STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	**2401 EAST EIGHTH STREET DES MOINES, IA 50316**

(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:_____. The following deficiencies resulted from the investigation of Complaint #109332-C and #112985-C and Facility Reported Incidents #112544-I and #112625-I , conducted July 3, 2023 to July 6 2023. Complaint # 112985-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 1	F 609		

investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility investigation file review, staff interviews, and policy review, the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals (DIA) within 24 hours for 1 of 2 residents reviewed for abuse (Resident #1). The facility reported a census of 47 residents.

Findings include:

The Quarterly Minimum Data Set (MDS) assessment dated 2/9/23 revealed Resident #1 had diagnoses of Schizophrenia, anxiety disorder, and bipolar disorder. The MDS identified the resident had impaired short-term and long-term memory and severely impaired decision-making skills. The MDS documented the resident also exhibited hallucinations, delusions, and had physical behaviors such as grabbing and scratching others, and rejected care 1 to 3 days during the look-back period.

The Care Plan revised 3/20/23 revealed Resident #1 had diagnosis of bipolar disorder, Schizoaffective disorder, and posttraumatic stress disorder (PTSD). The Care Plan also revealed the resident had alteration in mood and behaviors such as refusing medications due to paranoid delusions, and hit, pinched, and grabbed staff. The Care Plan staff directives included to provide clear, simple instructions,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 2	F 609		

utilize diversion techniques as needed, reapproach the resident if she had behaviors, and administer medications as ordered. The Care Plan also indicated the resident refused medications often and could become combative and agitated. Staff directives included to have another staff member offer the medication, and crush the medications and place medications in pudding or applesauce.

The Physician's Progress Note dated 2/16/23 revealed Resident #1 had Schizophrenia, paranoia, and delusional behaviors. The resident refused medications most of the time due to the resident belief she was "being poisoned". The resident was pleasantly confused, able to make her needs known, and more redirectable when she took her medications.

The Medication Administration Record dated 4/2023 revealed Morphine Sulfate 0.25 milliliters (ml) by mouth/sublingually (SL) every 8 hours (at 6:00 AM, 2:00 PM, and 10:00 PM).

A Health Status Progress Note dated 4/20/23 at 2:07 PM, but created on 4/22/23 at 2:15 PM by Staff A, agency Registered Nurse (RN), revealed: At 10:00 AM it was reported to Staff A Resident #1 was restless and combative. The Certified Nurses Aide (CNA) laid the resident down in bed. Assessment performed by Staff A. Staff A attempted to give the resident 0.25 ml of morphine for restlessness. The resident swatted the nurse and knocked the bottle of Morphine out of Staff A's hand. The Morphine spilled on the bed and the floor. Staff A documented she took the bottle to the Certified Medication Aide (CMA) and told her what happened. There was 0.5 ml left in the bottle and bottle placed back into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 3	F 609		

medication cart, and destroyed by Staff A and the oncoming nurse at 6:00 PM.

A facility investigation file revealed the following: On 4/22/23 at approximately 6:45 AM, the Human Resources (HR) Director received a phone call from Staff B, CMA, and Staff C, Licensed Practical Nurse (LPN) who reported a concern about Staff A's method of administering medication to Resident #1 during 4/20/23 in the late afternoon. Staff B reported Staff A held Resident #1's nose until the resident opened her mouth to breath, forcing the resident to open her mouth. Resident #1 held Staff B's hands with a grip that could not be immediately released. At approximately 7:00 AM, the HR Director notified the Administrator. The Administrator notified Staff G, interim Director of Nursing (DON). Staffing agency notified of incident and Staff A placed on suspension pending investigation. On 4/22/23 at approximately 12:42 AM, the Administrator called the Department of Health and Human Services hotline and reported the incident. Statements gathered from Staff A and Staff B. Staff B was the only employee present while Staff A administered medication to Resident #1. Staff A's interview and phone statement on 4/22/23 revealed how she administered medication to Resident #1. Staff A stated she had the CMA distract the resident and held the resident's hands while she put the medication inside the resident's cheek. Resident #1 had a history of combative behaviors and refused medication at times. Staff B stated she didn't report the incident sooner because she had to administer time sensitive medications and when she was able to visit with leadership, they had all left for the day. Staff B stated she was also off on Friday 4/21/23 and reported the incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 4	F 609		

immediately upon starting her shift on Saturday, 4/22/23. Staff B stated she didn't feel it was abuse at the time due to witnessing this method of administration at a previous job. The DON re-educated Staff B on abuse types and reporting guidelines.

Staff B's written statement dated 4/22/23, revealed on Thursday, 4/20/23, Staff A told Staff B she was going to give a PRN (as needed) dose of Morphine to Resident #1. Staff A removed the Morphine from the medication cart and headed to Resident #1's room. Staff B documented she quickly completed her current task and then went to Resident #1's room to assist. Staff A had the Morphine bottle in her hand as Staff B entered the room. Staff B asked Staff A why she had the bottle in the room as they normally drew medication up at the medication cart. Staff A then went into the bathroom in the resident's room and said she would draw the dose from the bottle. Staff A came out of the bathroom with the medication. Staff B knelt by the resident's bed. Resident #1 grabbed Staff B's hands with a very tight grip. Staff A reached down and held the resident's nose until the resident had to swallow and in order to breathe through her mouth. Staff B told Staff A her actions were unnecessary and the Morphine could've been given subligually and did not have to be swallowed. Staff A responded "It will?". Holding Resident #1's nose was unnecessary and wrong. These actions were witnessed mid to late afternoon on 4/20/23 between 3:00 to 5:00 PM. Staff B then returned to passing medications for other residents as they were very time sensitive medications and she needed to complete resident cares. Staff B wrote by the time she had a moment to consult management it appeared everyone had left for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 5	F 609		

the day. Staff B documented she was off the following day (on 4/21/23), and returned to work on 4/22/23 at approximately 6:00 AM, at which time she consulted the night nurse on duty with concerns about a nurse holding a resident's nose to force the resident to swallow the medication was in fact inappropriate and abuse. The night nurse (Staff C) called the HR Director to report Staff A's actions.

On 4/26/23 at approximately 5:21 PM, Staff I, acting DON, contacted DIA and left a voicemail to verify the facility's notification of abuse allegation to DIA received on 4/22/23.

A conclusion in the facility's investigation included the following: Staff A remained on suspension. Current staff re-educated on abuse and neglect including reporting guidelines. Abuse written education completed with the Administrator on the correct hotline phone number and reporting to DIA on all abuse allegations within 2 hours.

In an interview on 7/5/23 at 9:50 AM, the Regional Director of Operations (RDO), who was also the acting Administrator during 3/2023 to 4/2023 stated she received a phone call from the HR Director on the weekend, on 4/22/23. The HR Director told her when Staff A, agency RN, administered medication to Resident #1 she held the resident's nose. She believed in order for the resident not to have any behaviors. The RDO reported she started a mini-investigation to find out what happened. She contacted Staff B and interviewed her. She also called the State 800 number, but later found out it wasn't the 800 number for the DIA. She was from another state and didn't know what number to call. She told the person on the phone she needed to do a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 6	F 609		

self-report. The person told her to give her the information over the phone. She realized it wasn't DIA's number when she received a letter from Iowa Department of Human Services. The RDO reported after the facility conducted their investigation, she contacted the staffing agency, and requested not to have Staff A return to the facility. The RDO reported Staff A refused to return to the facility to talk to the HR Director or any administrative staff, and Staff A said she would not talk to the facility without a lawyer present.

During an interview 7/5/23 at 12:48 PM, the HR Director reported she received a call from Staff C and filtered the call to Staff G, former DON, and the acting Administrator. Staff had called to let her know a nurse was running late, and Staff C and Staff B started to tell her what happened when she requested to call the DON and Administrator so they could talk to them. She let staff know they need to report concerns right away.

During an interview 7/5/23 at 1:05 PM, Staff B, CMA, reported she worked at the facility from 3/2023- 4/2023. Staff B reported she had completed abuse training on-line and attended in-service related to abuse training, and kept abreast on the different forms of abuse, the things to look for, and what to do. Staff B reported if she saw concerns for abuse she would report to her charge nurse right away depending upon who was available. Staff B reported Resident #1 could go from being sweet as pie to throwing things or kicking staff. If Resident #1 got ahold of staff, she rubbed the top of the resident's hand and then slipped her thumb under the resident's thumb to loosen her grip. On the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 7	F 609		

day of the incident, Staff A was the nurse on duty but not assigned to a medication cart. The CMA's were assigned to the medication carts. Staff A came to her and wanted to give Morphine. Staff A told her she would give PRNs as that's how she liked to do things. Staff B reported she was in the middle of something and Staff A got into another medication cart. Resident #1's medications were on the opposite cart of the one Staff B used that day. Staff A got Morphine out of the cart then went into Resident #1's room. Staff B reported when she finished what she was doing, she went to Resident #1's room. Staff A was in the room and had a full bottle of Morphine in the room. She told Staff A they usually drew up medication at the medication cart. Staff A said she would go into the bathroom. Staff A went into the bathroom, then came out and started to give Resident #1 the medication. Staff A grabbed the resident's nose and syringed the Morphine into Resident #1's mouth. Staff B reported she knelt down by the resident and held her hand. She told Staff A it wasn't necessary to give the medication orally, the Morphine medication could be given sublingually. Staff B stated she had never seen anyone hold a resident's nose so they couldn't breathe, and force the resident to swallow. Staff B stated earlier on the same day, Staff A told her she took the stopper out of a bottle of Morphine and reported to Staff B she had spilled the Morphine when Resident #1 flailed her hand and knocked the bottle out of her hand. Staff A never showed her the empty bottle or the spillage, but wanted Staff B to chart the waste on the resident. Later, Staff B told Staff C, LPN, about the Morphine being spilled. Staff A sat at the nurse's station and looked nervous. Staff A said she didn't know how to chart the wastage. Staff B verified the incident when Staff A held Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 8	F 609		

#1's nose while she administered medication to the resident was on the same day but after the supposed Morphine spill. Staff B reported she couldn't say if the Morphine spill happened because she didn't see it. Staff B acknowledged she didn't report the incident to management because management had left the facility and she didn't see anyone in the office. She later told Staff C. When Staff C said there were other things that had happened he called the HR Director to make her aware. If a resident refused medication or she had trouble getting a resident to take medication, she reapproached the resident or tried to crush the medication, or give medication with something such as a shake. Staff B reported narcotic medication signed out as medication removed from the cart and whenever they gave the medication.

During an interview on 7/6/23 at 9:45 AM, Staff C, LPN, reported he worked the 6 PM to 6 AM shift. Staff C reported Resident #1 hit and kicked staff, and threw medication at staff or refused to take her medication. Staff C reported a nurse from the prior shift reported a small amount of Morphine wasted and asked for him to sign the wastage. The nurse told him she spilled the medication when the resident knocked it out of her hand. The nurse said it was witnessed by a staff supervisor. A new bottle of Morphine had been started after that. He signed the controlled substance sheet on the resident and made a note he didn't see it being wasted. The supervisor was coming in the AM. Later on when he got information from Staff B he reported it to his supervisor. Staff C reported there wasn't much left in the bottle, only about 2.5 to 3.0 ml remaining. They couldn't get the medication out. It was just droplets left in the bottle when they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 9	F 609		

wasted the remaining amount. The nurse had written on the form the amount wasted. He was told Staff A had to remove the stopper to get the medication out, Resident #1 hit the bottle, and the medication spilled onto the bed and the floor. He had worked the night before, and recalled there wasn't much in the morphine bottle at that time, and suspected not that much medication had been spilled.

Attempts to reach Staff G, former DON, on 7/5/23 at 10:40 AM, and 7/6/23 at 7:45 AM were unsuccessful. Staff G did not return phone calls to the surveyor.

During an interview on 7/5/23 at 10:55 AM, Staff F, CNA, reported she had worked as agency CNA for 5 months at the facility. Resident #1 fought and hit staff during cares. Staff F stated she tried to explain things to the resident. Staff F reported medications prepared from the medication cart. Staff F reported she had never seen staff pinch a resident's nose when they administered medication. Staff F reported she would report to the charge nurse if she ever observed staff being rough or unkind, or held a resident's nose to make the person swallow.

During an interview 7/5/23 at 2:30 PM, Staff E, CNA, reported Resident #1's mood changed from being really nice and sweet to combative and mean. Staff E reported she had not witnessed any staff holding a resident's nose to administer medication. Staff E reported if she had observed a concern with staff being unkind or rough, or signs of abuse, she would report to the nurse or go up the chain of command to report her concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 10	F 609		

During an interview 7/5/23 at 9:15 AM Staff A, agency RN, reported Resident #1 extremely confused,
very combative, and would hit and swing at staff whenever medications administered. Staff A reported she backed away from the resident and reapproached the resident later. Management would tell her she needed to give the resident something because the resident very combative and her behaviors were out of control. Staff A reported she obtained a bottle of morphine from the medication cart. Only 0.4 ml of morphine left in the bottom of the bottle, and couldn't draw up from the bottle so she took the top off of the bottle and as she drew the medication up, the resident knocked the bottle out of her hand and the medication went on the bed and the floor. Since CMA's not allowed to waste narcotic medication she locked the bottle up and later wasted it with the oncoming nurse. There was 0.5 ml still left in the bottle when she wasted it with the oncoming nurse. Staff A stated she had not witnessed staff being rough or unkind to residents, or witnessed anyone holding a resident's nose to administer medication. Staff A denied holding a resident's nose while she gave medications.

During an interview 7/6/23 at 11:30 AM Staff H, LPN, Unit Manager, reported she found out about narcotic medication spill during the AM meeting. Staff H reported she had not ever witnessed staff holding a resident's nose to administer medication. If she saw this, she would report it right away.

A facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigation Policy revised 9/2022 revealed all reports of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 609	Continued From page 11 resident abuse reported to local, state and federal agencies as required by current regulations. Any suspicion of resident abuse must be reported immediately to the Administrator and other officials according to state laws. The Administrator or individual making the abuse allegation must report suspicion of abuse to the state licensing/certification agency responsible for surveying and licensing the facility immediately within two hours of an allegation involving abuse or serious bodily injury or within 24 hours of an allegation that does not involve abuse.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 656	Continued From page 12	F 656		

recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interviews, direction for the Resident Assessment Instrument and policy review, the facility failed to fully develop a comprehensive care plan within the required time frame for two of four residents (Resident #7 & Resident #8) reviewed for care plans.

Findings include:

1. The Significant Change Minimum Data Set (MDS) of Resident #7 dated 3/17/23 documented the resident had a re-entry date to the facility from an acute care hospital on 3/14/23. The MDS triggered Care Areas included cognitive loss, Activity of Daily Living (ADL) function, urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 656	Continued From page 13	F 656		

incontinence, falls, pressure ulcers and psychotropic drug use. The MDS revealed all of these items would be included on the Care Plan.

The Comprehensive Care Plan for Resident #7, initiated on 11/4/22, failed to reveal any documentation of cognitive loss, falls or psychotropic drug use. The Care Plan focus area of Activities of Daily Living (ADLs) revealed minimal documentation of only the transfer status of the resident listed and no other ADL areas such as bathing, bed mobility, walking, eating, etc.

2. The Admission MDS of Resident #8 dated 2/8/23 documented the resident had an admission date of 2/2/23. The MDS triggered Care Areas included ADL function, urinary incontinence, falls, nutritional status, dehydration, pressure ulcers and psychotropic drug use. The MDS revealed all of these items would be included on the Care Plan.

The Comprehensive Care Plan for Resident #8, initiated on 2/9/23, failed to reveal any documentation of ADLs, dehydration of psychotropic drug use.

The MDS 3.0 RAI (Resident Assessment Instrument) Manual v1.17.1_October 2019, page 4-11 documents facilities have 7 days after the completing the assessment to develop or revise the resident's care plan. Pages V-5 and V-6 direct the Care Planning Decision column of the MDS must be completed within 7 days of completing the assessment, which is the date the care plan is completed. The Care Plan must be completed within 7 days of the completion of the comprehensive assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 656	Continued From page 14 On 7/6/23 at 1:40 pm the Regional MDS Travel Nurse stated that any Care Areas that trigger for care planning needs to be written as soon as the Care Area Assessment (CAA) portion of the MDS are completed. She stated her expection is for those items to be done within the 7 days of the MDS and kept up to date. The Policy Azria Care Plans, Comprehensive, Person Centered, revision date of March, 2022, directs: The comprehensive, person centered care plan is developed within 7 days of the completion of the required MDS assessment and no more than 21 days after admission.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and record review, the facility failed to provide showers on a routine basis for 2 of 3 residents reviewed (Resident #2 and #4). Findings include: 1. The Quarterly Minimum Data Set (MDS) for Resident #2, dated 5/8//23, identified a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. The MDS documented the resident was completely dependent for bathing and needed the assistance	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 677	Continued From page 15	F 677		

of 2 staff members for bathing.

The Comprehensive Care Plan for Resident #2 failed to reveal any direction to staff for providing bathing for Resident #2.

The Look Back report for the month of June of 2023 for Resident #2 revealed the resident only received one bath for the entire month of June, given on June 27th.

On 7/5/23 at 10:25 am, the State Surveyor was in the room of Resident #2 conducting an interview. During the interview, Staff J, Certified Nurse Aide (CNA), entered the room and offered Resident #2 a bed bath. Resident #2 stated she did not want a bed bath as she prefers showers. Staff J asked Resident #2 to sign a form stating she was refusing a bath that day. Staff J did tell Resident #2 she would complete resident bed baths and if she had time she would come back and provide a shower.

The Behavior Note dated 7/5/23 documented Resident #2 refused her shower. The Behavior Note documented the time as 10:00 am.

2. The Annual MDS assessment for Resident #4 dated 6/4/23 revealed Resident #4 had a BIMS score of 13, which indicated cognition intact. The MDS revealed the activity of bathing did not occur during the 7-day look back period.

The Care Plan for Resident #4 revealed a focus area dated 9/14/21 documenting staff having ongoing conversations with the resident regarding maintaining personal hygiene to include cleanliness and necessity of bathing or showering. No updates to this area of the care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 677	Continued From page 16 plan were documented since 2021. The Look Back report for the month of June of 2023 for Resident #4 revealed the resident only received two baths for the entire of June, given on June 6th and June 8th. On 7/3/23 at 4:38 pm, Resident #4 stated he gets short of breath in a shower so he prefers bed baths rather than showers. He stated he is lucky if he gets a bed bath every few weeks and his preference is at least once a week or at least every two weeks. He stated going a month or longer without a bath is ridiculous. On 7/5/23 at 1:46 pm, Staff K, CNA, stated baths are documented in Point Click Care (PCC, Electronic Health Record) and additionally on a form given to the Human Resources director. She stated if no baths are documented in PCC she would consider that to be accurate. On 7/5/23 at 3:49 PM the Human Resources Director stated all baths that are given are documented in PCC. She uses the forms turned in to her to double check all are documented in PCC then disposes of the forms.	F 677		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 725	Continued From page 17	F 725		

and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on facility record review, resident and staff interviews, and facility policy, the facility failed to answer the residents' call light in less than 15 minutes for 3 of 3 residents reviewed (Resident #3, 4 & 5) for call light response time.

Findings include:

1. The Quarterly Minimum Data Set (MDS) assessment for Resident #3 dated 4/17/23 revealed Resident #3 had a brief interview for mental status (BIMS) score of 13, which indicated cognition intact. The MDS revealed the resident totally dependent upon 2 person physical assistance for bed mobility, and transfers. The MDS revealed the resident required extensive assistance of two staff for toileting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 725	Continued From page 18	F 725		

The Care Plan focus area initiated 8/9/22 revealed social service provided the resident education on call light utilization, and informed the call light an essential means of communication in the facility. The call light sent alerts to the nursing station to indicate when a resident may have a perceived need and required the attention of the nurses on duty. The call light served as a lifeline linking resident to immediate assistance. Call lights had a direct effect on adverse events such as falling, and other general health outcomes. A better understanding of the interactions with the call light system could help to improve patient safety and increase the quality of care.

On 7/5/23 at 10:04 am, Resident #3 stated call lights are slow to be answered.

Record review of facility provided call light reports for 6/1/23-6/30/23 revealed Resident #3 had utilized his call light 55 times during the 30 day period. The longest response time documented was one hour, 22 minutes and 15 seconds. Of the 55 times the resident used his call light, 14 of the times had a response time of greater than 15 minutes.

2. The Annual MDS assessment for Resident #4 dated 6/4/23 revealed Resident #4 had a brief interview for mental status (BIMS) score of 13, which indicated cognition intact. The MDS revealed the resident independent with no setup help needed for bed mobility, transfers and toileting.

The Care Plan focus area Falls revised on 9/12/22 revealed an intervention of caregivers will remind the Resident to use his call device for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	2401 EAST EIGHTH STREET DES MOINES, IA 50316

(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 725	Continued From page 19	F 725		

On 7/3/23 at 4:38 pm, Resident #4 stated it takes "forever" for call lights to be answered. He stated he doesn't feel the facility has enough staff. If there is only 1 CNA for the hall and that person is at the other end it can take 20-30 minutes for a call light to be answered.

Record review of facility provided call light reports for 6/1/23-6/30/23 revealed Resident #4 had utilized his call light 48 times during the 30 day period. The longest response time documented was 52 minutes and 56 seconds. Of the 48 times the resident used his call light, 8 of the times had a response time of greater than 15 minutes.

3. The Annual Minimum Data Set (MDS) assessment for Resident #5 dated 5/18/23 revealed Resident #5 had a brief interview for mental status (BIMS) score of 13, which indicated cognition intact. The MDS revealed the resident required extensive physical assistance of 1 person for bed mobility, transfers and toilet use.

The Care Plan focus area Falls revised on 5/21/18 revealed an intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.

Record review of facility provided call light reports for 6/1/23-6/30/23 revealed Resident #5 had utilized his call light 86 times during the 30 day period. The longest response time documented was one hour, 9 minutes and 37 seconds. Of the 86 times the resident used his call light, 23 of the times had a response time of greater than 15 minutes.

On 7/5/23 at 3:03 pm, the Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. BUILDING _____ B. WING _____	C 07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH PARK PLACE	**2401 EAST EIGHTH STREET DES MOINES, IA 50316**

(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 725	Continued From page 20 the facility has been working on providing staff education regarding call light response times. He stated he feels the primary times call lights are an issue are on the weekends, and the facility is staffing higher on weekend to assist in improving this process. The facility additionally has had a Quality Assurance Performance Improvement (QAPI) meeting addressing call light response times. The document titled Azria Answering the Call light dated 10/2022 directs staff to answer the resident call system timely.	F 725		