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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 000 ✓ ok/CP	INITIAL COMMENTS Correction date: 9/16/2024 The following deficiencies resulted from the facility's Annual Recertification survey and investigation of Complaints #122398-C, #122465-C, #122469-C, #122480-C, #122615-C, and Facility Reported Incidents #122830-I, conducted August 19, 2024 to August 22, 2024. Complaint #122398-C, #122465-C, #122469-C, #122480-C, #122615-C were substantiated. Facility reported incident #122830-I was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Via of Des Moines denies 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 corrections 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 it is in compliance with the requirements of participation, or that corrective action was necessary.	
F 550 SS=E	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	F 550	In continuing compliance with F6550, Resident Rights/Exercise of Rights, Via of Des Moines corrected the deficiency by the DON completed all staff education on 8/23/2024 on appropriate cell phone use, ensuring that personal use of cell phones is not permitted while on duty, around any residents, and during cares, and that staff are to use the English language when around residents. To correct the deficiency and ensure the problem does not recur, the facility completed all staff education on 8/23/2024 on cell phone use in the facility and using English around residents. The Executive Director will audit staff for cell phone use and language with residents 3x/weekly x 4 weeks, 2x weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the Executive Director and/or designee will report identified concerns through the community's QA process.	9/16/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gianni Beer	Administrator	9/9/2024

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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must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
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.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) 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 observation, clinical record review, resident, family, and staff interviews, the facility failed to respect each resident's dignity throughout all cares provided or talk to residents with dignity and respect. The facility reported a census of 71.

Findings include:

1. A direct observation on 08/19/24 at 11:30 AM revealed Staff K, Certified Medication Aide (CMA), on her cell phone at this time. From a period lasting from 11:30 AM until 11:42 AM Staff K remained on her phone while residents were seated and began to eat in the dining room.

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A direct observation on 08/19/24 at 12:06 PM revealed Staff K, CMA, return to her phone for a period lasting until 12:15 PM. During the observation a resident was observed needing comfort because she was afraid she did not have enough money to pay for lunch. Another staff member intervened. Staff K finally put her phone down when a resident spilled a portion of her lunch on the floor and attempted to clean it herself, at which point Staff K put her phone away and assisted other staff members in intervening.

A direct observation on 08/20/24 at 12:23 PM revealed Staff L, Certified Nurse Aide (CNA), leave residents she was currently assisting in the dining room to position herself out of sight in the corner of the family room after receiving a cell phone notification. For a period of just over ten minutes, ending at 12:33 PM, Staff L continued to type on her phone without looking up or otherwise monitoring residents.

A direct observation on 08/20/24 at 02:39 PM revealed Staff L, CNA, use her phone to start music over a blue tooth device for residents. Music played for residents until 02:49 PM, at which time a phone notification sound could be heard over the blue tooth speaker playing music. Staff L took her phone out of her pocket and began to type on her phone. The reply disrupted the music playing, replacing it with a typing sound. Staff L remained on her phone typing until 03:08 PM, at which time the typing sound ended and she used her phone to resume the music for the few residents remaining in the dining room.

In a confidential interview on 08/19/24 at 10:42 AM a residents family member stated the staff are constantly on their phones, often seen

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ignoring residents. They stated they are in the facility almost daily and see staff members in the corners of the rooms on their phones, often while residents are eating.

In an interview on 08/22/24 at 09:18 AM with the Director of Nursing (DON), she stated staff members are to refrain from using their phones while not on break. The expectation is for staff members to keep their phones turned off while on the floor unless they have an extenuating circumstance and an exception to policy discussed with their supervisor. She acknowledged she did not know of any staff member with a current exception to policy working in the Chronic Confused Dementia (CCDI) unit.

Review of an undated facility policy titled "Cell Phone Usage Policy" documented all employees of the facility are expected to leave their personal cell phones in their vehicle or designated employee area. It further documented the use of cell phones during the work day is believed to negatively impact services provided to residents.

2. During a confidential interview on 8/19/24 at 1:45 PM, a resident stated staff are talking on their personal cell phones even when in the resident's room assisting the resident with cares. The resident also reported some staff talk in another language than English when in the resident's room and the resident feels it's rude as the resident does not know if the staff are talking about the resident.

3. During a confidential interview on 8/18/24 at 2:16 PM, a resident stated staff are on their personal cell phones a lot, talking and texting,

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F 550	Continued From page 4 while in the resident's room assisting with the resident's cares. Resident also stated some other staff don't talk English language while in the resident's room and makes the resident feel uncomfortable.	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584	In continuing compliance with F584, Safe/Clean/Comfortable/Homelike Environment, Via of Des Moines corrected the deficiency by the wooden pallet was removed from Station 2 common area on 8/22/2024; baseboard heaters on the 200 hallway were repaired on 8/23/2024; 100 and 200 hallways baseboard trim to be completed by 9/16/2024; the garbage bag near room 206 was removed from the doorway on 8/21/2024; and the soiled wash clothes near room 202 were removed on 8/21/2024; divider curtain of room 206 was removed for cleaning on 8/23/2024; Res. #23 headboard was fixed/replaced on 8/23/2024; and room 206 bathroom light was replaced on 8/23/2024. To correct the deficiency and ensure the problem does not recur, the facility completed all staff education on 8/23/2024 on ensuring appropriate reporting of broken furniture and any safety concerns. The Executive Director and/or designee will audit on ensuring the facility is providing a safe and homelike environment as appropriate 2x/weekly for 12 weeks and then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the Executive Director and/or designee will report identified concerns through the community's QA process.	9/16/2024

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F 584	Continued From page 5 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and policy review, the facility failed to provide a clean, comfortable and homelike environment. The facility identified a census of 71 residents. Findings include: Observations revealed the following: On 08/19/24 at 8:50 AM: a. A wooden pallet laid on the floor in the common area and smaller dining room across from the Station 2 nurse's station. The wooden pallet had boxes of flooring on it. b. The baseboard heaters on the 200 hall by the exit door had metal flaps that were bent up and torn away from the heater. c. The walls in the 100-400 hallways had missing baseboards (trim). d. A clear plastic bag of garbage contained a soiled brief, paper towels, and gloves, and a large black garbage bag laid on the floor by the doorway in room 206. e. Soiled washcloths lying on the floor by the door in room 202. A sign on the wall revealed the resident on enhanced barrier precautions. At 10:25 AM, the wooden pallet laid on the floor (between 2 recliner chairs) with boxes of flooring remained in the common area across from the	F 584		

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F 584	Continued From page 6 Station 2 nurse's station. At the time, five residents (Resident #9, #20,#26,#29, and #68) sat in the same common area /smaller dining room across from Station 2 nurse's station. On 08/20/24 at 7:59 AM: a. The divider curtain in room 206 had a dried brown stain on it. b. The headboard on Resident #23's bed was loose and slanted downward on the bed. The headboard wood felt rough and had particles of wood showing. Multiple black ties were wrapped around the headboard and bedframe. c. The bathroom light in room 206 was not working. On 08/22/24 at 10:35 AM, the pallet with flooring remained on the floor in the Station 2 common area. At the time, 5 residents were seated in the area watching tv or sleeping. On 08/22/24 at 10:42 AM, the divider curtain in room 206 still had a brown stain. Resident #23's headboard on the bed still broken and had multiple black ties on it. In an interview 08/21/24 at 9:01 AM, Staff F, Maintenance Assistant, reported he fixed the beds and whatever else needed done at the facility. Staff put in a work order in the TELS system or verbally notified him when something needed repaired. He called the company if a bed wasn't the facility's bed and in need of repairs or checked. Staff F reported a remodel project completed in the Iris Unit and they have been doing renovations on Station 2. In an interview 08/21/24 at 10:14 AM, the Regional Maintenance Director stated he came to	F 584		

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the facility about once a week. The new company took over around 4/2024 and they had been in the process of fixing things up. They removed the carpet in the halls and had been working on installing new flooring, and baseboards on Station 2. Some heater bases replaced but no plans to change out unless bad the heaters were badly damaged.

In an interview 08/22/24 at 10:57 AM, Staff G, housekeeper, reported she took the divider curtains down to launder them whenever she saw they were dirty.

In an interview 08/22/24 at 10:58 AM, Staff F, Maintenance Assistant, reported staff reported things that needed repaired or checked every day. He also checked the electrical remotes and fixed the beds about every day. Staff F reported Resident #23's headboard had been like that (slanted and loose) for awhile. He fixes the headboard but thought the resident knocked on it. At the time, Staff F observed the headboard on Resident #23's bed with the surveyor and stated the headboard needed repaired or replaced.

In an interview 08/22/24 at 11:11 AM, the housekeeping supervisor reported they tried to clean the divider curtains in the resident rooms, and aimed to do a hall a week.

In an interview 08/22/24 at 1:00 PM, Staff F reported he fixed the bed in room 206. The surveyor verified the headboard attached to the bedframe and no longer slanted and loose, and the headboard no longer had multiple ties to hold the headboard to the bedframe.

In an interview 08/22/24 at 1:30 PM, the

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F 584	Continued From page 8 Administrator reported a new company took over on 1/2024. The Administrator reported they tried to pull the manpower to lay the flooring and finish the trim by the nurse's station and common area. In an email dated 8/22/24 at 2:16 PM, the surveyor requested a policy for homelike environment. The surveyor's email also included to let the surveyors know if the facility had no policy. In an email 8/22/24 at 4:21 PM, the Administrator wrote we do not have policies for the other requests (homelike environment).	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625	In continuing compliance with F625, Notice of Bed-Hold Policy Before/Upon Transfer, Via of Des Moines corrected the deficiency by providing 1:1 education with the Social Worker on ensuring bed holds for Res. #36, #43, and all like residents are completed in a timely manner on 8/21/2024. To correct the deficiency and ensure the problem does not recur, the facility completed staff education on 8/23/2024 on ensuring that bed hold notices are delivered in a timely manner to residents. The DON and/or designee will audit 2x weekly for 12 weeks and then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview the facility failed to provide the resident/resident representative notice of the bed hold policy at the time of transfer for hospitalization for two (Residents # 36 and #43) of three residents reviewed. The facility reported a census of 71 residents.

Findings include:

1. A Minimum Data Set for Resident #36 dated 6/6/24, included diagnoses of heart failure and diabetes. A Brief Interview for Mental Status score of 15 indicated no cognitive impairment for decision-making.

Review of resident's progress notes documented the resident was admitted to the hospital 5/26/24 and returned to the facility 6/3/24.

Review of resident's clinical record lacked documentation of notification to the resident/ resident's representative regarding the bed-hold policy when transferred to the hospital.

2. Minimum Data Set for Resident #43 dated 8/8/24, included diagnoses of diabetes and cancer. A Brief Interview for Mental Status score of 15 indicated no cognitive impairment for decision-making.

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F 625	Continued From page 10 Review of resident's progress notes documented the resident was admitted to the hospital 5/9/24 and returned to the facility 5/14/24. Review of resident's clinical record lacked documentation of notification to the resident/ resident's representative regarding the bed-hold policy when transferred to the hospital. Interview on 8/21/24 at 3:26 PM, the Administrator confirmed no bed hold forms completed for Residents #36 and Resident #43. Interview on 8/22/24 at 10:40 AM, the Director of Nursing stated expectation for a bed hold to be completed with any hospital transfer.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655	In continuing compliance with F655, Baseline Care Plan, Via of Des Moines corrected the deficiency by completing 1:1 education with the MDS coordinator on 8/23/24 by the DON on development and completion of the baseline care plan and that it includes the instructions needed to provide effective and person-centered care for Res. # 76 and all like residents. To correct the deficiency and ensure the problem does not recur, the facility completed staff education on 8/23/2024 on ensuring appropriate high-risk medications are in baseline care plans. The DON and/or designee will audit baseline careplans 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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F 655	Continued From page 11 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop and implement a Baseline Care Plan that included anticoagulant (blood thinner), antipsychotic, and antidepressant medications and monitoring for one (Resident #76) of three residents reviewed. The facility reported a census of 71 residents. Findings include: A Minimum data set (MDS) assessment dated 8/14/24 for Resident #76, included diagnoses of heart failure, anxiety disorder, and mood disorder.	F 655		

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F 655	Continued From page 12 Review of resident's order summary report dated 8/21/24, listed the following medications: 1. Apixaban (anticoagulant) 5 milligrams (mg)- 2 times daily. 2. Duloxetine(antidepressant) 40 mg. in the morning and 60 mg. at bedtime. 3. Risperdal (antipsychotic) 1 mg.- 2 times a day. Review of resident's Baseline Care Plan, dated 8/8/24, lacked documentation of the anticoagulant, antidepressant, and antipsychotic medications. Interview on 8/22/24 at 10:27 AM, the Director of Nursing stated expectation for the medications to be included in the baseline care plan. Interview on 8/22/24 at 1:00 PM, the Administrator stated there was no facility policy for the Baseline Care Plan, facility is expected to follow the regulations.	F 655		
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 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: Based on clinical record review, resident, family, and staff interviews, the facility failed to	F 684	In continuing compliance with F684, Quality of Care, Via of Des Moines corrected the deficiency by the DON providing education with the nursing staff on 8/23/2 on expectations of reporting resident change of conditions or concerns to the appropriate facility staff Resident #61 and all like residents to ensure the facility is addressing resident quality of care in a timely manner. To correct the deficiency and ensure the problem does not recur, the facility initiated Stop and Watch forms on 8/23/2024 on ensuring staff notify nurse leadership of any resident concerns. DON and/or designee will audit the Stop and Watch forms and their follow-through as appropriate 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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appropriately provide assessment and interventions for the necessary care and services, to maintain the residents' highest practical physical well-being. Clinical record review revealed the nursing staff failed to provide thorough assessment, did not contact the resident's physician in a timely manner or provide treatment for 1 of 18 residents reviewed. (Resident#61).

Findings include:

The Minimum Data Sample (MDS) for Resident #61, dated 06/27/24, documented a brief interview for mental status score (BIMS) of 99, indicating the resident was unable to complete the interview. The MDS documented relevant diagnoses of Non-Alzheimer's Dementia, anxiety disorder, and bipolar disorder.

The Care Plan, last updated on 07/15/2024, documented Resident #61 is dependent on staff to meet her emotional, intellectual, physical, and social needs.

Review of a health status note dated 07/22/2024 documented a phone call between a resident family member and Staff M, Registered Nurse (RN), in which the family member states she had spoken to staff members over the course of two weeks about reported pain in Resident #61's right thumb.

In an interview on 08/22/24 at 08:11 with Staff M, RN, she stated Resident #61 had mentioned pain in her right thumb for approximately two weeks before an order for an X-ray was received on 07/25/24. She assessed Resident #61 for impairment to the range of motion or swelling and

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didn't note anything. She stated she had provided as needed Tylenol after assessing the resident's thumb.

In an interview on 08/22/24 at 08:35 AM with Staff K, Certified Medication Aide (CMA), reported Resident #61 had been complaining of pain in her right thumb and been more resistant to cares for at least two weeks leading up to the resident's X-ray on 07/25/24. She stated she did not believe she had reported the pain to anyone else or documented it in the electronic health record (EHR). She stated she had provided as needed (PRN) Tylenol on several occasions.

In an interview on 08/22/24 at 08:53 AM with Staff L, Certified Nurse Aide (CNA), she stated Resident #61 had been reporting pain in her right thumb for days before receiving an X-ray on 07/25/24.

Review of Resident #61's Medication Administration Record (MAR) dated from 07/01/24 to 08/22/24 documented that her as needed Tylenol had only been documented as administered on one occasion between 07/01/24 and 08/22/24, on 08/06/24.

In an interview on 08/22/24 at 09:18 AM with the Director of Nursing (DON), stated the expectation is for staff members to take all newly reported resident pain seriously by informing nursing staff and document in the Electronic Health Record (EHR) to track. She acknowledged she expects nursing staff to use their best nursing judgement and to contact the physician if assessment reveals something abnormal.

In an email sent by the facility administrator on

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F 684	Continued From page 15 08/22/24 at 12:53 PM she stated the facility does not have a policy for assessment and intervention.	F 684		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, staff interview, competency checklist, and a mechanical lift manufacturer user instruction manual, the facility staff failed to utilize safe transfer technique when they used a mechanical lift (Hoyer) transfer device for 1 of 3 residents observed for transfers and required a mechanical lift for transfers (Resident #23). The facility also failed to ensure adequate ventilation and temperature controls in a room that contained servers and electronic devices. The facility also failed to ensure bathroom call lights accessible for residents and staff for 1 of 3 units observed. The facility reported a census 71 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 6/20/24 revealed Resident #23 had diagnoses of dementia, muscle weakness, and anxiety. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of	F 689	In continuing compliance with F689, Free of Accident Hazards/Supervision/Devices, Via of Des Moines corrected the deficiency by the DON provided education with nursing staff on 8/23/2024 on expectations on the proper use of mechanical lifts with Resident #23 and all like residents. On 8/22/2024 the server room was equipped with a portable AC unit. The call light in room 206 was replaced on 8/23/2024. All resident rooms call lights were audited for proper functioning on 8/23/2024 by the Maintenance Director. To correct the deficiency and ensure the problem does not recur, the facility hung manufacturer operating instructions on lifts on 9/6/2024; completed a plan to schedule the installation of a cooling apparatus in the server room by (DATE); and the facility installed an apparatus to render the call light usable by Resident #75. The DON will audit mechanical lift transfers 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. The Executive Director and/or designee will audit the server room for appropriate temperature/door closure 2x/weekly x 12 weeks then PRN to ensure continued compliance. The Maintenance Director will audit 10 rooms calls weekly x 12 weeks to ensure they are in functioning status and then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the Executive Director and/or designee will report identified concerns through the community's QA process.	9/16/2024

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3 out of 15, which indicated severely impaired cognition. The MDS documented the resident had dependence on staff for transfers.

The Care Plan revised 6/21/24 revealed the resident had a self-care deficit in activities of daily living related to dementia, impaired cognition, and impaired safety awareness. The Care Plan directed staff to use a Hoyer (mechanical lift) and two staff for transfers.

During observation on 08/20/24 at 7:55 AM, Staff D, Certified Nursing Assistant (CNA), placed a sling under Resident #23 while the resident laid in bed. At 7:57 AM, Staff C, CNA, and Staff D attached the sling straps to a mechanical lift. Staff D moved the leg bars together, raised the resident up in the mechanical lift, and transferred the resident from the bed to a broda chair. Staff D opened the legs (outward) on the mechanical lift as she moved the lift under the broda chair in order for the lift legs to straddle around the broda chair. Staff D lowered the resident into the broda chair and removed the straps from the bar on the mechanical lift. Staff D then moved the mechanical lift legs together on the lift after she pulled the mechanical lift machine out from under the broda chair.

In an interview 08/21/24 at 1:55 PM, the Director of Nursing (DON) reported the proper use of a mechanical lift. The mechanical lift legs should be "in" whenever the lift had no resident in it. The mechanical lift legs should be open whenever there was a resident in the lift and during the transfer of a resident so it is safe for the resident. The mechanical lift legs left open to prevent the resident from hitting their feet on the mechanical lift, and also in order to balance the resident and

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the machine so the lift doesn't tip.

The facility's Hoyer Lift Competency updated 5/11/21 revealed the following:
1. Place sling under the resident
2. Position and secure the brakes on the bed or chair
3. Place the lift with the legs of the lift opened to the widest setting and the boom arm is centered over the resident. Lower the boom arm to hook the sling on the lift.
4. The lead caregiver uses the controls to raise the resident off the bed. The "helper" assures the sling is secured and may need to hold the resident's head.
5. The "lead" pulls the lift from the bed.
6. Ensure the resident's safety and properly positioned, then resume transfer. If possible, turning the lift should be avoided by moving the wheelchair to the lift.
7. Lower and position the resident into the chair.
8. Remove the sling

An undated Hoyer User Instruction Manual revealed the mechanical lift is not intended to be a transport device. The legs on the Hoyer HPL 700 are electrically adjustable for width. The legs opened to enable access around chairs and wheelchairs. The lift legs should be in the closed position for negotiating narrow doorways and passages.

2. Observations revealed the following:
On the Skilled Unit:
a. On 08/19/24 at 2:22 PM, a folding chair propped the door open to the server room. A small fan sat on top of the folding chair and faced toward the server room. The air temperature in the hallway leading up to the server room and the

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server room felt extremely warm.
b. On 08/21/24 at 7:41 AM, a folding chair propped the door open to the server room. A fan sat on top of the folding chair and faced toward the inside of the server room. A larger fan sat on the floor in the hallway near the door to the server room. The air temperature in the room and surrounding hallway continued to feel hot.
c. On 08/22/24 at 10:20 AM, the folding chair continued to prop the door open to the server room. A fan sat on top of the folding chair and faced toward the inside of the server room. A larger fan sat on the floor in the hallway near the door to the server room.

In an interview 08/22/24 at 10:33 AM, Staff J, certified medication aide (CMA) reported the door to the server room propped open and had a fan blowing (into the room) because the room got really hot. He was unsure what the temperature got up to in the room. Staff J reported IT checked the temperature and monitored things in the server room. At the time, two residents resided on the skilled unit. Staff J reported one resident independent and able to go outside of her room.

In an interview 08/22/24 at 10:58 AM, Staff F, Maintenance Assistant, reported the server room got really warm. They ran the air conditioner (AC) in the room to help cool the room but it didn't seem to help. Staff F reported they kept the door to the server room open and used a fan to circulate the air.

In an interview 08/22/24 at 12:49 PM, the Information Technologist (IT) reported he came to the facility about four times a month, but he had remote access to the VPN and the server. The IT reported the servers and electronic equipment

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such as the video and call systems in a small room on the lower lever and it had been that way since he started working for the company in 2015. The air conditioner (AC) unit in the server room had been a challenge because they no longer made parts for this AC unit . It was a challenge to keep the room cool so they put fans in there. The AC worked a month ago but then had problems with the AC again recently. The IT reported there is no way to vent the room into an open area due to the concrete floor and no subflooring under the room to do so. The IT reported there was not alot of server equipment or sensitive equipment hurt by the heat in that room. He kept the equipment clean and blew the units out regularly. He had replacement equipment and most generally could have things back up and running in an hour if something went down.

On 08/22/24 at 1:10 PM, a Room Temperature app (application) revealed the temperature at 78 degrees Fahrenheit (F) in the server room. At the time, the IT reported the air conditioner wasn't working when he entered the room. The IT stated the AC unit was in the ceiling. He checked the thermostat on the wall behind the door and something had tripped so he called and got the thermostat reset. The IT reported the AC ran now but would take awhile to cool the area.

3. On 08/19/24 at 2:32 PM, Resident #75 reported an incident when staff left him in the bathroom. The bathroom had no call light for him to pull to let staff know he needed assistance. At the time, the surveyor observed a chrome cover with a small metal lever but no string or device to pull the call light in the bathroom.

On 08/20/24 at 7:59 AM, the call light in the

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F 689	Continued From page 20 bathroom in room 206 had a very small metal level on it and no device for a resident or staff member to pull the call light.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690	In continuing compliance with F690, Bowel/Bladder Incontinence, Catheter, UTI, Via of Des Moines corrected the deficiency by the DON completed education with staff on 8/23/2024 on expectations regarding proper methods of peri care for Resident #23 and all like residents to ensure the facility is providing proper bowel/bladder care. To correct the deficiency and ensure the problem does not recur, the DON completed nursing staff education on 8/23/2024 regarding proper peri care for residents. The DON and/or designee will audit peri cares 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, staff interview, and the facility policy review, the facility staff failed to provide complete incontinence care for one of three residents reviewed (Resident #23). The facility reported a census of 71 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 6/20/24 revealed Resident #23 had diagnoses of dementia. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severely impaired cognition. The MDS documented the resident had incontinence, and had dependence on staff for toileting hygiene.

The Care Plan revised 2/8/24 revealed the resident had a self-care deficit in activities of daily living and had incontinence. The resident required maximum assistance for bed mobility and dressing. The care plan directed staff to clean the peri-area after each incontinence episode.

During observation on 08/20/24 at 07:44 AM, Resident #23 ly in bed while Staff C, certified nursing assistant (CNA), provided cares. Staff C donned gloves, removed the tabs on the resident's brief, then took a disposable wipe and cleansed the resident's groin bilaterally. Staff C then took one wipe and cleansed down the front (peri-area). Staff C pushed each wipe down and left the soiled wipes in place after she cleansed

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each area. Staff C rolled the resident onto her right side, removed the soiled brief and soiled wipes under the resident, then grabbed the trashcan and placed the items into the trash. Staff C took one wipe and cleansed the buttocks, then placed a clean brief under the resident. Staff C removed her gloves, donned a pair of shorts on the resident, and washed her hands.

In an interview 08/20/24 at 8:05 AM, Staff C, CNA, reported Resident #23's brief was wet when she performed cares and provided incontinence care on 8/20/24 AM while the surveyor observed.

In an interview 08/21/24 at 1:55 PM, the Director of Nursing (DON) reported she expected staff follow the policy whenever they provided peri-care. She also expected staff changed their gloves and sanitized their hands whenever going from a dirty to a clean area.

The facility's Peri Care Competency revealed the following procedural steps:
1. Assemble equipment and supplies.
2. Wash hands and don gloves.
3. Gently separate the labia, wash one side then the other cleansing from front to back.
4. Wash the left and right inner thighs. Use a new wipe for each area and one swipe wipe technique.
5. Place soiled wash cloths into a plastic bag.
6. Remove gloves before turning the resident onto their side.
7. Wash the anal area front to back.
8. Wash the buttocks and both hips.
9. Remove gloves, wash hands, and roll the resident onto their side and onto a clean, dry surface.
10. Remove gloves and cleanse hands.

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F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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 §483.71. §483.35(a)(3) 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. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. 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 direct observation, family and staff interviews, the facility failed to appropriately supervise and have interventions in place to ensure the resident's individual safety in the Chronic confusion and dementing illnesses	F 726	In continuing compliance with F726, Competent Nursing Staff, Via of Des Moines corrected the deficiency by the Executive Director terminating the employment on 8/21/2024 of Staff N who was witnessed sleeping at the facility. To correct the deficiency and ensure the problem does not recur, all staff were educated on 8/23/2024 on the facility policy of not sleeping while on duty. The Executive Director and/or designee will observe the staff at different times of day 3x/weekly x 12 weeks and then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the Executive Director and/or designee will report identified concerns through the community's QA process.	9/16/2024

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F 726	Continued From page 24	F 726		

(CCDI) unit. The facility reported a census of 28 in the CCDI unit and a total census of 71.

Findings include:

In a confidential interview on 08/19/24 at 10:42 AM with a resident Family Member A, they stated they felt they had to take over many of the cares their family member received because the facility staff had a pattern of ignoring their loved ones needs. They stated they were performing several of their family members activities of daily living after discovering their family member soiled with dried feces on them.

In a confidential interview on 08/19/24 02:22 PM with Resident Family Member B, they stated their loved one had been found on multiple occasions heavily soiled with dried feces on their body. They stated staff members often told them the resident had refused all cares, and had not showered in weeks as a result.

A continuous direct observation that started on 08/20/24 at 10:32 PM of the CCDI unit revealed Staff N, Certified Nurses Aide (CNA), asleep in a chair positioned towards the center of the CCDI unit. A resident was actively having a behavioral episode that could be heard down the hallway and through the locked doors of the CCDI unit. Staff N resisted attempts from Staff O to wake her up by loudly clearing her throat and making loud vocalizations. She continued to sleep as the surveyor introduced himself, only waking up when Staff O directly addressed her by name. After waking up she continued to fall asleep until she requested to go on break at 08/20/24 11:28 PM.

During the observation 08/20/24 at 10:48 PM,

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F 726	Continued From page 25 Staff N was approached by Resident #12 who asked for a glass of orange juice or hot chocolate. Staff N attempted to redirect Resident # 12, informing her they were out of orange juice and the kitchen was closed. Resident #12 continued to ask and be denied her request until Staff N stated "fine" and left the unit at 08/20/24 11:11 PM to get Resident #12 a hot chocolate. Upon receiving the hot chocolate, Resident #12 immediately returned to her bedroom. In an interview on 08/22/24 at 09:18 AM with the Director of Nursing (DON), she stated it was unacceptable for staff members to sleep during their shift. She stated it was explicitly against the code of conduct. Review of an undated facility document titled "Work Rules", under section 5, records that staff members are prohibited from sleeping on the job.	F 726		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interview, and policy review the facility failed to assure a medication error rate of less than 5%. During observation of medication administration, the facility had 5 errors out of 37 opportunities for error resulting in an error rate of 13.51% (Residents #69). The facility identified a census of 71 residents	F 759	In continuing compliance with F759, Free of Medication Errors, Via of Des Moines corrected the deficiency by providing 1:1 education to Staff A on 9/4/2024 by DON on following physician orders for g-tube medications for Res #69 and all like residents. Physician was notified and order received to cocktail Res #69 medications on 8/23/2024. To correct the deficiency and ensure the problem does not recur, the DON provided education to nurses on 8/23/2024 on the importance of avoiding medication errors and ensuring physician orders are being followed when administering medications . The DON and/or designee will audit g-tube medications to ensure they are being delivered per physician order 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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F 759	Continued From page 26	F 759		

Findings include:

During observation on 08/20/24 at 3:28 PM, Staff A, Licensed Practical Nurse (LPN), checked the electronic health record (EHR) and obtained a Styrofoam cup with hot water. Staff A reported the hot water would help dissolve the pills better. Staff A prepared the following medication for Resident #69:
1. Amantadine (anti-seizure/tremor medication) 15 milliliters (ml)
2. Docusate sodium (stool softener) 30 ml
3. Atorvastatin (for cholesterol)10 milligrams (mg)
4. Eliquis (blood thinner) 5 mg
5. Metoprolol (for blood pressure) 25 mg
Staff A crushed the pills (atorvastatin, eliquis, and metoprolol) and placed them into the liquid medication and warm water mixture in the Styrofoam cup. Staff A then stirred the contents together.
At 3:37 PM, Staff A donned a gown and gloves, and placed the Styrofoam cup with medications on a table. Staff A checked placement of the Peg tube. Staff A attached a syringe to the Peg Tube, poured an unmeasured amount of water into the syringe, then poured the medication mixture into the syringe until the stryofoam cup emptied, and then poured 60 ml of water into the syringe. Staff A removed the syringe and plugged the Peg tube.

An order summary report revealed Resident #69 on a mechanical soft diet. An active verbal order started on 04/29/2024 revealed medications may be given through the Peg tube as needed. The order summary lacked an order to cocktail medications whenever g-tube (gastrostomy) (a tube in the stomach) medications administered.

The Medication Administration Record (MAR)

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F 759	Continued From page 27 dated 8/1/24 to 8/31/24, revealed amantadine, docusate sodium, atorvastatin, eliquis, and metoprolol administered by Staff A on 8/20/24 on the evening/PM shift. In an interview 08/21/24 at 1:40 PM, the Director of Nursing (DON) reported she expected staff followed the policy for g-tube medication administration. The DON stated g-tube medications given individually along with the amount of water flush per the physician's orders. At the time, the DON checked Resident #69's EHR and reported an order for medications may be given through the Peg tube as needed. The DON confirmed no order to cocktail the medications for Resident #69. In an interview 08/22/24 at 10:50 AM, Staff I, LPN, reported medications given one at a time whenever medications given through a g-tube. A facility's Medication Administration via Enteral Tube Policy revised 1/31/24 revealed each medication administered separately unless had a physician's written order that medications may be combined and given all together. The enteral tube flushed with at least 15 ml of water after each medication administered.	F 759	In continuing compliance with F760, Residents are Free of Significant Med Errors, Via of Des Moines corrected the deficiency by providing 1:1 education with Staff A on 9/4/2024 by the DON on following physician orders for g-tube medications for Res #69 and all like residents. The physician was notified and order received to cocktail Res #69 medications on 8/23/2024. To correct the deficiency and ensure the problem does not recur, the DON provided education to nurses on 8/23/2024 on the importance of avoiding medication errors and ensuring physician orders are being followed when administering medications. The DON and/or designee will audit g-tube medications to ensure they are being delivered per physician order 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024
F 760 SS=D	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, observation, staff interview, and policy review, the facility failed	F 760		

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to follow the physician's orders and administer medications as ordered. Facility staff administered medications through a gastrostomy tube instead of by mouth as ordered for 1 of 7 residents observed during medication administration. The facility reported a census of 71 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 7/3/24 revealed Resident #69 had diagnoses of stroke, non-Alzheimer's dementia, seizure disorder, and dysphagia. The MDS documented the resident had impaired short-term and long-term memory and severely impaired decision making skills. The MDS indicated the resident on a mechanically altered diet and had a tube feeding.

The Care Plan revised 5/3/24 revealed the resident had a Peg tube placed during hospitalization. The care plan directed staff to administer medications as ordered.

The Medication Administration Record (MAR) dated 8/1/24 to 8/31/24, revealed Staff A, Licensed Practical Nurse (LPN) documented amantadine, docusate sodium, atorvastatin, eliquis, and metoprolol medications administered on 8/20/24 on the evening/PM shift.

An order summary report revealed Resident #69 had physician's order to administer amantadine, docusate sodium, atorvastatin, apixaban (eliquis), and metoprolol by mouth. An active verbal order started on 04/29/2024 revealed medications may be given through the Peg tube as needed. The order summary lacked an order to cocktail

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medications whenever g-tube (gastrostomy) (tube in the stomach) medications administered.

During observation on 08/20/24 at 3:28 PM, Staff A, Licensed Practical Nurse (LPN), checked the electronic health record (EHR) and obtained a Styrofoam cup with hot water. Staff A reported the hot water would help dissolve the pills better. Staff A prepared the following medication for Resident #69:
1. Amantadine (anti-seizure/tremor medication) 15 milliliters (ml)
2. Docusate sodium (stool softener) 30 ml
3. Atorvastatin (for cholesterol)10 milligrams (mg)
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Staff A crushed the pills (atorvastatin, eliquis, and metoprolol) and placed them into the liquid medication and warm water mixture in the Styrofoam cup. Staff A then stirred the contents together.
At 3:37 PM, Staff A donned a gown and gloves, and placed the Styrofoam cup with medications on a table. Staff A checked placement of the Peg tube. Staff A attached a syringe to the Peg Tube, poured an unmeasured amount of water into the syringe, then poured the medication mixture into the syringe until the stryofoam cup emptied, then poured 60 ml of water into the syringe. Staff A removed the syringe and plugged the Peg tube. Removed her gown and gloves, and washed her hands.

In an interview 08/21/24 at 1:40 PM, the Director of Nursing (DON) reported she expected staff followed the policy for medication administration. The DON stated g-tube medications given individually along with the amount of water flush per the physician's orders. At the time, the DON

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checked Resident #69's EHR and reported an order for medications may be given through the Peg tube as needed. The DON confirmed no order to cocktail the medications for Resident #69.

In an interview 08/22/24 at 10:50 AM, Staff I, LPN, reported medications given one at a time whenever medications given through a g-tube.

In an interview 08/22/24 at 10:24 AM, Staff H, Speech Therapist (ST), reported Resident #69 discharged from ST on 7/18/24. The ST stated she worked with the resident on diet texture and swallowing. The ST stated she was unsure if Resident #69 took pills orally or if nursing staff gave the medications through the g-tube.

In an interview 08/22/24 at 12:55 PM, a family member reported the resident received medications through the Peg tube in her abdomen but he was not here all of the time to see if staff gave the medications another route. The family decided to leave the tube in place in case she had a seizure or something happened and she wouldn't be able to eat or take things orally. The resident had been eating with much encouragement from family members.

In an interview 08/22/24 at 1:20 PM, Staff H, ST, reported she thought the nursing staff gave Resident #69's medications through the g-tube. The ST reported if a resident on a regular diet, the resident may be able to take medications orally. The resident went to the hospital after she had a seizure, and that's when the feeding tube was placed. Staff H reported Resident #69's tube got pulled out once and staff had concerns they couldn't replace the tube until the following week,

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F 760	Continued From page 31 and at that time, staff had a concern for making sure the resident got her medications. The ST stated the resident had receptive aphasia. She thought maybe the resident didn't understand fully and maybe staff wanted to ensure she got her medications so that is why the medications administered through the tube. A facility's Medication Administration via Enteral Tube Policy revised 1/31/24 revealed each medication administered separately unless had a physician's written order that medications may be combined and given all together. The enteral tube flushed with at least 15 ml of water after each medication administered.	F 760		
F 880 SS=E	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	F 880	In continuing compliance with F880, Infection Prevention and Control, Via of Des Moines corrected the deficiency by the Director of Nursing or designee completing education with staff on 8/23/2024 that Residents #6, #7, #17, #28, #41, and all like residents are to be cared for while adhering to infection prevention and control best practices, including EBP. To correct the deficiency and ensure the problem does not recur, the DON educated all nursing staff on ensuring that orders are on on the TAR to rinse nebulizers after each use; gloving use and hand hygiene; donning/doffing of PPE with residents on EBP; adhering to infection control standard when it comes to process to empty a catheter bag/dressing changes/treatments/pericare process/ and how to disinfect care devices between residents. The DON and/or designee will audit infection control practices 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then PRN to ensure continued compliance. As a part of Via of Des Moines' ongoing commitment to quality assurance the DON and/or designee will report identified concerns through the community's QA process.	9/16/2024

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conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(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
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observation, staff interviews, and policy review the facility failed to utilize infection control techniques in order to prevent cross contamination for 2 of 3 residents reviewed for catheter care, treatments, and dressing changes (Resident #6 and #28). The facility also failed to ensure staff changed gloves and performed hand hygiene when contaminated for two of three residents observed. The staff failed to utilize a barrier and disinfect contaminated equipment and surfaces after use for 1 of 3 units observed. The facility staff also failed to don personal protective equipment on a resident on enhanced barrier precautions prior to catheter care for 1 of 3 units observed. The facility also failed to provide peri-care in a manner to prevent cross-contamination and infection for 1 of 3 residents observed for peri-care. The facility also failed to disinfect resident care devices when soiled for 2 of 3 residents observed during incontinence/catheter cares (Resident #6 and #41). The facility staff failed to rinse nebulizer equipment after use with hot water for 1 0f 1 treatments observed. (Resident#7). The facility reported a census of 71 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 7/18/24 revealed Resident#6 had diagnosis of neurogenic bladder, renal insufficiency, and urinary retention. The MDS indicated the resident

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had an indwelling catheter.

The Care Plan revised 4/5/2024 revealed the resident had a suprapubic catheter and a history of UTI (urinary tract infection).

During observation on 08/20/24 at 12:10 PM, Resident #6 lying in bed. An EBP sign sat on the counter by the sink. Staff C, certified nursing assistant, donned gloves, sat a graduate container on the floor by the resident's bed. Staff C unclamped and drained the catheter into the graduate container, the replaced the catheter port into the holder on the catheter bag. Staff C measured the amount of urine in the graduate then emptied the graduate into the toilet. Staff C then took toilet paper and wiped the inside of the graduate container and placed the graduate on the back of the toilet. Staff C removed her gloves. Staff C placed her hand under the soap dispenser but no soap came out. Staff C stated no soap in the soap dispenser and no soap in the resident's room for her to use. Staff C washed her hands with water. Staff C failed to follow enhanced barrier precautions and don an isolation gown prior to handling and care of the catheter. Staff C did not use a barrier to place the graduate container on, and did not cleanse the catheter port with alcohol after she emptied the catheter. Staff C failed to perform hand hygiene appropriately after she handled the urinary catheter.

In an interview 08/20/24 at 3:40 PM, Staff A, Licensed Practical Nurse (LPN), reported EBP required for residents with a catheter. Gown and gloves worn during cares whenever a resident on EBP.

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

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F 880	Continued From page 35 In an interview 08/21/24 at 11:38 AM, the Infection Preventionist (IP) reported residents who had a catheter or any tubes coming out of the body placed on EBP. She expected staff to put personal protective equipment such as gown and gloves on whenever they entered the resident's room. At the time, the IP provided a list of resident on EBP. The IP confirmed Resident # 6 on EBP according to her EBP list. The IP reported an EBP sign placed inside the room above the light switch in the resident's room. The IP reported she expected staff used a barrier whenever they emptied a catheter. The IP reported staff needed to clean the catheter port with an alcohol swab after a catheter emptied. She expected staff rinsed the graduate with soap and water after the graduate emptied. The IP reported the housekeeping supervisor checked the soap dispensers in the resident rooms weekly and ensured they worked and had soap in them. Observation on 08/22/24 at 10:42 AM revealed the soap dispenser in room 208 still not working. In an interview 08/22/24 at 10:50 AM, Staff I, Licensed Practical Nurse (LPN) reported the housekeepers filled the soap dispensers and maintenance checked the soap dispensers to ensure they worked. In an interview 08/22/24 at 10:57 AM, Staff G, Housekeeper, reported she checked the soap dispensers. Staff let them know when soap dispensers ran out of soap. In an interview 08/22/24 at 10:58 AM, Staff F, Maintenance Assistant, reported staff reported things that needed repaired or checked every	F 880		

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day. Housekeeping filled the soap dispensers but he fixed the soap dispensers and replaced the batteries. At the time, Staff F checked the soap dispenser in Rm 208. Staff F placed his hand under the dispenser but no soap came out or sound heard. Staff F reported the soap dispenser not working. Staff F opened the front of the dispenser, removed the batteries and put the batteries back in, then closed the front of the dispenser. Staff F stated the dispenser needed batteries. At the time, the EBP sign remained on the sink counter in the resident's room

An Enhanced Barrier Precautions policy updated 5/6/24 revealed EBP implemented for the prevention of transmission of multidrug resistant organisms. A gown and gloves used during high contact resident care activities including handling and care of a urinary catheters.

In an email dated 8/22/24 at 2:16 PM, the surveyor requested a policy for emptying the catheter bag. The surveyor's email also included to let surveyors know if the facility had no policy.

In an email 8/22/24 at 4:21 PM, the Administrator wrote we do not have policies for the other two requests (homelike environment and emptying the catheter bag).

2. The MDS assessment dated 7/11/24 revealed Resident #28 had diagnosis of diabetes with foot ulcer, viral hepatitis, and a Stage 3 pressure ulcer on the right heel.

The Care Plan revised 5/2/24 revealed Resident #28 had an unstageable pressure area on her right heel. The resident had potential for impaired

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skin related to diabetes and impaired mobility. The care plan staff directives included treatments per physician's orders

The order summary revealed an order to cleanse the right heel wound with wound cleanser, apply Clobetasol 0.05% to periwound (surrounding around the wound), then apply collagen sheet to the wound, cover with ABD (large dressing) pad, and secure with a gauze roll daily and PRN (as needed) started on 07/18/24.

During observations on 08/21/24 at 9:35 AM, Staff A, Licensed Practical Nurse (LPN), placed supplies on a towel on an overbed table by the bed. Staff A washed her hands, then donned a gown and gloves. Staff A reported Resident #28's right heel wound dressing off because therapy had just performed an ultrasound to the foot. Staff A reached into her uniform pocket, pulled out a pair of scissors and cut a roll of gauze. Staff A sprayed wound cleanser onto the resident's right heel, then took gauze and wiped the area. Staff A changed her gloves, then took a q-tip and applied Clobetasol to the skin around the wound area. Staff A applied Puracol collagen and an ABD dressing over the right heel wound. Staff A pulled and moved the yellow gown with her gloved hand, reached into her uniform pocket to get tape, and applied tape to the dressing. Staff A reached into her uniform pocket again, pulled out a pen, and wrote the date and her initials on the tape. Staff A removed one glove, then removed the yellow gown and her other glove, and rolled the gown up and placed the gown and glove into the trashcan. Staff A washed her hands, donned a glove, rolled the wound cleanser, tape, scissors, and hand sanitizer into the towel on the overbed table, tucked the towel and supplies

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against her uniform, opened the door to the resident's room with her gloved hand, then removed the glove, and took the towel with supplies rolled up inside to the soiled utility room. Staff F, Assistant Director of Nursing, stood in the room with the surveyor and observed Staff A during the procedure.

In an interview 08/21/24 at 11:38 AM, the Infection Preventionist reported some residents with a wound placed on EBP. At the time, the IP provided a list of resident on EBP. The IP confirmed Resident #28 on EBP according to her EBP list. The IP reported she expected staff removed gloves and gown, and sanitized hands before they removed an item from their pocket, then wash or sanitize hands again, and reapply a gown and gloves to resume the treatment. The IP reported staff should plan accordingly and place supplies on barrier prior to a procedure. If staff forgot something, then they needed to remove the gown and gloves, wash their hands, obtain the supplies, re-sanitize hands, and reapply the gown and gloves. She expected staff to clean scissors with alcohol prior to and after use. Soiled linens should not be carried against the uniform due to infection control reasons.

A facility's Dressing Change Competency updated 5/11/21 revealed the following procedural steps:
1. Gather necessary equipment: plastic biohazard bag, clean towel for clean field, dressing supplies, gloves, pen for making dressing, tape.
2. Wash hands, don gloves
3. Perform treatment: cleanse wound and perform treatment according to the orders
4. Apply dressing and date
5. Discard all waste into a plastic bag

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6. Remove gloves
7. Wash hands
8. Discard waste into biohazard waste and return supplies (clean scissors)

Enhanced Barrier Precautions policy updated 5/6/24 revealed EBP implemented for the prevention of transmission of multidrug resistant organisms.

3. During observation on 08/21/24 at 8:10 AM, Staff E, Licensed Practical Nurse (LPN) prepared and administered an albuterol treatment to Resident #17. Staff E placed the medication solution into the nebulizer chamber, then attached the chamber to a mask and applied the mask over the resident's face. Staff E turned the machine on and set a timer. At 08:26 AM, Staff E removed the nebulizer mask from the resident's face and placed the mask with nebulizer chamber onto the nebulizer machine holder on the bedside table.
Staff E did not rinse the nebulizer chamber parts and mask after the treatment completed.

In an interview 08/21/24 at 1:55 PM, the DON reported staff should pull the nebulizer chamber apart after a nebulizer treatment administered, rinse the nebulizer chamber and mask with water, and allow the pieces to dry.

The facility's Nebulizer Treatment competency update 5/11/21 revealed after treatment administered, take the mouthpiece apart and rinse with hot water and allow to air dry after each use.

4. The MDS assessment for Resident #41, dated

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6/27/24, included diagnoses of diabetes and anxiety disorder and documented the resident had an indwelling catheter (tube into the bladder to drain urine).

Observation on 8/20/24 at 12:53 PM, Staff P, Certified Nurse Aide (CNA) and Staff A, Licensed Practical Nurse (LPN) washed hands and applied a gown and gloves, then proceeded to transfer Resident #41 from the wheel chair to the bed, with a mechanical stand lift, hooking the resident's catheter bag to the arm of the lift during the transfer. Staff P, with the same gloves, proceeded to touch the lift, lift sling, bed and bed rail while transferring the resident and moving the catheter bag from the lift to the bed frame. Staff P, with the same gloved hands, got a graduate (container to empty and measure urine) from the bathroom and placed a paper towel on the floor under the graduate. Staff P proceeded with the same gloved hands and cleansed the tip of the catheter bag tubing with an alcohol swab, emptied the catheter, and cleansed the tip again. Staff P removed her gown and gloves, washed her hands, and placed the mechanical stand lift in hallway.

Interview on 8/20/24 at 1 PM, Staff A confirmed the mechanical stand lift is used for other residents and expectation to wash hands and apply new gloves before emptying catheter bag after touching other items, to keep the catheter bag below the level of the bladder, and clean the mechanical stand lift after use.

Interview on 8/22/24 at 10:21 AM, the Director of Nursing stated expectation to complete hand hygiene when going from dirty surfaces/items to clean and to clean equipment after use.

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