submission of this Plan of Correction does not constitute an admission on the part of the Facility as to the accuracy of the surveyors' findings nor the conclusions drawn therefrom. The	
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 observation, clinical record review, and interviews, the facility failed to provide a safe method of transfer for one of four residents reviewed, (Resident #153.) The resident fell and sustained fractures of the bones in the left shoulder and right hip when staff failed to use a full mechanical lift. The facility reported a census of 53 residents. Findings include: 1. The Minimum Data Set (MDS) with	F 689	Facility's submission of this Plan of Correction does not constitute an admission on the part of the Facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Once facility identified care plan and facility protocol was not being followed, employee was put on administrative leave pending further investigation and subsequently resigned his position never again working in facility. The employee involved had completed and signed Resident Assistant competency training that included facility policy use of mechanical lifts, walkie talkie use, safe patient handling and vulnerable adult reporting upon hire. Hire date was 3/27/20. Also, upon hire, the employee completed Relias course Iowa Dependent Adult abuse	

training, dated 4/1/20.
Following incident, facility completed staff re-training on mechanical lift transfers, policy, procedure, and expectation of 2 staff members being present to complete a mechanical lift transfer. Staff re-trained on PHS Vulnerable Adult Policy. Resident interviews were conducted without concerns and per feedback denied any safety concerns during lift transfers. Audits were completed of lift transfers and no concerns were identified. Consistent practice and adherence to policy was present during all observations.

Facility standard training plan at time of hire includes Relias modules, orientation shifts alongside a team member until confident, competency class which includes a hands-on skills portion. Employee involved completed all portions of his onboarding training without concerns.

Facility determined this to be an isolated occurrence. Employee chose not to follow care plan and facility protocol despite proper training. On 6/22/20 The employee acknowledged he was properly trained and chose not to follow facility protocol. The employee also chose not to use his communication tool, his walkie talkie to call for assistance. Facility feels correction of incident was corrected as of 9/29/2021

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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 689	Continued From page 1 assessment date 6/11/20 revealed Resident #153 had a Brief Interview for Mental Status score of 11, which indicated of moderately impaired cognition. The resident required the extensive assistance of two staff for transfers, bed mobility and toilet use. A balance during transition and walking test identified the resident as not steady but able to stabilize with staff assistance when moving from surface to surface transfer such as from between chair and bed. The active diagnoses listed on the MDS included:Non-Alzheimer's Dementia and hemiplegia (paralysis of one side of the body). Review of the Care Plan, on 9/22/21, with revised date 6/11/20 revealed Resident #153 was dependent on two staff with use of a full mechanical lift and the extra-large sling for transfers. Review of the facility document Team Sheet for Spring Park Rooms 46-51 revealed Resident #153 required a full mechanical lift for all transfers. The Progress Note dated 6/20/20 at 1:36 am documented Staff A, Registered Nurse was calledto Resident #153's room and the resident was lying on the floor near the recliner. According to the CNA (Certified Nursing Assistant) Resident #153 slid down the recliner while being assisted. The resident was then transferred to bed with full mechanical lift, vital signs checked and recorded and no new injuries or bruises sustained. Resident #153 continued to be monitored. Intervention put into place was to keep dycem (non- slip material) in the recliner at all times. A Progress Note dated 6/21/20 at 5:30 am titled	F 689		

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F 689	Continued From page 2 Fall Follow Up revealed Resident #153 was assessed, no changes in range of motion and no new injuries or bruises seen. The resident did not complain of any pain during the shift. The Progress Note dated 6/21/21 at 9:27 am revealed trace edema noted to bilateral lower extremities. Legs elevated with pillow in bed at this time. Resident had complaint of left arm pain this am unable to rate and routine Tramadol given. The Progress Note dated 6/21/20 at 6:27 pm revealed the facility had received call from the resident's daughter and she requested Resident #153 be evaluated related to discomfort. Assessment done by Staff B, Registered Nurse, revealed extreme pain with any movement to right lower extremity. Slight shortening and rotation to the right hip noted and no bruising. Residnet #153 complained of discomfort to left shoulder. The Director of Nursing and On Call Provider was notified. Resident #153 transferred by ambulance to the emergency room. The Progress Note dated 6/21/20 at 11:20 pm revealed a call was placed to the emergency room for update on resident status. Resident #153 was admitted to the hospital with left shoulder fracture and right hip fracture. Review of the hospital Health Care form titled Results of X-ray of Hip reviewed on 9/22/21 with a service date of 6/21/20 revealed a displaced, comminuted (bone splintered) and angulated (distal fracture fragment is in relation to the proximal fragment) of the intertrochanteric (right hip).	F 689		

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F 689	Continued From page 3 Review of hospital Health Care form titled Results of X-ray of Shoulder reviewed on 9/22/21 with a service date of 6/21/20 revealed displaced left proximal humeral fracture, (fracture of upper arm bone). An Operative Note written on 6/22/20 at 2:38 pm revealed Resident #153 had a surgical procedure done which included inserted a nail/rod into the intramedullary (metal rod placed into a bone cavity) right femur. Review of Medication Administration record, on 9/22/21, dated 6/1/20-6/30/20 revealed Resident #153 received tramadol 50 mg (pain med) by mouth every 6 hours related to displaced fracture of right femur and unspecified fracture of upper end of left humerus with an ordered date of 6/26/20. Review of Medication Administration record, on 9/22/21, dated 7/1/20-7/31/20 revealed Resident #153 received tramadol 50 mg (pain med) by mouth every 6 hours related to displaced fracture of right femur and unspecified fracture of upper end of left humerus with an ordered date of 6/26/20. Discontinued date of 7/14/20. On 9/22/21 at 10:20 am Staff D, Registered Nurse stated she heard Staff C, CNA, from the North Hall called for help from Resident #153's room during rounds. Staff D saw Resident #153 on the floor just below the recliner and the male CNA was in the room. Stated no other staff members were present in the room when she entered. The nurse arrived and made the initial assessment and then lifted the resident with full mechanical lift into the bed. Staff D stated when she entered the room the mechanical lift was in	F 689		

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F 689	Continued From page 4 the cove and not in the resident's room. Staff D stated Resident #153 did not seem to be in pain when she was put back to bed. Stated Staff C had called for help over the radio twice when the resident had fallen. Stated she had not seen Staff C at work since this incident. On 9/22/21 at 11:20 AM Staff E, CNA Staffing Agency, stated she went into Res #153's room to assist when the resident was on the floor. Staff E stated that Staff C had never called for help with the lift transfer. Staff E stated she thought Staff C used the lift by himself. Staff E stated the nurse asked her if she helped with the lift transfer and she stated no she did not help, the male CNA never called her for help on the radio. Staff E stated the facility trained her on their lifts and even had to take a test related to the use of lifts. On 9/22/21 at 11:40 a.m. Staff A, RN, stated Resident #153's fall occurred around midnight and heard the CNA calling for help after he transferred the resident by himself. Staff A stated she had just been in Resident #153's room to help her reposition. Resident #153 had been asking for pain pill prior to fall. After the fall the charge nurse assessed Resident #153 with vital signs, neuro checks and range of motion. Staff A stated Resident #153 did not appear to be in pain,gave the pain med because she had asked for it prior to the fall. On 9/22/21 at 12:23 pm the Clinical Administratorstated she was notified of the fall that occurred with Resident #153 around midnight on 6/20/20. Clinical Administrator stated she received a text related to the fall. Clinical Administrator stated at the time of the fall they did not have concerns of injuries or anything out of the ordinary had	F 689		

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happened. She stated it was not until later the next day possible concern of fractures arose and then Resident #153 was sent to the emergency room. She stated she was never told the Care Plan might not have been followed and concerns never arose until her investigation when they questioned if the Care Plan was followed. She stated Staff C, CNA, initially was not forth coming and said he found her in the recliner in an awkward position and had complained of right hip pain. Staff C then told the Clinical Administrator that he tried to adjust the resident and she had slipped to the floor. Staff C then called the Clinical Administrator back the same day and admitted that he didn't want the resident to fall to the floor so he obtained the sit to stand lift to readjust Resident #153. Staff C admitted he placed the sling for the mechanical lift behind the resident and then she slipped out of the recliner. Staff C, CNA, carried a radio and did not call for help until after Resident #153 was on the floor. The Clinical Administrator stated Staff C, CNA, was trained on the mechanical lifts, slings and pause for the cause which is to double check that everything is hooked up right and that it takes two staff to utilize the lifts. The Clinical Administrator stated this training for Staff C had been done before he worked the floor. The Clinical Administrator stated after the incident he did not work again related to the investigation and he was placed on administrative leave.

During an interview on 9/22/21 at 3:31 PM Staff C, CNA, stated he took care of Resident #153 the night she fell. Staff C stated the fall occurred around midnight and the resident had stayed in her recliner late and then wanted to go to bed. Staff C stated he obtained the lift and strapped Resident #153 into the sling. Staff C stated he

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waited for the other staff to come help transfer but he got impatient. Staff C stated he started to raise Resident #153 up in the lift by himself and resident started sliding but she was still over the recliner. Staff C, CNA stated it was his fault that he started to pick her up in the lift and didn't wait for another staff person to help with the transfer. Staff C stated the facility had provided him training related to mechanical lifts and needed to have two people at all times even when just placing the sling. Staff C again stated it was all of his fault and for whatever reason that night he got impatient. Staff C admitted he did not call for help with the transfer over the radio. Staff C, CNA stated he got Resident #153 immediate attention when she started sliding.

On 9/23/21 at 12:18 pm Staff C, CNA was asked how he knew how to care for the residents. Staff C stated he got report from the off going staff every night when he came in and they would update him on residents with changes. Staff C verified he knew the resident was a full mechanical lift and he acknowledged there was a Care Plan to provide instruction and he did not follow it. Staff C, stated he grabbed the mechanical sit to stand lift that was right outside of her room. Staff C stated the slings for the lifts are color coded for sizes and used the extra-large one because the resident is bigger. Staff C stated he had used the full mechanical lift the other times like the Care Plan said but he had gotten in a hurry. Staff C acknowledged they had Care Plans they could carry with them but he did not have one that night.

During an interview on 9/23/21 at 12:27 pm the Clinical Administrator stated Staff C attempted touse the sit to stand lift on Resident #153. The

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F 689	Continued From page 7 Clinical Administrator stated she had a picture of Staff C (see exhibit A) with the Sit to Stand lift coming in and out of Resident #153's room. The Clinical Administrator verified a full mechanical lift should have been used per the Care Plan. The Clinical Administrator stated not sure which exact size sling he used, it was a Sit to Stand sling. Shestated the cubby where the lifts and slings are kept in the Spring Park hallway was very close tothe resident's room. The Clinical Administrator stated Resident #153 did not have a change in her activities of daily living status (ADL) when shereturned from the hospital after having a hip fracture repaired. She stated the resident was dependent on staff for her ADL's before she sustained fractures. She stated Resident #153 had a left shoulder fracture and a right hip fracture which required surgical intervention for the hip. She verified she had no change in transfer status, remained a mechanical lift. The Clinical Administrator stated she provided education to all of the nursing staff related to the use of mechanical lifts and following the Care Plans and education was completed by 6/23/20. On 9/27/21 at 8:27 am the Clinical Administratorstated she would expect the Care Plan to be followed. During record review on 9/28/21 of a facility provided form titled RA Skills Competency signed on 4/9/20 revealed Staff C had demonstrated skillcompetency in the use of mechanical lifts.	F 689		