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VIA OF DES MOINES	4911 SW 19TH STREET DES MOINES, IA 50315

(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 ✓ ok/CP	INITIAL COMMENTS Correction date: February 21, 2025 The following deficiencies resulted from investigation of Complaints #123812-C, 123915-C, 124924-C, and 126146-C and facility reported incidents #125061-I, #126549-I, and #126550-I, conducted February 10, 2025 to Feb 17, 2025. Complaints #123812-C, 123915-C, 124924-C, and 126146-C were substantiated. Facility reported incidents #125061-I, #126549-I, and #126550-I were substantiated. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F 000	Via of Des Moines denied it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains and is in compliance with the requirements of participation, or that corrective action was necessary.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review,	F 600	In continued compliance with F600, Freedom from Abuse, Neglect, and Exploitation Via of Des Moines corrected the deficiency by providing resident 4 with treatment for UTI and scheduling an anti-anxiety medication. Residents number: 5, 6, 11, 13 and all other residents are free from freedom of abuse, neglect and exploitation. To correct the deficiency and to ensure the problem does not recur, resident number 4 was discharged home with family. The facility also hired an activity assistant to assist in the CCDI unit. Finally, all staff were educated on the importance of resident's being free from abuse, neglect and exploitation on 2/18/2025 by the executive director and/or designee. Resident 4's care plan was updated to detail all behaviors and interventions that have been put in place to intervene with resident 4's residents behaviors.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — (X6) DATE

Sara Sampson, MSN, RN Interim DON 3/5/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 600	Continued From page 1 and staff interviews, the facility failed to protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident to resident altercations (Resident #5, #6, #11, #13). On 7/20/24, Resident #4 scratched Resident #13. On 11/22/24, Resident #4 hit Resident #5 in the hand with an empty plastic pop bottle and shortly after hit Resident #6 in the back. On 2/4/25, Resident #4 hit Resident #11 on the head and shoulder and kicked her knees. The facility reported a census of 79 residents. Findings include: 1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 10/10/24, listed diagnoses for Resident #4 which included non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) for 1-3 days out of the 7 day review period and listed a Brief Interview for Mental Status(BIMS) score as 11 out of 15, which indicated moderately impaired cognition. The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy" updated 10/19/22, stated residents had the right to be free from abuse and must not be subjected to abuse by anyone, including other residents. The policy included assault as an example of Dependent Adult Abuse and defined "Assault of a Dependent Adult" as any act which was generally intended to cause pain or injury or which was generally intended to result in physical contact which could be considered by a reasonable person to be insulting or offensive.	F 600	The executive director and/or designee will audit nurses notes and risk management for behaviors: 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x weekly x 4 weeks, then PRN to ensure continued compliance. As part of Via of Des Moines's ongoing commitment to quality assurance, the executive director and/or designee will report identified concerns through the community's QA process	2/21/25

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A 1/18/24 Care Plan entry stated the resident was at risk for alterations in her mood and behavior related to anxiety, depression, and dementia and directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Further entries on 1/18/24 directed staff to provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures, and memory boxes.
A 7/20/24 Care Plan entry stated the residents were separated. The Care Plan lacked information regarding why the residents were separated.
A 12/30/24 Care Plan entry directed the staff to implement 15 minute checks.

The resident's Care Plan lacked documentation of the resident's history of resident to resident physical altercations and lacked direction for staff regarding how to prevent future incidences.

a. Resident #4 and Resident #13

The Quarterly MDS assessment tool, dated 10/31/24, listed diagnoses for Resident #13 which included Alzheimer's, anxiety disorder, and heart failure. The MDS listed her BIMS score as 0 out of 15, which indicated severely impaired cognition.

A 7/20/24 PACH Verbal Aggression Received report stated Resident #4 scratched Resident #13's arm. The facility separated the residents and initiated 15 minute checks.

Health Status Note dated 7/20/24 at 9:29PM documented the following; Resident sitting in

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chair crying accompanied by staff states "she scratched me look at my arm" resident obtained red bruise to right forearm approximate 1 centimeter (cm) by 4 cm, clean area with soap and water took resident back to her room, performed head to toe assessment no other redness or bruises noted, temperature 97.9, pulse 89 blood pressure 144//88. Physician called, and family notified.

Incident Note dated 8/11/24 at 4:20PM documented the following; This nurse summoned to resident hallway outside of Resident#13's room and noted resident yelling, "please, somebody do something with her, she came in my room and slapped me!" Resident then started pointing to her right, arm, and stated "Right there, this is where she hit me!" This nurse assessed resident's arm, and no redness or markings present upon assessment. Both residents were immediately separated to avoid further allegations. On call provider was informed. Statements provided by CNA's working that incident was not witnessed. The residents record lacked documentation of follow-up interventions, or review as to how to prevent futher similar incidents.

b. Resident #4 and Resident #5

The Quarterly MDS assessment tool, dated 9/5/24, listed diagnoses for Resident #5 which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. The MDS listed her cognition as severely impaired.

An 11/22/24 5:31PM Alleged Abuse report stated Resident #5's tablemate(Resident #4) was upset and hit the resident in the right hand with a soda

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bottle in the dining room.

c. Resident #4 and Resident #6

The Quarterly MDS assessment tool, dated 8/22/24, listed diagnoses for Resident #6 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety. The MDS listed a BIMS scores as 3 out of 15, which indicated severely impaired cognition.

An 11/22/24 2:30PM Alleged Abuse report stated another resident(Resident #4) walked through the dining room and struck Resident #6 in the back/shoulder area with a pop bottle.

d. Resident #4 and Resident #11

The Quarterly MDS assessment tool, dated 11/21/24, listed diagnoses for Resident #11 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety. The MDS listed her BIMS score as 6 out of 15, which indicated severely impaired cognition.

A 2/4/25 at 7:00PM Physical Aggression Initiated report stated Resident #4 became rude, aggressive, and verbally abusive to a group of residents who sat at the adjacent dining room table. Resident #4 then hit Resident #11 on her head, shoulders, and kicked her knees. The facility initiated 15-minute checks.

On 2/12/25 at 1:53 p.m. Staff E Certified Medication Aide stated (on 11/22/24) Resident #4 and Resident #5 argued and it became more aggressive. He stated Resident #4 reached across the table and hit Resident #5 with her plastic soda bottle. He stated they separated the

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residents but Resident #4 got ahead of the staff and hit Resident #6 in the left shoulder. Staff E stated the resident had always been "explosive" and they had to keep her "corralled" He said he tried to keep her away from certain tables and looked at verbal cues. He stated they were not always successful(in preventing her physical aggression with other residents) but they tried.

On 2/12/25 at 2:18 p.m., Staff F Licensed Practical Nurse (LPN) stated(on 11/22/24) she heard Resident #4 screaming profanities at other residents and she pointed a soda bottle. She stated she went to get her out of the dining room but they had to walk past two tables and when they did so, she hit Resident #6 but did not hit her hard at all. Staff F stated she did not know why she did this as Resident #6 did nothing to provoke this. She stated she didn't know how to handle Resident #4 and she hit other residents. She stated she was not sure if she had triggers and stated she did not hear of any concrete interventions she could carry out to prevent these incidents.

On 2/12/25 at 3:40 p.m., Staff G Registered Nurse (RN) stated Resident #4 was verbally and physically aggressive. She stated she lashed out at several residents and she could go from "0 to 360 in 2 seconds". She stated the other residents were fearful when she screamed loudly and that she was very impulsive. Staff G stated if they did not stand right next to her within a couple of feet, she did not feel they could stop a future physical altercation.

On 2/13/25 at 8:25 a.m., Staff H LPN, Assistant Director of Nursing (ADON) stated Resident #4 was triggered easily. She stated her behaviors

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F 600	Continued From page 6 were very unprovoked and came out of nowhere. She would just go over and hit someone. She stated they tried several different interventions but it was difficult. She stated she didn't know if there was a way to 100% prevent her physical aggression towards other residents. On 2/13/25 at 3:12 p.m., the interim Director of Nursing (DON) stated the goal of the facility was for residents to be free from physical aggression. She stated with Resident #4, they tried their best to intervene but at times she got to the point where she "picks on someone" before they were able to intervene. She stated they did everything they could besides removing her from the facility.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	In continued compliance with F657, Via of Des Moines corrected the deficiency by revising resident #4 care plan to include history of abuse, behaviors and their respective interventions by the MDS Coordinator on 2/17/2025. All care plans were reviewed for behaviors and corresponding interventions by the interdisciplinary leadership team. To correct the deficiency and to ensure the problem does not recur, the MDS Coordinator was educated on the importance of care plan revisions on 2/18/2025 by the executive director and/or designee. The director of nursing and/or designee will audit nurse notes and risk management for behaviors to ensure on care plans: 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x weekly x 4 weeks, then PRN to ensure continued compliance. As part of Via of Des Moines's ongoing commitment to quality assurance, the director of nursing and/or designee will reported identified concerns through the community's QA process.	2/19/25

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(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, policy review, and staff interviews, the facility failed to implement resident centered care plan interventions to protect the resident's right to be free from physical abuse for 4 of 7 residents reviewed for resident to resident altercations (Resident #5, #6, #11, #13). The facility continued to use the intervention of resident separation, and implimentation of 15-minute checks, with additional follow up intervention. On 7/20/24, Resident #4 scratched Resident #13. On 11/22/24, Resident #4 hit Resident #5 in the hand with an empty plastic pop bottle and shortly after hit Resident #6 in the back. On 2/4/25, Resident #4 hit Resident #11 on the head and shoulder and kicked her knees. The facility reported a census of 79 residents.

Findings include:

1. The Quarterly Minimum Data Set(MDS) assessment tool, dated 10/10/24, listed diagnoses for Resident #4 which included non-Alzheimer's dementia, anxiety, and depression. The MDS stated the resident had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) for 1-3 days out of the 7 day review period and listed a Brief Interview for Mental Status(BIMS) score as 11 out of 15,

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indicating moderately impaired cognition.

The facility "Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting Policy" updated 10/19/22, stated residents had the right to be free from abuse and must not be subjected to abuse by anyone, including other residents. The policy included assault as an example of Dependent Adult Abuse and defined "Assault of a Dependent Adult" as any act which was generally intended to cause pain or injury or which was generally intended to result in physical contact which could be considered by a reasonable person to be insulting or offensive.

The facility policy "Comprehensive Care Plans", revised 1/30/24, stated the facility would develop and implement a person-centered Care Plan for each resident. The policy stated the Care Plan would include measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs.

A 1/18/24 Care Plan entry stated the resident was at risk for alterations in her mood and behavior related to anxiety, depression, and dementia and directed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Further entries on 1/18/24 directed staff to provide structured activities such as toileting, walking inside and outside, and reorientation strategies including signs, pictures, and memory boxes.
A 7/20/24 Care Plan entry stated the residents were separated. The Care Plan lacked information regarding why the residents were separated.
A 12/30/24 Care Plan entry directed the staff to

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implement 15 minute checks.

The resident's Care Plan lacked documentation of the resident's history of resident to resident physical altercations and lacked direction for staff regarding how to prevent future incidences.

a. Resident #4 and Resident #13

The Quarterly MDS assessment tool, dated 10/31/24, listed diagnoses for Resident #13 which included Alzheimer's, anxiety disorder, and heart failure. The MDS listed her BIMS score as 0 out of 15, indicating severely impaired cognition.

A 7/20/24 7:25PM PACH Verbal Aggression Received report stated Resident #4 scratched Resident #13's arm. The facility separated the residents and initiated 15 minute checks.

b. Resident #4 and Resident #5

The MDS assessment tool, dated 9/5/24, listed diagnoses for Resident #5 which included Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. The MDS listed her cognition as severely impaired.

An 11/22/24 Alleged Abuse report stated Resident #5's tablemate(Resident #4) was upset and hit the resident in the right hand with a soda bottle.

c. Resident #4 and Resident #6

The MDS assessment tool, dated 8/22/24, listed diagnoses for Resident #6 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety. The MDS listed a BIMS scores as 3 out of 15, indicating severely impaired cognition.

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An 11/22/24 Alleged Abuse report stated another resident(Resident #4) walked through the dining room and struck Resident #6 in the back/shoulder area with a pop bottle.

d. Resident #4 and Resident #11

The MDS assessment tool, dated 11/21/24, listed diagnoses for Resident #11 which included Alzheimer's disease, non-Alzheimer's dementia, and anxiety. The MDS listed her BIMS score as 6 out of 15, indicating severely impaired cognition.

A 2/4/25 Physical Aggression Initiated report stated Resident #4 became rude, aggressive, and verbally abusive to a group of residents who sat at the adjacent dining room table. Resident #4 then hit Resident #11 on her head, shoulders, and kicked her knees. The facility initiated 15-minute checks.

On 2/12/25 at 1:53 p.m. Staff E Certified Medication Aide stated(on 11/22/24) Resident #4 and Resident #5 argued and it became more aggressive. He stated Resident #4 reached across the table and hit Resident #5 with her plastic soda bottle. He stated they separated the residents but Resident #4 got ahead of the staff and hit Resident #6 in the left shoulder. Staff E stated the resident had always been "explosive" and they had to keep her "corralled" He said he tried to keep her away from certain tables and looked at verbal cues. He stated they were not always successful(in preventing her physical aggression with other residents) but they tried.

On 2/12/25 at 2:18 p.m., Staff F Licensed

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Practical Nurse(LPN) stated(on 11/22/24) she heard Resident #4 screaming profanities at other residents and she pointed a soda bottle. She stated she went to get her out of the dining room but they had to walk past two tables and when they did so, she hit Resident #6 but did not hit her hard at all. Staff F stated she did not know why she did this as Resident #6 did nothing to provoke this. She stated she didn't know how to handle Resident #4 and she hit other residents. She stated she was not sure if she had triggers and stated she did not hear of any concrete interventions she could carry out to prevent these incidents.

On 2/12/25 at 3:40 p.m., Staff G Registered Nurse(RN) stated Resident #4 was verbally and physically aggressive. She stated she lashed out at several residents and she could go from "0 to 360 in 2 seconds". She stated the other residents were fearful when she screamed loudly and that she was very impulsive. Staff G stated if they did not stand right next to her within a couple of feet, she did not feel they could stop a future physical altercation.

On 2/13/25 at 8:25 a.m., Staff H LPN, Assistant Director of Nursing(ADON) stated Resident #4 was triggered easily. She stated her behaviors were very unprovoked and came out of nowhere. She would just go over and hit someone. She stated they tried several different interventions but it was difficult. She stated she didn't know if there was a way to 100% prevent her physical aggression towards other residents.

On 2/13/25 at 3:12 p.m., the interim Director of Nursing(DON) stated the goal of the facility was for residents to be free from physical aggression.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. BUILDING _____ B. WING _____	C 02/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIA OF DES MOINES	4911 SW 19TH STREET DES MOINES, IA 50315

(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 657	Continued From page 12 She stated with Resident #4, they tried their best to intervene but at times she got to the point where she "picks on someone" before they were able to intervene. She stated they did everything they could besides removing her from the facility. On 2/17/25 at 10:57 a.m., Staff I MDS Coordinator stated she did not include specifics in Care Plans such as resident physical aggression and the details of the altercation.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to follow physician's orders for a genetic testing referral for 1 of 3 residents reviewed for a physician's orders(Resident #4). The facility reported a census of 79 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 6/20/24, listed diagnoses for Resident #2 which included non-Alzheimer's dementia, seizure disorder, and diabetes. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition.	F 658	In continued compliance with F658, Services Meets Professional Standards Via of Des Moines corrected the deficiency by resident 2 receiving genetic testing on 2/19/2025. No other residents were impacted. To correct the deficiency and to ensure the problem does not recur, nursing staff were educated on the importance of following physician orders on 2/18/2025 by the director of nursing and/or designee. The director of nursing implemented a triple check process for physician orders. The Director of Nursing and/or designee will audit physicians orders: 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x weekly x 4 weeks, then PRN to ensure continued compliance. As part of Via of Des Moines's ongoing commitment to quality assurance, the director of nursing and/or designee will reported identified concerns through the community's QA process.	2/19/25

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F 658	Continued From page 13	F 658		

A 7/31/24 clinic Patient Encounter Form stated the resident had newly diagnosed breast cancer. The form listed a referral to genetic testing for history of ovarian cancer and now breast cancer with an extensive family history.

The facility lacked documentation the resident completed genetic testing and lacked information regarding the resident's appointments and a reason she did not attend.

On 2/11/25 at 10:06 a.m., Staff A Cancer Center representative stated Resident #2 had an appointment scheduled for genetic testing on 9/4/24 and the facility called and canceled the appointment right before the appointment time and stated they did not have a ride for the resident. She stated the resident had an appointment rescheduled on 10/8/24 but she did not show up.

On 2/12/25 at 10:01 a.m. the interim Administrator stated the genetic testing was not completed.

On 2/12/25 at 12:40 p.m., Staff D Staffing Coordinator stated she did not see an appointment for the resident on 9/4/24 when she reviewed the calendar. She stated she did have an appointment on 10/8/24 and she (Staff D) thought that another driver would take her to the appointment. She stated when she found out the other driver was not taking her she went to the resident's room and was going to rush to get her there. Staff D stated the resident did not want to rush to get to the appointment and also did not feel well. Staff D stated she did not document this anywhere. She stated no one at the facility rescheduled the appointment.

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F 658	Continued From page 14 On 2/12/25 at 12:43 p.m., Staff C Driver stated there were times when the facility had to reschedule appointments the day of the appointment if the nurse forgot to put a note in. On 2/13/25 at 3:12 p.m., the interim Director of Nursing (DON) stated the facility should follow physician's orders which would include referrals. On 2/17/25 at approximately 12:00 p.m., the Administrator stated the facility did not have a policy for physician's orders and they utilized the standards of practice as a guideline.	F 658		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interviews, the facility failed to maintain hot holding temperatures above 135 degrees Fahrenheit for 1 of 1 meal observed. The facility reported a census of 79 residents. Findings include: On 2/12/25 at 11:09 a.m., the Dietary Services Manager placed plated food into two warming	F 804	In continued compliance with F804, Nutritive Value/Appear, Palatable/Prefer Temp Via of Des Moines corrected the deficiency by changing out a breaker that was non-functional causing the food-warmer not to work on 2/14/2025 by the maintenance director. No residents were impacted. To correct the deficiency and to ensure the problem does not recur, the maintenance department was educated on the importance of auditing the breakers to ensure they're functional on 2/18/25 by the executive director and the nursing and dietary departments were educated on the importance of auditing food temperatures on 2/18/25 by the executive director as the breaker tripped causing the food holding equipment not to hold temperature. The executive director and/or designee will audit food temperatures 3x weekly x 4 weeks, then 2x weekly x 4 weeks, then 1x weekly x 4 weeks, then PRN to ensure continued compliance. As part of Via of Des Moines's ongoing commitment to quality assurance, the executive director and/or designee will reported identified concerns through the community's QA process. Via of Des Moines date certain is 2/21/25.	

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F 804	Continued From page 15	F 804		

carts. When she completed filling the first cart, Staff B Dietary Aide took the cart to the Chronic Confusion Dementing Illness (CCDI) unit. At 11:19 a.m., she finished filling the last cart and the State Agency (SA) requested she place a test tray and a thermometer on the last warming cart. At 11:21 a.m., Staff B took the second cart to the CCDI unit.

At 11:24 a.m., staff in the CCDI unit began to pass out trays to the resident. At 11:43 a.m., Staff C Restorative Aide stated they passed all of the trays with the exception of a few residents who were not in the dining room yet. The SA immediately obtained the following temperatures on the test tray: mixed vegetables 115 degrees Fahrenheit and tuna casserole 128 degrees Fahrenheit. The SA tasted the tuna casserole and it was warm but not hot.

On 2/13/25 at approximately 2:00 p.m., the Dietary Services Manager stated she expected hot foods held above 140 degrees Fahrenheit.

The facility policy "Food Temperatures", dated 2021, stated foods will be transported and delivered to unit storage areas to maintain at temperature above 135 degrees Fahrenheit or above.