

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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  Correction Date <u>4-26-2021</u>  The following deficiencies relate to a revisit of a COVID-19 Focused Infection Control Survey and 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 conducted in conjunction with the investigation of new facility reported incidents 96260-I, 96392-I, and 95558-I and new complaints 96355-C, 95510-C, 95066-C, 94688-C, and 96356-C, conducted on March 4 - April 1, 2021.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jammy Bushong* TITLE *Admin* (X6) DATE *4/23/21*

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.

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 550	<p>Continued From page 1 residents regardless of payment source.</p> <p><b>§483.10(b) Exercise of Rights.</b> The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p><b>§483.10(b)(1)</b> The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p><b>§483.10(b)(2)</b> The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, resident interview, and staff interview, the facility failed to treat residents respectfully for 2 of 9 residents reviewed for dignity (Residents #21 and #22). The facility reported a census of 85 residents.</p> <p>Findings include:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 2/5/21, listed diagnoses for Resident #21 that included cerebrovascular accident(stroke), difficulty walking, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene and bathing, and extensive assistance of 2 staff for bed mobility, transfers, dressing, eating, and toilet use. The MDS listed the resident's BIMS(Brief Interview for Mental Status)</p>	F 550			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 550	<p>Continued From page 2</p> <p>score as 15 out of 15, indicating intact cognition.</p> <p>Care plan entries, dated 6/29/21, stated the resident was dependent for meeting emotional and social needs and directed staff to converse with the resident while providing care.</p> <p>During an interview on 3/17/21 at 10:45 a.m., Resident #21 stated Staff K CNA (Certified Nursing Assistant) transferred her alone with the mechanical lift from the bathroom back to her bed. She stated Staff K was "rough" with the lift and she thought she was going to fall. She also stated Staff K was "rough" with her when assisting her with dressing. The resident stated she felt "scared" that she was going to fall during the transfer.</p> <p>2. The MDS assessment tool, dated 2/12/21, listed diagnoses for Resident #22 that included need for assistance with personal care, muscle weakness, and diabetes. The MDS stated the resident required extensive assistance of 1 staff for dressing, toilet use, personal hygiene, and bathing, and extensive assistance of 2 staff for bed mobility and transfers. The MDS documented the resident was frequently incontinent of urine and always incontinent of bowel. The MDS stated the resident did not refuse assistance with personal cares and listed the resident's BIMS score as 14 out of 15, indicating intact cognition.</p> <p>The untitled electronic health record report for ADL(Activities of Daily Living) assistance for Resident #22 documented Staff K assisted the resident with personal cares twice on the night shift on 3/11/21-3/12/21. The form did not indicate a refusal of care.</p>	F 550			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 550	<p>Continued From page 3</p> <p>Care plan entries, dated 8/19/20, stated the resident required staff assistance and cueing for personal hygiene. The care plan stated the resident was incontinent of bladder and directed staff to clean the resident's perineal area with each incontinent episode.</p> <p>Care plan entries, dated 8/25/20, stated the resident was dependent on staff for meeting their emotional and social needs and directed staff to converse with the resident while providing care.</p> <p>Nursing notes for the night shift on 3/11/21-3/12/21 lacked documentation that showed the resident refused cares.</p> <p>The facility policy "Quality of Life-Dignity", dated August 2009, directed staff would treat residents with dignity and respect at all times and stated staff would respond to the resident's request for assistance with toilet use.</p> <p>On 3/17/21 at 9:30 a.m., Resident #22 stated during the night shift on 3/11/21-3/12/21, Staff K CNA came into his room at 1:30 a.m. and changed his incontinent brief, but did not say anything to the resident prior to this. When finished, she did not give him a wipe or cleanse his perineal area. He stated she came in again at 3:00 a.m. and changed his brief. He asked her for a wipe and she gave him one and told him to wipe his own bottom. The resident stated Staff K did not assist him with perineal cares and stated in general Staff K had no "bedside manner". He stated if she wanted him to turn a certain way while changing his brief, she just pointed, she did not ask him to turn. The resident stated one of the times she came into his room, she woke him</p>	F 550		
-------	---	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 550	Continued From page 4 up from a sound sleep and his reaction was to take off his CPAP(Continuous Positive Airway Pressure) machine. He stated when he did this, the strap of the CPAP accidentally hit Staff K on the arm and she told him she was going to report him. He stated when Staff K would not help him he felt "upset".  On 3/23/21 at 8:33 a.m. Staff K CNA stated the last night she worked with the resident, he hit her in the face with his CPAP strap and she stated she reported this to Staff L LPN(Licensed Practical Nurse). She stated the resident refused cares and when he did that, she left him alone.  On 3/18/21 at 8:27 a.m., Staff L LPN stated no one reported anything to her with regard to any conflict between Resident #22 and Staff K.  On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated staff should assist Resident #22 with perineal cares as he wasn't able to do this himself.	F 550			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 607	<p>Continued From page 5</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:</p> <p>Based on personnel file review, policy review, and interview, the facility failed to ensure 3 of 6 new hires reviewed had background checks completed prior to hire(Staff U, Staff A, and Staff K). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The facility new hire list documented a hire date of 3/16/20 for Staff A CNA(Certified Nursing Assistant).</p> <p>Staff A's file contained 2 SINGs(Single Contact License and Background Check) completed on 9/14/16 and 6/19/19. Staff U's file lacked documentation of a SING completed after this date.</p> <p>2. The facility new hire list documented a hire date of 8/19/20 for Staff U CNA.</p> <p>The facility completed a SING for Staff U on 8/24/20. Staff U's file lacked documentation of a SING completed prior to this date.</p> <p>3. The facility new hire list documented a hire date of 10/14/20 for Staff K CNA.</p> <p>Staff K's file did not contain a SING.</p> <p>The facility policy "Abuse Prevention Program", revised December 2016, stated residents had the right to be free from abuse and neglect and stated the facility would conduct employee</p>	F 607		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 607	Continued From page 6 background checks.	F 607		
F 658 SS=D	<p>On 3/16/21 at approximately 2:00 p.m., the Administrator acknowledged the staff files did not contain additional background checks. She stated they would conduct audits on all employee files to ensure background checks were complete.</p> <p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to follow physician orders for 1 of 22 residents reviewed(Resident #11). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 2/19/21, listed diagnoses for Resident #11 that included cancer, heart failure, and kidney disease. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.</p> <p>A 2/22/21 Nursing Note stated the resident had a</p>	F 658		

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 658	Continued From page 7 ruptured blister and severe edema (swelling) to the lower right leg. The physician increased the resident's Lasix (a diuretic-rids the body of water).  The February 2021 TAR (Treatment Administration Record) listed a 2/22/21 order for a daily weight x 3 days.  The facility lacked documentation of a weight obtained on 2/23/21 and 2/24/21.  A 2/21/21 care plan entry stated the resident was on diuretic therapy due to edema.  The facility policy "Medication and Treatment Orders", revised July 2016, stated orders for medications and treatments would be consistent with principles of safe and effective order writing.  The facility policy "Weighing and Measuring the Resident", revised March 2011, stated a resident's weight provided a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident.  On 3/10/21 at 2:36 p.m., the 3rd floor ADON (Assistant Director of Nursing) stated the facility did not complete Resident #11's weights because she was in quarantine and they did not think she could come out of her room. The ADON added the facility did not have a mobile scale.	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	F 684			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 684	<p>Continued From page 8</p> <p>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:</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to assess and treat a resident's pain for 1 of 22 residents reviewed(Resident #16). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 2/11/21, listed diagnoses for Resident #16 included heart failure, cerebrovascular accident, and hemiplegia(one-sided paralysis). The MDS stated the resident required limited assistance of 2 staff for walking, extensive assistance of 1 staff for personal hygiene and bathing, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended completely on 1 staff for eating. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.</p> <p>A 2/5/21 nursing note stated the resident admitted to the facility and the skin to the buttocks and bilateral(both sides) groin was red with flaky skin.</p> <p>A 2/16/21 3:38 p.m. nursing note stated the resident complained of having a "sore butt" and staff turned the resident on his side. The notes contained no subsequent follow up assessment related to the resident's pain.</p>	F 684			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 684	<p>Continued From page 9</p> <p>A 2/18/21 3:00 p.m. nursing note stated the resident complained about pain on his bottom. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/20/21 6:16 p.m. nursing note stated the resident had vocal complaints of pain in the buttock rated as a 5. The note stated the resident reported the pain occurred multiple times per day and non-medication interventions did not provide relief. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/21/21 6:59 p.m. nursing note stated the resident had vocal complaints of pain in the buttock rated as a 5. The note stated the resident reported the pain occurred multiple times per day and non-medication interventions did not provide relief. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/22/21 9:13 p.m. nursing note stated the resident had pain in the bottom rated at 5/10. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/23/21 6:38 a.m. nursing note stated the resident had pain 6/10 in his legs and "bottom". The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/23/21 11:43 a.m. nursing note stated the resident complained of being sore to his bottom.</p> <p>A 2/24/21 12:34 p.m. nursing note stated the resident complained his bottom was sore. The</p>	F 684		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 684	<p>Continued From page 10</p> <p>notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/25/21 12:40 a.m. nursing note stated the resident had pain to the left leg, knee, buttock/coccyx rated at 5/10. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/25/21 10:43 a.m. nursing note stated the resident complained of severe pain in his coccyx wound area rated at 8/10. The note stated the facility obtained a wound culture "overnight" and it was currently at the lab.</p> <p>A 2/25/21 nursing note stated the facility received an order to transport the resident to the hospital.</p> <p>The resident's clinical record lacked documentation of physician notification of the resident's buttocks pain from 2/16/21-2/25/21 when the facility sent the resident to the hospital.</p> <p>The facility policy "Acute Condition Changes-Clinical Protocol", revised March 2018, stated staff would assess, document, and report baseline information such as pain and any recent changes in pain level. The policy stated the physician would help identify and authorize appropriate treatments.</p> <p>On 3/22/21 at 4:38 p.m., Staff M CNA(Certified Nursing Assistant) stated Resident #16 had a wound on his bottom, was in pain, and only got up for 1 meal. She stated the pain from sitting up was too much on his bottom. She stated he was "in a lot of pain".</p> <p>On 3/23/21 at 5:05 a.m., Staff H RN(Registered</p>	F 684		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 684	Continued From page 11 Nurse) stated Resident #16 had pain related to his bottom. She stated when she obtained the culture, the old dressing contained yellow green drainage.  On 3/23/21 at 9:33 a.m., Staff J LPN(Licensed Practical Nurse) stated Resident #16 was not comfortable and had pain daily.  On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated if a resident was having pain, she would want the nurses to call the doctor.  On 3/24/21 at 2:30 p.m., the DON stated she could not find anything related to physician notification of the resident's pain.	F 684			
F 686 SS=D	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 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, policy review, and staff interview, the facility failed to promptly follow orders related treatment and a wound	F 686			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 686	<p>Continued From page 12</p> <p>culture for 1 of 4 residents reviewed with a pressure ulcer(Resident #16). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 2/11/21, listed diagnoses for Resident #16 included heart failure, cerebrovascular accident, and hemiplegia(one-sided paralysis). The MDS stated the resident required limited assistance of 2 staff for walking, extensive assistance of 1 staff for personal hygiene and bathing, extensive assistance of 2 staff for bed mobility, transfers, dressing, and toilet use, and depended completely on 1 staff for eating. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.</p> <p>A 2/5/21 nursing note stated the resident admitted to the facility and the skin to the buttocks and bilateral(both sides) groin was red with flaky.</p> <p>The February 2021 TAR(Treatment Administration Record) documented a foam border dressing to the left and right buttocks started 2/10/21. The TAR lacked documentation of a dressing initiated from the resident's admission on 2/5/21 at 5:05 p.m. to 2/10/21.</p> <p>Facility Weekly Wound Assessments documented the following measurements to a Stage 2(partial thickness loss of skin presenting as a shallow open ulcer with a red pink wound bed) wound to the coccyx(tailbone)(length x width x depth in centimeters): 2/8/21 2.4 x 1.9 x 0.0 2/10/21 2.7 x 2.1 x 0.1</p>	F 686			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 686	<p>Continued From page 13</p> <p>2/17/21 2.6 x 1.4 x 0.0 2/22/21 2.9 x 2.0 x 0.0 2/24/21 2.6 x 1.8 x 0.7</p> <p>A 2/16/21 3:38 p.m. nursing note stated the resident complained of having a "sore butt" and staff turned the resident on his side.</p> <p>A 2/18/21 3:00 p.m. nursing note stated the resident complained about pain on his bottom.</p> <p>A 2/20/21 6:16 p.m. nursing note stated the resident had vocal complaints of pain in the buttock rated as a 5. The note stated the resident reported the pain occurred multiple times per day and non-medication interventions did not provide relief.</p> <p>A 2/21/21 6:59 p.m. nursing note stated the resident had vocal complaints of pain buttock rated as a 5. The note stated the resident reported the pain occurred multiple times per day and non-medication interventions did not provide relief.</p> <p>A 2/22/21 9:13 p.m. nursing note stated the resident had pain in the bottom rated at 5/10.</p> <p>A 2/23/21 6:38 a.m. nursing note stated the resident had pain rated at 6/10 in his legs and "bottom."</p> <p>A 2/23/21 11:43 a.m. nursing note stated the resident complained of a sore to his bottom.</p> <p>A 2/23/21 Wound Treatment Plan, authored by Staff I DNP(Doctor of Nursing Practice), stated staff reported the resident's wound was deteriorating in appearance and they noted an</p>	F 686			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 686	<p>Continued From page 14</p> <p>odor with dressing changes. The wound measurements were 2.6 x 1.8 x 0.7 with moderate-large serous exudate(drainage) with a strong odor. The plan directed the facility to obtain a culture with C &amp; S(Culture and Sensitivity-a test used to determine microorganisms present in the wound and which antibiotic was effective against the microorganism).</p> <p>A 2/24/21 12:34 p.m. nursing note stated the resident complained his bottom was sore. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A hospital laboratory requisition stated staff obtained the resident's wound culture on 2/25/21 at 12:01 a.m. The facility lacked documentation of prior attempts to obtain a wound culture between 2/23/21 and 2/25/21.</p> <p>A 2/25/21 12:40 a.m. nursing note stated the resident had pain to the left leg, knee, buttock/coccyx at 5/10. The notes contained no subsequent follow up assessment related to the resident's pain.</p> <p>A 2/25/21 10:43 a.m. nursing note stated the resident complained of severe pain in his coccyx wound area rated at 8/10. The note stated the facility obtained a wound culture "overnight" and it was currently at the lab.</p> <p>A 2/25/21 nursing note stated the facility received an order to transport the resident to the hospital.</p> <p>A 2/27/20 laboratory report stated the resident's wound contained moderate growth of Escherichia coli and Enterococcus species(types of bacteria).</p>	F 686		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 686	<p>Continued From page 15</p> <p>The facility policy "Pressure Ulcers/Skin Breakdown", revised April 2018, stated the physician would order pertinent wound treatments.</p> <p>The facility policy "Medication and Treatment Orders", revised July 2016, stated orders for medication and treatments would be consistent with principles of safe and effective order writing.</p> <p>On 3/22/21 at 4:38 p.m., Staff M CNA(Certified Nursing Assistant) stated Resident #16 had a wound on his bottom, was in pain, and only got up for 1 meal. She stated the pain from sitting up was too much on his bottom. She stated he was "in a lot of pain".</p> <p>On 3/23/21 at 5:05 a.m., Staff H RN(Registered Nurse) stated Resident #16 had pain related to his bottom. She stated when she obtained the culture, the old dressing contained yellow green drainage.</p> <p>On 3/23/21 at 9:33 a.m., Staff J LPN(Licensed Practical Nurse) stated Resident #16 was not comfortable and had pain daily.</p> <p>On 3/23/21 at 3:34 p.m., Staff I DNP(Doctor of Nursing Practice), CWS(Certified Wound Specialist) stated when she gave orders to the facility, they received them via fax and email the same day as her visit, by 6:00 p.m. She stated with regard to Resident #16, the most important piece was getting the culture done and stated she had wanted staff to obtain the wound culture that day. She stated if a resident came in with an area on the skin, the facility should notify the primary physician and initiate a treatment right</p>	F 686		
-------	---	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 688	Continued From page 16 away.  On 3/24/21 at 9:36 a.m., Staff C LPN, Facility Wound Nurse, stated if a resident had a skin issue the wound treatment should start that day. She stated if Staff I ordered something such as a wound culture, staff should obtain it as soon as they receive the orders. With regard to Resident #16's culture, she stated she didn't know why it took the nurses so long to complete this and stated she would have liked for it to be sooner than that.  On 3/24/21 at 2:14 p.m., Staff R Nurse Consultant stated she would want staff to complete a wound culture in 12-24 hours. She stated if there was a concern with a wound infection, staff could just take the dressing off and complete(the culture).  On 3/24/21 at 10:49 a.m., Staff C LPN stated she completed the treatment to Resident #16's bottom on the morning of 2/8/21 but it was not documented on the TAR.  On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated staff should complete wound cultures within 24 hours. She stated Resident #16's culture could have been done sooner in the day and didn't recall what happened that day and why staff had obtained it so late.	F 686			
F 689 SS=D	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	F 689			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 689	Continued From page 17  §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 staff interview, the facility failed to utilize a gait belt when transferring 2 of 2 residents requiring assist of 1 staff for transfers(Residents #4 and #18), failed to safely operate a mechanical lift for 1 of 6 residents reviewed for mechanical lifts(Resident #21), and failed to utilize foot pedals during wheelchair transport for 1 resident identified during general observations(Resident #18). The facility reported a census of 85 residents.  Findings:  1. The MDS(Minimum Data Set) assessment tool, dated 1/26/21, listed diagnoses for Resident #4 included hypertension, schizophrenia, and discitis(inflammation of the discs of the spine). The MDS stated the resident required supervision assistance of 1 staff for personal hygiene, extensive assistance of 1 staff for bed mobility, walking, dressing, and bathing, and extensive assistance of 2 staff for transfers and toilet use. The MDS stated the resident was not steady and only able to stabilize with staff assistance when moving from seated to standing, walking, turning around, moving on and off the toilet, and transferring between bed and chair or wheelchair. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 15 out of 15, indicating intact cognition.  During an observation on 3/8/21 at 12:21 p.m.,	F 689			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 689	<p>Continued From page 18</p> <p>the 3rd floor ADON(Assistant Director of Nursing) changed a dressing on the resident's buttock while the resident stood with his walker in front of his recliner. The resident did not wear a gait belt and the dressing change took several minutes. The ADON did not hold onto the resident throughout the dressing change and at times the resident began to shake.</p> <p>The care plan, reviewed 2/7/21, stated the resident had the potential for falls due to poor balance. The care plan stated the resident had a fall in his room and required assist of 1 staff for toilet use and transfers.</p> <p>2. The MDS assessment tool, dated 1/22/21, listed diagnoses for Resident #18 included diabetes, morbid obesity, and renal(kidney) disease. The MDS stated the resident required limited assistance of 1 staff for transfers and walking and extensive assistance of 1 staff for bed mobility, dressing, toilet use, personal hygiene and bathing. The MDS stated the resident was not steady and only able to stabilize with staff assistance when moving from seated to standing, walking, turning around, moving on and off the toilet and transferring between bed and chair or wheelchair. The MDS stated the resident had 1 fall without injury since the prior assessment and listed the resident's BIMS score as 9 out of 15, indicating moderately impaired cognition.</p> <p>During an observation on 3/16/21 at 12:05 p.m., Staff S RN(Registered Nurse) assisted Resident #18 to stand up from the bed and transfer to the wheelchair. Staff S did not utilize a gait belt. The resident did not appear steady and lightly hit the armrest of the wheelchair when sitting down.</p>	F 689			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 689	<p>Continued From page 19</p> <p>Staff S then pushed the resident in the wheelchair from his room to the dining room without foot pedals. She stated after doing this that she should have had pedals on but he usually pushed himself so he didn't have pedals.</p> <p>The care plan, reviewed 12/27/20, stated the resident required extensive assist of 1 staff with transfers and had experienced a fall with no injury due to poor balance.</p> <p>The undated facility policy "Use of Transfer Belt/Gait Belt", directed staff to utilize gait belts when transferring resident who required assistance with transfers.</p> <p>3. The MDS assessment tool, dated 2/5/21, listed diagnoses for Resident #21 that included cerebrovascular accident(stroke), difficulty walking, and muscle weakness. The MDS stated the resident required extensive assistance of 1 staff for personal hygiene and bathing, and extensive assistance of 2 staff for bed mobility, transfers, dressing, eating, and toilet use. The MDS listed the resident's BIMS score as 15 out of 15, indicating the resident demonstrated intact cognition.</p> <p>A 10/16/20 care plan entry documented the resident required assist of 2 staff and the mechanical lift EZ Stand for transfers.</p> <p>During an interview on 3/17/21 at 10:45 a.m., Resident #21 stated on the night shift on 3/11/21-3/12/21, Staff K CNA(Certified Nursing Assistant) transferred her with the EZ Stand mechanical lift alone with no other staff members around.</p>	F 689			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 689	<p>Continued From page 20</p> <p>On 3/23/21 at 8:33 a.m. Staff K stated the last night she worked with Resident #21(the night shift 3/11/21-3/12/21), Staff L LPN(Licensed Practical Nurse) assisted her in transferring the resident with the mechanical lift.</p> <p>On 3/18/21 at 8:27 a.m., Staff L LPN stated she did not assist Resident #21 transfer with the mechanical lift.</p> <p>On 3/18/21 at 11:24 a.m., Staff D LPN stated she did not assist in transferring Resident #21 in the mechanical lift.</p> <p>On 3/22/21 at 10:00 a.m., Staff N CNA stated she had not assisted in transferring Resident #21 with the mechanical lift since February 2021.</p> <p>On 3/23/21 at 5:05 a.m., Staff H RN stated she did not transfer Resident #21 with the mechanical lift with Staff K.</p> <p>On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated Resident #4 and #18 required the assistance of 1 staff for transfers and staff should utilize a gait belt. She stated staff should utilize foot pedals when pushing residents in a wheelchair.</p> <p>On 3/24/21 at 12:53 p.m., the DON stated 2 staff members should assist with mechanical lift transfers.</p> <p>During a phone interview on 3/31/21 at 8:54 a.m., the Administrator stated the facility did not have a policy specific to the EZ Stand or wheelchair foot pedals.</p>	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance	F 692			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 692	<p>Continued From page 21 CFR(s): 483.25(g)(1)-(3)</p> <p>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to weigh residents monthly as ordered, failed to notify the physician of a weight change for 1 of 3 residents reviewed that experienced a weight loss(Resident #20) and failed to follow the physician's nutritional feeding orders for 1 of 1 residents(Resident #2) reviewed with a g-tube(gastrostomy tube-a tube inserted into the stomach through the abdominal wall to provide liquid nutrition). The facility reported a census of 85 residents.</p> <p>Findings:</p>	F 692		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 692	<p>Continued From page 22</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 3/16/21, listed diagnoses for Resident #20 included diabetes, Alzheimer's disease, and vitamin deficiency. The MDS stated the resident required supervision and setup assistance with eating, set up assistance with personal hygiene, limited assistance of 1 staff for bed mobility, transfers, walking, dressing, and toilet use, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 14 out of 15, indicating intact cognition.</p> <p>A 10/26/20 physician's order directed the facility to obtain a full set of vitals and weights monthly for the resident.</p> <p>The resident's Weights and Vitals Summary for the period of 8/4/21-3/23/21 revealed the following weights(in lbs):</p> <p>6/16/20 158 7/16/20 156.4 8/4/20 147 8/11/20 146 8/24/20 146.6 9/1/20 146 10/1/20 146 11/11/20 149.8 12/1/20 138.1 2/3/21 139.8 3/1/21 132 3/18/21 132.2 3/19/21 133 3/20/21 97.0(struck through with the note, "incorrect documentation" dated 3/23/21 3/23/21 135</p> <p>A 12/17/20 Nutrition Assessment stated the</p>	F 692		
-------	--	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 692	<p>Continued From page 23</p> <p>resident had significant weight losses noted: 7.3% in 30 days and 12.2% in 180 days. The note stated the RD(Registered Dietician) requested a reweigh on 12/10/20, but this was not done due to the resident being in isolation. The RD requested a reweigh after the resident completed the isolation period.</p> <p>Clinical record review revealed no weight obtained from 12/1/20-2/3/21.</p> <p>A Weight Change Notification, dated 3/18/21, stated the resident had a 5.6% (significant) weight loss in the last 30 days, calculated from the resident's most recent weight on 3/1/21. The facility lacked physician notification of the weight loss during the period of 3/1/21 and 3/18/21.</p> <p>A 3/20/21 Weights and Vitals entry listed the resident's weight as 97 lbs, down 36 lbs from the previous weight. The facility lacked an recheck or follow up to this weight from 3/20/21-3/22/21, when asked about it.</p> <p>Care plan entries, revised 3/15/21, stated the resident had a significant weight loss x 1 and 6 months in December 2020 and a significant weigh loss x 1 month in March of 2021. A 3/18/21 care plan entry directed staff to weigh per facility protocol and notify the physician of significant weight changes.</p> <p>2. The MDS assessment tool, dated 11/23/20, listed diagnoses for Resident #2 that included diabetes, hemiplegia(one-sided paralysis), and schizophrenia. The MDS stated the resident depended completely on 1 staff for eating, and depended completely on 2 staff for bed mobility, transfers, dressing, toilet use, personal hygiene,</p>	F 692			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 692	<p>Continued From page 24 and bathing. The MDS listed the resident's cognition as severely impaired.</p> <p>A 2/12/21 order directed staff to administer Jevity 1.5(a type of liquid nutrition instilled via a g-tube) 60 ml(milliliters)/hour continuously.</p> <p>A 2/18/21 nursing note stated staff held the resident's insulin(used to lower blood sugar) due to a blood sugar of 74 mg/dl(milligrams/deciliter) and increased the rate of the resident's tube feeding to 90 ml/hour.</p> <p>A 2/23/21 nursing note stated the resident's blood sugar was 86 mg/dl and the nurse increased the rate of the resident's tube feeding to 90 ml/hour until the resident's blood sugar reached 100 mg/dl.</p> <p>A 2/24/21 nursing note stated the rate of the resident's tube feeding continued at 90 ml/hour related to blood sugar less than 100 mg/dl.</p> <p>A 2/25/21 Nutrition Assessment stated when the resident readmitted to the facility a clarification was needed with regard to staff increasing the tube feeding to 90 ml/hr due to low glucose(blood sugar) levels. The note stated this may not be the most appropriate intervention for these instances.</p> <p>A 2/25/21 Nutrition Assessment note stated the last time the RD assessed the resident he did not have an order to increase the tube feeding to 90 ml/hr and stated the resident's tube feeding was already providing excess calories and providing even more may exacerbate his already impaired renal(kidney) system.</p>	F 692		
-------	---	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 692	<p>Continued From page 25</p> <p>Care plan entries, dated 8/8/20, stated the resident received tube feedings and would have no complications through the review date.</p> <p>The facility policy "Medication and Treatment Orders", revised July 2016, stated orders for medications and treatments would be consistent with principles of safe and effective order writing.</p> <p>The facility policy "Weight Assessment and Intervention", revised September 2008, stated the facility would weigh each resident monthly and staff would reweigh a resident who had a any change of 5% or more. The policy stated that a 5% loss in 1 month was significant and the physician would identify conditions and medications that caused the weight loss.</p> <p>On 3/23/21 at 5:05 a.m., Staff H RN(Registered Nurse) stated Resident's #2's tube feeding rate may have been set at more than 60 if his blood sugars were low.</p> <p>On 3/23/21 at 9:09 a.m., Staff R Nurse Consultant stated she could not locate an order for 90 ml/hr for the resident's tube feeding.</p> <p>On 3/23/21 at 11:41 a.m., the 3rd floor ADON(Assistant Director of Nursing) stated they reweighed Resident #20 today and he was 135 lbs.</p> <p>On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated Resident #20 should have had a weight completed between December 2020 and February 2021. She stated it would be important to get that weight and she would want the physician notified of a weight loss of 5% in 1 month.</p>	F 692			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 726 SS=D	<p><b>Competent Nursing Staff</b> CFR(s): 483.35(a)(3)(4)(c)</p> <p><b>§483.35 Nursing Services</b> The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p><b>§483.35(a)(3)</b> The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p><b>§483.35(a)(4)</b> Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p><b>§483.35(c) Proficiency of nurse aides.</b> The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to ensure nurse aides demonstrated competency in skills for 3 of 5 temporary nurse aides reviewed(Staff P, Staff Q, and Staff T). The facility reported a census of 85</p>	F 726			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 726	<p>Continued From page 27 residents.</p> <p>Findings:</p> <p>1. The facility new hire list documented a hire date of 6/1/20 for Staff P and listed her position as Hospitality Aide, but the file lacked documentation to indicate Staff P was a CNA(Certified Nursing Assistant).</p> <p>A Temporary Nurse Aide certificate documented Staff P completed the course on 2/26/21 .</p> <p>Staff P's file lacked documentation she completed the course prior to 2/26/21 and did not contain documentation to show Staff P could demonstrate competency in skills and techniques necessary to care for residents.</p> <p>2. The facility new hire list documented a hire date of 1/7/21 for Staff Q and listed her position as Hospitality Aide, but the file lacked documentation Staff Q was a CNA.</p> <p>A Temporary Nurse Aide certificate documented Staff Q completed the course on 11/6/20.</p> <p>Staff Q's file lacked documentation Staff Q was able to demonstrate competency in skills and techniques necessary to care for residents.</p> <p>3. The facility new hire list documented a hire date of 4/7/20 for Staff T and listed her position as Certified Aide, but her file failed to contain information to indicate Staff T was a CNA.</p> <p>A 75-Hour Nurse Aide Training Program certificate documented Staff T completed the course on 4/3/20.</p>	F 726			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 726	Continued From page 28  A Temporary Nurse Aide certificate documented Staff T completed the course on 3/6/21.  Staff T's file lacked documentation Staff T was able to demonstrate competency in skills and techniques necessary to care for residents.  The facility policy "Nurse Aide Qualifications and Training Requirements", revised October 2017, stated the facility would not utilize any individual as a nurse aide unless the facility determined them competent.  On 3/16/21 at approximately 2:00 p.m., the Administrator verified she could not locate any competencies in the staff's files.  On 3/18/21 at 9:36 a.m., Staff P stated she was a Hospitality Aide and changed briefs, completed perineal cares, assisted residents to the bathroom and assisted CNAs with transfers.  On 3/18/21 at 9:40 a.m., Staff Q stated she could do all things a CNA would normally do such as perineal cares, changing incontinent briefs, and transferring residents. She stated she was "temporary" and signed up for the CNA test.	F 726			
F 729 SS=D	Nurse Aide Registry Verification, Retraining CFR(s): 483.35(d)(4)-(6)  §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program	F 729			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 729	<p>Continued From page 29</p> <p>approved by the State; or</p> <p>(ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>§483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual.</p> <p>§483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by:</p> <p>Based on employee personnel file review, policy review, and interview, the facility failed to obtain registry verification prior to hire for 2 of 2 newly hired CNAs(Certified Nursing Assistants)(Staff A and Staff U). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The facility new hire list documented a hire date of 3/16/20 for Staff A.</p>	F 729		

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 729	Continued From page 30  Staff As file contained a 6/19/19 SING(Single Contact License and Background Check) which stated Staff A was eligible as a Nurse Aide. Staff A's file did not contain a registry check dated upon hire.  2. The facility new hire list documented a hire date of 8/19/20 for Staff U.  Staff U's file contained an undated registry check which stated he was "active" as a CNA. Staff U's file contained no dated documentation stating when the facility checked the registry upon hire.  The facility policy "Registry of Nurse Aides" revised October 2017, stated the facility would contact the State Nurse Aide Registry to determine the validity of a nurse aide's certification status.  On 3/16/21 at approximately 2:00 p.m., the Administrator acknowledged the staff files did not include anything further indicating the date which the facility checked the CNA registry.	F 729			
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to ensure residents were free of significant medication errors for 3 of 22 residents reviewed for medications(Residents #4, #5, and #11), failed to	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 760	<p>Continued From page 31</p> <p>ensure residents received insulin within ordered blood sugar parameters for 1 of 4 residents reviewed for insulin administration(Resident #5), failed to ensure residents received insulin in a timely manner as ordered for 2 of 4 residents reviewed for insulin use(Residents #13 and #14), and failed to ensure a safe system of monitoring blood sugars by having night shift staff obtain blood sugars for the day shift. The following circumstances constituted an Immediate Jeopardy (IJ) to resident health and safety. The facility reported a census of 85 residents.</p> <p>Findings include:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 5/8/21, listed diagnoses for Resident #5 included heart failure, kidney disease, and diabetes. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfer, dressing, toilet use, and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 10 out of 15, indicating moderately impaired cognition.</p> <p>a. A 2/3/21 facility Medication Error Report stated a staff member administered another resident's medications to the resident during the morning medication pass. The facility transferred the resident to the ER and he stayed for 24 hour observation.</p> <p>A 2/3/21 11:06 a.m. nursing note stated Staff A CMA(Certified Medication Aide) reported she administered Resident #15's medications to Resident #5. The nurse called the physician and</p>	F 760		
-------	---	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>
--	--

(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 760	<p>Continued From page 32</p> <p>checked the resident's blood pressure. The nurse rechecked the blood sugar at 8:30 a.m. and it was 73/45 mm/hg(millimeters/mercury). The facility attempted to start an IV(intravenous line) and transferred the resident to the hospital.</p> <p>Review of Resident #15's MAR(Medication Administration Record) revealed the following morning medications(administered in error to Resident #5 on 2/3/21): Amlodipine(for high blood pressure) 10 mg(milligrams), Aspirin 81 mg, Duloxetine(an antidepressant) 30 mg, Esomeprazole(controls stomach acid) 40 mg, Fenofibrate(for high blood pressure) 48 mg, Garlic 10 mg, Levothyroxine(for thyroid disorder) 100 mcg(micrograms), Loratadine(for allergies) 10 mg, Multivitamin, Olmesartan(for blood pressure) 40 mg, Psyllium(for constipation) 1 packet, Spironolactone(for blood pressure) 25 mg, Vitamin C 500 mg, Vitamin D3 25 mcg, Advair(for breathing) 250-50 1 puff, Dicyclomine(for irritable bowel syndrome) 10 mg, Metformin (for diabetes) 500 mg, Sucralfate(for ulcers) 1 gram.</p> <p>A 2/4/21 hospital report stated the resident admitted to the hospital for hypotension(low blood pressure) secondary to a medication error. The note stated the incorrect medications the resident received were: Metformin 500 mg, Singulair(used to treat asthma) 10 mg, Olmesartan 40 mg, and Carafate 1 gram. The note stated the resident received 2 liters of fluid in the ER which improved his blood pressure and the hospital admitted him for observation overnight.</p> <p>A 2/4/21 nursing note stated the resident returned from the hospital.</p>	F 760		
-------	---	-------	--	--

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 33</p> <p>Resident #5's face sheet revealed the resident was a white or Caucasian male.</p> <p>Resident #15's face sheet revealed the resident was a black or African American female.</p> <p>On 3/10/21 at 9:22 a.m., Staff A CMA stated she normally worked on a different floor but the facility assigned her to pass medications on Resident #5's floor. She stated she prepared Resident #15's medications and went to the room which had Resident #15's name on the door. She stated she walked in and stated to the resident in the room "I have your medication (Resident #15's name)", and the resident stated "ok". The resident was a male. He then stated he didn't have an inhaler. Staff A then went to sign off the medications in the EHR(Electronic Health Record) and saw that the picture was of a woman. She stated she notified the nurse of the error. Later during breakfast, the resident's blood pressure was low. She stated she had not heard in report that the resident had changed rooms.</p> <p>During an interview on 3/10/21 at 9:30 a.m. Staff B RN(Registered Nurse) stated the CMA informed her she made an error(with Resident #5's medications) and she assessed the resident and called the physician. She stated when she rechecked the resident's blood pressure later it was low so they sent the resident to the hospital.</p> <p>b. A 2/5/21 facility Medication Error Report stated staff administered insulin when a blood sugar was less than 150 mg/dl(milligrams/deciliter).</p> <p>Review of the February 2021 TAR(Treatment Administration Record) listed an order for Insulin Gargine(a type of insulin-used to lower blood</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 34</p> <p>sugar in diabetics) 60 units at bedtime, hold if blood sugar less than 150. The TAR documented on 2/5/21 staff administered the insulin and the resident's blood sugar was 106 mg/dl. The TAR also listed an order for Insulin Aspart 10 units before meals, hold if blood sugar less than 150. The TAR documented staff administered the insulin with a blood sugar less than 150 mg/dl 27 times.</p> <p>A 3/3 Medication Error Report stated staff administered insulin when the resident's blood sugar was 72.</p> <p>The March TAR listed an order for Insulin Aspart 10 mg before meals, hold if blood sugar less than 150. The TAR indicated staff administered the insulin on 3/3/21 and the resident's blood sugar was 72 mg/dl.</p> <p>2/4/21 Care Plan entries stated the resident had diabetes and directed staff to administer diabetes medication as ordered by the physician.</p> <p>2. The MDS assessment tool, dated 2/19/21, listed diagnoses for Resident #11 that included cancer, heart failure, and kidney disease. The MDS revealed the resident required limited assistance of 1 staff for bed mobility, transfers, walking, dressing, toilet use, and personal hygiene, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>A Medication Error Report, dated 3/5/21, stated on 2/22/21 the physician ordered the resident's Furosemide(a diuretic-used to rid the body of fluid) to increase to 40 mg twice daily for 3 days then resume to 40 mg daily.</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 35</p> <p>The February 2021 MAR documented the resident received Furosemide twice daily from 2/22/21-2/25/21. The MAR lacked documentation to show the resident received any Furosemide from 2/26/21-2/28/21.</p> <p>The March 2021 MAR lacked documentation the resident received Furosemide from 3/1/21-3/5/21.</p> <p>The February 2021 TAR listed a 2/22/21 order for a daily weight x 3 days, but the facility could locate no documentation that showed staff obtained a weight on 2/23/21 and 2/24/21.</p> <p>An undated, untitled facility document which described the medication error related Resident #11 revealed on 3/5/21, the resident asked the medication aide why she was not getting her white pill anymore. The facility then reviewed the resident's chart and noticed a transcribing error from 2/22/21.</p> <p>A 2/21/21 care plan entry documented Resident #11 as on diuretic therapy due to edema(swelling).</p> <p>3. The MDS assessment tool, dated 1/26/21, listed diagnoses for Resident #4 included hypertension, schizophrenia, and discitis(inflammation of the discs of the spine). The MDS stated the resident required supervision assistance of 1 staff for personal hygiene, extensive assistance of 1 staff for bed mobility, walking, dressing, and bathing, and extensive assistance of 2 staff for transfers and toilet use. The MDS listed the resident's BIMS score as 15 out of 15, indicating an intact cognitive status.</p>	F 760		

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 36</p> <p>A 1/21/21 hospital Medication Discharge Report listed an order for Vancomycin(an antibiotic) 1.5 grams IV every 24 hours for 6 weeks, stop date 2/28/21. The order directed staff to remove the resident's PICC(Peripherally Inserted Central Catheter-a tube inserted into a vein, used for long-term intravenous antibiotics or other medications) line after the last dose of antibiotics.</p> <p>The January 2021 TAR listed an order for Vancomycin 1.5 grams daily until 2/28/21. The TAR indicated the resident received the medication from 1/23/21-1/27/21. The TAR lacked documentation the resident received the medication from 1/28/21-1/31/21.</p> <p>The February 2021 TAR listed an order for Vancomycin 1500 mg at bedtime. The TAR documented the resident did not receive the medication from 2/1/21-2/10/21.</p> <p>A 3/9/21 physician's progress note stated the resident was supposed to continue with his Vancomycin until 2/28/21 but this was stopped on 1/28/21 per the facility staff and the facility also removed the resident's PICC line. A PICC was placed on 2/10/21 and the resident resumed his Vancomycin for a total of 6 weeks from 2/10/21.</p> <p>The care plan, reviewed 2/7/21, identified the resident underwent IV antibiotic therapy to treat discitis.</p> <p>4. The MDS assessment tool, dated 1/26/21, listed diagnoses for Resident #13 that included diabetes, heart failure, and obesity. The MDS stated the resident required supervision</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 37</p> <p>assistance of 1 staff for transfers, walking, and toilet use, limited assistance of 1 staff for dressing, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.</p> <p>Care plan entries dated 1/8/21, documented the resident had diabetes and directed staff to monitor blood glucose.</p> <p>The March 2021 TAR listed an order for Lantus(a type of insulin) 30 units scheduled at 7:30 a.m. The TAR documented staff administered the insulin late on the following dates and times:</p> <p>a. 3/6/21 at 10:35 a.m. b. 3/7/21 at 9:46 a.m. c. 3/11/21 at 11:53 a.m. d. 3/13/21 at 10:59 a.m. e. 3/14/21 at 9:15 a.m. f. 3/21/21 at 10:10 a.m.</p> <p>The March 2021 TAR listed an order for Lantus 30 units scheduled at 7:30 p.m.. The TAR documented staff gave the insulin late on the following dates and times:</p> <p>a. 3/4/21 at 9:54 p.m. b. 3/5/21 at 10:38 p.m. c. 3/6/21 at 9:32 p.m. d. 3/7/21 on 3/8/21 at 12:45 a.m., e. 3/10/21 at 9:54 p.m. f. 3/11/21at 11:47 p.m. g. 3/12/21 at 10:00 p.m. h. 3/13/21 at 9:18 p.m. i. 3/14/21 at 10:37 p.m. j. 3/15/21 at 9:20 p.m. k. 3/18/21 at 9:42 p.m. l. 3/20/21 at d at 9:22 p.m.</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	Continued From page 38  5. The MDS assessment tool, dated 1/29/21, listed diagnoses for Resident #14 that included diabetes, kidney failure, and non-Alzheimer's dementia. The MDS stated the resident required limited assistance of 1 staff for bed mobility, transfers, dressing, toilet use and personal hygiene, and required extensive assistance of 2 staff for bathing. The MDS listed the resident's BIMS score as 6 out of 15, indicating severely impaired cognition.  The care plan, reviewed 2/7/21, stated the resident was insulin dependent and had the potential for hyper/hypo(high/low) blood sugars.  The February 2021 TAR listed an order for Levemir(a type of insulin) 10 units scheduled at 7:30 a.m. The TAR documented the insulin given late on the following dates and times:  a. 2/13/21 at 3:03 p.m. b. 2/14/21 at 11:35 a.m. c. 2/20/21 at 4:43 p.m. d. 2/21/21 at 3:18 p.m.  The February 2021 TAR listed an order for Novolog( a type of insulin) per sliding scale scheduled at 7:30 a.m. The TAR documented the insulin given late on the following dates and times: 2/14/21 documented as administered at 11:36 a.m., 2/27/21 documented as administered at 9:23 a.m.  The February 2021 TAR listed an order for Novolog( a type of insulin) per sliding scale scheduled at 7:00 p.m. The TAR documented the insulin given late on the following dates and	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 39 times:</p> <p>a. 2/12/21 on 2/13/21 at 12:41 a.m. b. 2/14/21 at 9:51 p.m. c. 2/15/21 on 2/16/21 at 12:02 a.m. d. 2/18/21 at 11:42 p.m. e. 2/20/21 on 2/21/21 at 12:33 a.m., f. 2/21/21 at 11:13 p.m. g. 2/26/21 11:32 p.m. h. 2/27/21 on 2/28/21 at 1:04 a.m. i. 2/28/21 at 10:59 p.m.</p> <p>6. An untitled facility posting, dated 3/4/21, stated effective immediately, night nurses and medication aides would no longer obtain blood sugars for the day shift nurses.</p> <p>The facility policy "Medication and Treatment Orders", revised July 2016, stated orders for medications and treatments would be consistent with principles of safe and effective order writing. The policy stated staff should immediately record all verbal orders in the resident's chart.</p> <p>The facility policy, "Insulin Administration", revised September 2014, stated the facility would verify the type of insulin, dosage requirements, strength, and method of administration prior to the administration of insulin to assure it corresponded with the order on the medication sheet and the physician's order. The policy directed staff to check blood glucose per physician order or facility protocol prior to the administration of insulin.</p> <p>The facility policy, "Administering Medications", revised December 2012, stated the individual administering the medication must check the label 3 times to verify the right resident, right</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 40</p> <p>medication, right dosage, right time, and right route prior to giving the medication.</p> <p>On 3/10/21 at 9:40 a.m., Staff C LPN(Licensed Practical Nurse) stated the night shift nurses obtained the blood sugars in the past but recently the day shift began to obtain them. With regard to Resident #11's medication error, she stated she took multiple orders from the physician over the phone. She stated she input an order to increase the resident's Lasix(Furosemide) for 3 days but forgot to put in the order to continue the maintenance dose after the resident completed the 3 days. She stated the facility now had a system to double check orders.</p> <p>On 3/10/21 at 10:52 a.m., Staff D LPN stated at times she worked with a medication aide who could not administer insulin. She stated the time period of 6:00 p.m. to 10:00 p.m. was busy and by the time she administered insulin, it was late, it was midnight.</p> <p>On 3/10/21 at 11:57 a.m., Staff E RN stated the night shift obtained blood sugars around 5:30-5:45 a.m. or close to 6:00 a.m. She stated the day nurses administered insulin when the breakfast trays arrived, usually around 7:30 a.m.-8:00 a.m. She stated the night shift reported the blood sugars to the day shift nurses and the day shift nurses input them into the electronic record.</p> <p>On 3/10/21 at 2:36 p.m., the 3rd floor ADON(Assistant Director of Nursing) stated if the nurse followed the "7 Rights" of medication administration, the error with Resident #5 would not have happened. She stated staff should change door name signs at the time a resident</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 41 changed rooms.</p> <p>On 3/10/21 at 3:11 p.m., Staff F LPN stated until recently, the day shift utilized the blood sugars the night shift obtained to administer the resident's insulin. She stated the night shift reported the blood sugars to the day shift and the day shift input them into the electronic record. She didn't know for sure but thought this recently changed because a resident received insulin when his blood sugar was too low. She stated when she was the only nurse with a med aide, there were times when residents had already eaten breakfast when she gave insulin.</p> <p>On 3/11/21 at 10:05 a.m., Staff G LPN stated in the past, the night shift nurses obtained the blood sugars and the day shift utilized those blood sugars. She stated on the day of the error she was involved in with Resident #5, the insulin parameters on the MAR were not clear. She stated on this day, the night shift nurse obtained the resident's blood sugar. She stated there were times when nurses did not give insulin until after breakfast.</p> <p>On 3/11/21 at 10:47 a.m., Staff B RN stated when the night shift obtained the blood sugars, they wrote them on a piece of paper and gave them to the day shift. She stated the day shift nurses then utilized those blood sugars to give the day shift insulin.</p> <p>On 3/11/21 at 11:39 a.m. the DON(Director of Nursing) stated she was not aware the night shift obtained the blood sugars and stated staff should obtain blood sugars closer to the time of insulin administration. She stated they couldn't utilize blood sugars obtained 3 hours earlier. She</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	<p>Continued From page 42</p> <p>stated if an order directed nurses to hold insulin for blood sugars under 150 mg/dl, they should hold the insulin.</p> <p>On 3/11/21 at approximately 12:00 p.m., the 3rd floor ADON stated she was not aware the night shift was obtaining blood sugars for sliding scale insulin and stated the person administering the insulin should obtain the blood sugar.</p> <p>On 3/11/21 at 12:22 p.m., the Administrator stated if the nurse looked at the picture in the electronic chart and followed the rights of medication administration, the mistake with Resident #5 should not have happened. She stated staff should not take blood sugars until after 7:30 a.m. and stated she was not aware the night shift obtained the blood sugars.</p> <p>On 3/24/21 at 12:53 P.M., the DON stated a staff member entered Resident #4's Vancomycin order incorrectly and this was the reason the facility stopped it in error. She stated the resident's PICC line was discontinued and he went about a week without his Vancomycin. She stated they then restarted it and he just completed it. She stated she had done education with staff regarding this.</p> <p>The facility was notified an Immediate Jeopardy (IJ) had been identified on 3/11/21. After the facility submitted additional information, it was identified the IJ had been removed on 3/5/21 after the investigation began, but prior to the Department representative's exit. The IJ was lowered in scope and severity from a "K" to an "E" when the facility took the following actions:</p>	F 760			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 760	Continued From page 43  1. All nurses and agency staff have been educated regarding the policy and procedures for following physician orders. Any staff that the facility was unable to reach were educated prior to working with resident. Education included proper transcription of orders, administering insulin, obtaining blood sugars as ordered, and the 7 "rights" of medication administration (right patient, right drug, right dose, right time, right route, right reason and right documentation).  2. The facility immediately implemented a double check system that required the nurse that administered the insulin to verify the 7 rights of medication administration with either another nurse or a Certified Medication Aide.  3. The facility immediately implemented a system that ensured the Director of Nursing would review any new medication orders and accompanying progress notes to ensure accuracy prior to the daily morning quality assurance meeting.  4. On 3/4/21, the Director of Nursing and the Assistant Director of Nursing audited all blood sugars and insulins for accuracy in transcription and administration.  5. The facility implemented medication audits two times weekly for four weeks, then one time weekly for four weeks, and then as needed according to quality assurance committee recommendations	F 760			
F 839 SS=D	Staff Qualifications CFR(s): 483.70(f)(1)(2)  §483.70(f) Staff qualifications.	F 839			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 839	<p>Continued From page 44</p> <p>§483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>§483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on personnel file review and staff interview, the facility failed to verify professional nurse credentials upon hire for 2 of 2 facility nurses reviewed(Staff B and Staff G). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The facility new hire list documented a hire date for Staff B RN(Registered Nurse) as 10/13//20.</p> <p>Staff B's file contained an RN License Verification dated 3/16/21. Staff G's file did not contain a verification prior to this.</p> <p>2. The facility new hire list documented a hire date for Staff G LPN(Licensed Practical Nurse) as 9/4/20.</p> <p>Staff G's file contained an LPN License Verification dated 2/25/21. Staff G's file did not contain a verification prior to this.</p> <p>The facility policy "Credentialing of Nursing Service Personnel", revised August 2006, stated the facility would contact the State Licensing Board to obtain verification of nursing licenses.</p>	F 839			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 839	Continued From page 45 On 3/16/21 at approximately 2:00 p.m., the Administrator stated she did not locate further documentation of the nursing licenses checked prior to the above dates.	F 839			
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)  §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;  §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to carry out a QAA(Quality Assessment and Assurance) meeting at least quarterly. The facility reported a census of 85 residents.  Findings:  1. On 3/30/21, the surveyor requested QAA meeting sign-in sheets for the period of 1/1/21-current.	F 868			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 868	Continued From page 46 Facility Continuous Quality Improvement Meeting Minutes documented meetings conducted 10/16/20 and 3/26/21.  On 4/1/21 at 920 a.m., the Administrator stated the facility had a QAA meeting in October of 2020 and on 3/26/21. She stated the facility did not conduct a QAA meeting between October of 2020 and 3/26/21. She stated the Medical Director had the 3/26/21 sign-in sheet and she was waiting for him to return it.	F 868			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and	F 880			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 880	<p>Continued From page 47</p> <p>procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its</p>	F 880			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>		
(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 880	<p>Continued From page 48</p> <p>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out infection control measures in order to prevent infection for 1 of 2 residents reviewed with a urinary catheter(Resident #20). The facility reported a census of 85 residents.</p> <p>Findings:</p> <p>1. The MDS(Minimum Data Set) assessment tool, dated 3/16/21, listed diagnoses for Resident #20 included diabetes, Alzheimer's disease, and vitamin deficiency. The MDS stated the resident required supervision and setup assistance with eating, set up assistance with personal hygiene, limited assistance of 1 staff for bed mobility, transfers, walking, dressing, and toilet use, and extensive assistance of 1 staff for bathing. The MDS listed the resident's BIMS(Brief Interview for Mental Status) score as 14 out of 15, indicating intact cognition.</p> <p>A 10/18/20 care plan entry stated the resident had a urinary catheter. A 3/1/21 entry stated the resident would show no signs of urinary infection through the review date.</p> <p>Observations at the following times revealed the resident in bed and his urinary catheter bag lying directly on the floor with no barrier: 3/16/21 at 8:32 a.m., 3/17/21 at 9:54 a.m., 3/22/21 at 9:05 a.m.</p> <p>A 12/20/20 Order Details document listed an order for Augmentin(an antibiotic) 875 mg(milligrams)-125 mg 1 tablet two times daily</p>	F 880			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE</b> <b>DES MOINES, IA 50314</b>
--	--

(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 880	Continued From page 49 for UTI(Urinary Tract Infection).  The facility policy "Catheter Care, Urinary", revised September 2014, stated the purpose of the procedure was to prevent catheter-associated UTIs and directed staff to keep catheter tubing and drainage bags off the floor.  On 3/24/21 at 12:53 p.m., the DON(Director of Nursing) stated staff should place catheters in privacy bags.	F 880		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)  §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-  §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.  §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property  §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on employee personnel file review, policy review, and staff interview, the facility failed to ensure 3 of 9 employees reviewed(Staff V, Staff G, and Staff W) completed training on the prevention and reporting of abuse including neglect, exploitation, and misappropriation of	F 943		

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 943	<p>Continued From page 50</p> <p>resident property. The facility reported a census of 85 residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>The facility new hire list documented a hire date for Staff V as 9/1/20.</li> </ol> <p>Staff V's file contained documentation of the completion of Dependent Adult Abuse Mandatory Reporter Training on 3/16/21. Staff V's file did not contain documentation of the training completed within 6 months of hire.</p> <ol style="list-style-type: none"> <li>The facility new hire list documented a hire date for Staff G as 9/4/20.</li> </ol> <p>Staff G's file contained documentation of the completion of Dependent Adult Abuse Mandatory Reporter Training on 3/16/21. Staff G's file did not contain documentation of the training completed within 6 months of hire.</p> <ol style="list-style-type: none"> <li>The facility's Nurse Aide Roster listed a hire date for Staff W of 1/2/14.</li> </ol> <p>Upon surveyor review on 3/16/21, Staff W's file did not contain documentation of the completion of Mandatory Reporter Training.</p> <p>The facility policy "Abuse Prevention Program", revised December 2016, stated residents had the right to be free from abuse and neglect and stated the facility required staff to complete training programs that included prevention, identification, and reporting of abuse.</p> <p>On 3/16/21 at approximately 2:00 p.m., the Administrator stated the facility had staff come to</p>	F 943			

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

PRINTED: 04/16/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>165272</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/01/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PARK NURSING &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>233 UNIVERSITY AVENUE DES MOINES, IA 50314</b>		
(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 943	Continued From page 51 the facility "today" to complete Mandatory Reporter Training and stated this was prompted when she was asked about it.	F 943			

## University Park Plan of Correction for Survey ending 4/1/2021

This serves as the credible allegation of compliance for University Park Nursing and Rehabilitation. 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 University Park Nursing and Rehabilitation Center is committed to delivering high quality healthcare 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 resurvey.

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 because of the findings from survey exiting 4/1/2021. The facility will be in substantial compliance by 4/26/2021.

### F 550 SS D RESIDENT RIGHTS/EXERCISE OF RIGHTS:

University Park Nursing and Rehabilitation will ensure that residents are treated with respect and dignity and care that is provided in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life, recognizing each resident's individuality. The facility will protect and promote the rights of the residents. Following the investigation, the employee is no longer employed by the facility effective 4/2/2021. Staff were re-educated at facility in-services on 3/5/2021, 4/5/2021 and 4/8/2021 by the Facility Administrator, Director of Nursing, and the Corporate Director of Clinical services regarding treating residents with dignity and respect, proper procedure of lifts, and peri-care. Random interviews will be conducted with alert and oriented residents to ensure compliance with resident rights, privacy, dignity, lift procedures and peri-care. Any infractions based on interviews will be addressed immediately by the facility administrator and QAPI team. The facility will continue to report any allegations of abuse or dignity concerns to DIA should they occur. Staff were informed of a zero-tolerance policy which includes immediate suspension up to and including termination of employment should any infractions occur with resident rights, dignity, or meeting care needs. The facility administrator will attend the resident's monthly council meeting after gaining permission to address any concerns the residents may voice related to privacy, dignity, adherence to resident rights and provision of cares for immediate follow up as needed. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator and Interdisciplinary Team are responsible for ongoing compliance.

#### F 607 SS=D DEVELOP/IMPLEMENT/ABUSE/NEGLECT POLICIES:

University Park Nursing and Rehabilitation Center will ensure that policies and procedures are followed to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Allegations of abuse will be thoroughly investigated. The facility will ensure background checks are completed prior to hire. The employees identified during survey have had his/her background checks completed with a copy placed in their respective personnel file. The Human Resources Director has completed an audit of employee files and background checks are now in place for 100% compliance. Ongoing, background checks will be completed prior to hire by the HR Director. The HR director will complete monthly audits of employee personnel records to ensure ongoing compliance. The Human Resource Director will report to the facility QAA team monthly. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator and HR Director are responsible for ongoing compliance.

#### F 658 SS=D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS:

University Park Nursing and Rehabilitation Center will ensure professional quality of standards are met and physician orders are followed as written. Licensed staff were re-educated by the Director of Nursing, Assistant Director of Nursing on 3/5/21, and 4/5/21 regarding the importance of following physician's orders. On 4/8/2021 The Director of Clinical Services also re-educated licensed nursing staff on completion and following of physician orders. Education included the importance of obtaining a resident's weight timely as ordered. The facility purchased an additional scale for use while residents are in quarantine and placed on the unit on 3/31/2021. Effective immediately, the Director of Nursing and/or Assistant Director of Nursing or designee, will run a physician order and missing entries report prior to the morning clinical QA meeting to ensure orders are transcribed correctly and documented accordingly. Additionally, the facility is now conducting a weekly weight meeting with the IDT (Interdisciplinary Team) to review weights and documentation thereof. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing and/or designee is responsible for ongoing compliance.

#### F 684 SS=D QUALITY OF CARE:

University Park Nursing and Rehabilitation will ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident choices. The facility will ensure that residents are assessed and treated appropriately for pain. Resident # 16 no longer resides at the facility. Licensed staff were re-educated by the Director of Nursing and Assistant Director of nursing on 3/5/2021 and 4/5/2021 regarding the importance of completing pain assessments and follow up documentation on the effectiveness of non-pharmacological and pharmacological interventions. The Director of Clinical Services repeated the education reviewing pain assessments and documentation on 4/8/2021. Effective immediately, any resident having unrelieved pain issues will be placed on a "hot charting" rack and the physician notified until the resident voices or demonstrates adequate pain relief. Residents are assessed for pain each shift with a corresponding pain number documented on the MAR (Medication Administration Record). Clinical progress notes will be reviewed by the DON/ADON or designee in the morning quality assurance clinical meeting for additional intervention as indicated. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing and/or designee is responsible for ongoing compliance.

#### F 686 SS=D TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCER:

University Park Nursing and Rehabilitation Center will ensure that residents receive care, consistent with professional standards of practice, to prevent pressure ulcers from developing unless the individuals 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. The facility will ensure prompt treatment of wounds. Resident # 16 no longer resides at the facility. The Director of Nursing, Assistant Director of Nursing, and Corporate Director of Clinical Services conducted facility in-services on 3/5/2021, 4/5/2021 and 4/8/2021 with staff on pressure ulcer prevention, treatment, infection control and obtaining cultures timely. Effective 4/5/2021 the facility promoted a new wound nurse to the position who has become wound care certified through VOHRA. The Director of Clinical Services followed the new wound nurse on 4/13/2021 and 4/14/2021 during wound rounds to ensure competency in wound identification, treatment, documentation, and proficiency in infection control practices. A copy of proficiency testing and wound certification placed in employees personnel file. The wound nurse will be responsible for making rounds with the DNP (Doctor of Nursing Practice) to ensure adequate monitoring of wounds and that new physicians orders are noted and completed. In the event the wound nurse is unavailable, the ADON on each floor will be responsible for completing rounds. The newly promoted wound nurse will complete weekly measurements and assessments on

residents with wounds. Braden scales have been updated on residents to ensure those at "high risk" have preventative measures in place such as nutritional supplements, pressure relieving devices and frequent turning and repositioning. The DON/ADON completed walking rounds to ensure residents at high risk had pressure relieving devices in place. The Director of Clinical services reached out to Telligen (The facilities QIO) for recommendations and training on pressure ulcer care and wound prevention. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting as indicated. The Director of Nursing/Assistant DON, and/or designee will be responsible for ongoing compliance.

#### F 689 SS=D FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES:

University Park Nursing and Rehabilitation Center will ensure that residents environment remains as free of accident hazards as is possible; and each resident receives supervision and assistance devices to prevent accidents. The facility will ensure transfers are completed safely and residents are propelled throughout the facility with foot pedals. On 3/5/2021 and 4/5/2021 the Director of Nursing and Assistant Director of Nursing completed re-education on the appropriate use of lifts and propelling of wheelchairs with foot pedals to prevent injury. A facility in-service was also conducted by the Corporate Director of Clinical Services on 4/8/2021 reviewing the lift policy and ensuring use of foot pedals while propelling a wheelchair to prevent injury. The facility conducted an inventory of wheelchairs and foot pedals to ensure the residents using a W/C for mobility had pedals to accompany their W/C. Those residents who were missing foot pedals had them replaced. Those residents who desire to have no foot pedals due to self-propelling have been care planned as such. Staff have completed competencies of gait belt and mechanical lift transfers with a copy of the proficiency testing placed in the employees personnel file. Staff competency evaluations will be completed at time of hire and repeated on a quarterly basis for ongoing compliance. Random audits of employees completing transfers will be completed by the Director of Nursing and Assistant Director of Nursing for ongoing compliance. During daily rounds, the DON/ADON will observe for proper use of foot pedals throughout the facility for ongoing compliance and to prevent injury. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The facility administrator, DON and ADON are responsible for ongoing compliance.

#### F 692 SS=D NUTRITION/HYDRATION STATUS MAINTENANCE:

University Park Nursing and Rehabilitation Center will ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the residents clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; is offered sufficient fluid intake to maintain proper hydration and health; is offered a therapeutic diet. The facility will ensure that weights are obtained per physician's orders. On 3/5/2021, The Director of Nursing and Assistant Director of Nursing re-educated staff on the importance of obtaining weights as per physician order, documentation thereof, and notification of physician of any significant weight changes. Education was repeated on 4/5/2021. The Director of Clinical Services also conducted an in-service on 4/8/2021 reviewing the importance of obtaining weights, documenting them, and notifying physician of any significant weight changes. Resident # 2 has been discharged from the facility. Residents who require tube feedings have been assessed by the dietician to ensure the resident is receiving adequate nutrition without complications. The physician has been notified of any dietary recommendations based on the dietitian assessment. Effective immediately, the Director of Nursing and/or Assistant Director of Nursing will print progress notes and missed entry reports prior to the morning clinical quality assurance compliance meeting to ensure weights are obtained as ordered and the physician has been notified of any significant weight changes. Weights will be reviewed during the monthly QAA meeting with the physician in attendance. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing/ADON and/or designee is responsible for ongoing compliance.

#### F 726 SS=D COMPETENT NURSING STAFF:

University Park Nursing and Rehabilitation Center will ensure that there is sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care, number, acuity, and diagnosis of the facilities population in accordance with the facility assessment. TNA (Temporary Nurse Aides) will no longer be employed at the facility. Staff identified have had their competencies completed in skills and techniques necessary to care for residents. The HR Director has completed an audit of employee files and updated competency checks as needed. New hires will have competency testing completed prior to working the floor and updated bi-annually. The HR director will audit direct care staff files monthly to ensure competencies have been completed timely. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator, Director of Nursing and HR Director is responsible for ongoing compliance.

#### F 729 SS=D NURSE AIDE REGISTRY VERIFICATION, RETRAINING:

University Park Nursing and Rehabilitation Center will ensure that registry verification is received, and the individual has met competency evaluation requirements. The employees identified during survey have had his/her registry verification completed. Effective immediately, the HR Director is designated to ensure registry verification is completed prior to hire. The HR Director has completed an audit of employee files. Employees who lacked registry verification documentation now have a copy in their respective personnel file. To ensure ongoing compliance, the HR director will audit the employee records monthly with copies of the audit given to the facility administrator for review. Additionally, the employee files will be audited by Corporate staff during their internal mock survey process and any immediate corrections made as needed. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator, and HR Director is responsible for ongoing compliance.

#### F 760 SS=K (Scope and severity reduced to an E on 4/16/2021) RESIDENTS ARE FREE FROM SIGNIFICANT MEDICATION ERRORS:

University Park Nursing and Rehabilitation Center will ensure that its residents are free from any significant medication errors. Licensed nurses were reeducated by the Director of Nursing and Assistant director of Nursing on 3/5/2021 and 4/5/2021 and by the Director of Clinical Services on 4/8/2021 regarding the importance of ensuring insulin and medications are administered properly, blood sugars are obtained timely, and physicians are notified when blood glucose is outside the desired parameters. Reviewed the "seven rights" of medication pass. (Right patient, right drug, right dose, right time, right route, right reason, and right documentation) Day shift is now obtaining their blood sugars to be in the desired time frames for insulin administration. During QAPI review, and with Medical Director approval, the documentation of 2 nurses with insulin administration has been removed. It was determined by the quality assurance team that it was resulting in "late" insulin administration as was the case during survey. The Director of Nursing, Assistant Director of nursing, and/or designee are running medication administration reports from PCC (Point Click Care-The facilities EMR system) daily to ensure insulin and medications are given timely, blood sugars have been completed, and that the physician is notified if the blood sugar is outside of desired parameters. The Director of Nursing and Assistant Director of Nursing review medication orders and accompanying progress notes to ensure accuracy prior to the morning quality assurance clinical meeting. The Director of Nursing and Assistant Director of Nursing implemented medication audits two times weekly for four weeks, then weekly for four weeks and then as needed according to quality assurance recommendations. Random medication pass observations have been conducted and the Director of Clinical Services has arranged for ongoing medication pass audits to be performed by the pharmacy consultant beyond the plan of correction date to ensure continued

compliance with the regulation. Pharmerica completed med pass observations on 4/20/21. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing/Assistant Director of Nursing and/or designee is responsible for ongoing compliance.

F 839 SS=D STAFF QUALIFICATIONS: University Park Nursing and Rehabilitation Center will ensure verification of professional nurse credentials upon hire is completed. The nurses identified during survey have had their license verified via NURSYS with a copy placed in the employees personnel file. The Human Resources Director has completed an audit of Licensed Nurses personnel records to ensure proof of licensure with a background check and date stamp. Files have been brought current and nurses' licensure will be verified prior to hire via background check to ensure ongoing compliance. As part of the facilities quality assurance plan the HR Director will audit employee files monthly to ensure all required documents are in place. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing and HR Director is responsible for ongoing compliance.

F 868 SS=D QAA COMMITTEE:

University Park Nursing and Rehabilitation Center will ensure QAA (Quality Assessment and Assurance) meetings are held at a minimum of quarterly. The facility had a Quality assurance meeting on 3/26/2021. QA meetings will be conducted on the third Thursday of every month going forward. The Director of Clinical Services has provided direction to the QAPI team and materials to be utilized to have an effective QA program and approach. Discussed root cause analysis and identification and resolution of internal issues within the facility. The Corporate Clinical Director will attend at a minimum of quarterly meetings to ensure the QA committee is adhering to policy and QAPI plans are written to achieve desirable outcomes. The facility administrator will be responsible for setting up the QA meetings and ensuring the signature sheet is signed and filed in the QAPI binder following the meeting. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator and IDT (Interdisciplinary Team) is responsible for ongoing compliance.

#### **F 880 SS=D INFECTION PREVENTION AND CONTROL:**

University Park Nursing and Rehabilitation Center will establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. University park will ensure infection control policies and procedures are in place with catheter care to prevent infection. Staff were re-educated on proper catheter care by the Director of Nursing and Assistant Director of Nursing on 3/5/2021, and 4/5/2021. An additional in-service was held on 4/8/2021 with the Corporate Director of Clinical Services reviewing catheter care and ensuring that catheter tubing is off the floor. Random audits will be conducted by the Director of Nursing, Assistant Director of Nursing and/or designee to ensure catheter tubing is off the floor and catheter bags are placed in privacy/dignity bags. Those residents that require a low bed where catheter tubing may come in contact with the floor will have the catheter bag and tubing placed in a wash basin as a barrier to the floor. Residents who require this technique will be care planed as such. Central Supply has stocked each floor with catheter bag covers to ensure privacy/dignity bags are always available. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing, Assistant Director of Nursing, and Infection preventionist nurse are responsible for ongoing compliance.

#### **F 943 SS=D ABUSE, NEGLECT, AND EXPLOITATION TRAINING:**

University Park Nursing and Rehabilitation Center will ensure training is completed per regulation on the prevention and reporting of abuse including neglect, exploitation, and misappropriation of resident property. Staff were re-educated by the Director of Nursing, Assistant Director of Nursing on 3/5/2021 and 4/5/2021 and again by the Corporate Director of Clinical Services on 4/8/2021. Education included abuse prevention and reporting of abuse, neglect, exploitation, and misappropriation of resident property. Effective immediately, the Human Resources Director is responsible for ensuring staff have dependent adult abuse and mandatory reporter training PRIOR to hire with a copy of the certificate placed in the employee file. Employee files have been audited and the facility is compliant with training. The HR Director will audit employee files going forward monthly to ensure ongoing compliance with abuse training and reporting. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator and HR Director are responsible for ongoing compliance.

L 190 GENERAL POLICIES: University Park Nursing and Rehabilitation Center will complete physical examinations and TB skin tests prior to employment. Physicals and TB skin tests will be updated annually. University Park Nursing and Rehabilitation Center completed BASELINE TB skin tests on staff as part of the plan of correction and employee physicals were also updated on staff. Copies of TB skin tests and physicals have been placed in the employee's personnel file and will be updated annually. The Human Resources Director will audit TB skin tests and Employee files quarterly to ensure ongoing compliance. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Director of Nursing and HR Director are responsible for ongoing compliance.

L 705 SAFETY University Park Nursing and Rehabilitation Center will ensure a safe environment for residents and personnel to include a written emergency plan for fire, tornado, explosion, or another emergency. The facility will complete elopement and weather drills per policy. The Director of Clinical Services re-educated staff at a facility wide in-service on 4/8/2021 and reviewed the weather and elopement policy. The facility administrator, and/or designee, will conduct elopement drills quarterly. The Maintenance Supervisor conducted fire, and weather drills on March 25, 2021 and will be repeated monthly on different shifts per Life Safety Regulations. The Maintenance Director has scheduled drills on TELS (An electronic maintenance program) to ensure compliance with regulation. Drills will be completed monthly and every shift will be drilled to ensure compliance. Concerns identified will be addressed and reported in the facilities quality assurance compliance meeting for additional intervention as indicated. The Facility Administrator and Maintenance Director are responsible for ongoing compliance.