STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Jewish Senior Life Center	900 Polk Boulevard Des Moines, IA 50312

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility record review, and facility policy review, the facility failed to ensure sanitary conditions in the main kitchen and failed to properly sanitize the dining room tables in one of the two facility dining rooms used by the residents for their mealtimes. These failures posed the risk of food borne illness to the residents receiving food from the kitchen and eating in the main dining room. The facility reported a census of 40 residents. Findings include: During an interview on 3/31/26 at 12:51 p.m. with the Dietary Manager, he revealed he had been promoted to the Dietary Manager position three months ago. When asked regarding the sanitizing solution used to clean and sanitize surfaces and equipment in the kitchen and how staff test the sanitizing solution for proper chemical sanitization, he provided a small plastic container of a roll of chemical sanitizer test strips. The plastic container was without a label and he stated he was not sure where the product label was. During an observation of the kitchen on 3/31/26, after the Dietary Manager interview, another container of chemical sanitizer test strips was found by the mechanical dishwasher, the second plastic container was without a label. Continued observations revealed a third container of chemical sanitizer test strips was found by the three-compartment sink. The third plastic container had a label with the product name, colored columns indicating the corresponding Parts Per Million (ppm) for 0, 150, 200, 400, and 500 levels of Quaternary Ammonium (disinfectant/sanitizer), instructions for use, and an expiration date. The expiration date listed was Exp [DATE]. During the continued interview with the Dietary Manager on 3/31/26, he was shown the third container of chemical sanitizer test strips with the label and he agreed the expiration date was January 1, 2025 which was 15 months ago. He could not confirm the expiration dates of the other two containers of chemical sanitizer test strips without labels. Sanitizer test strips with labels were requested from the Dietary Manager. During a further interview on the afternoon of 3/31/26, after the above interview with the Dietary Manager, he was asked how they sanitize the dining room tables and he stated the dietary staff used a packaged Quix Plus product that was labeled Water Release Surface Sanitizing Towel. During an interview and continuous observation on 3/31/26 from 1:30 p.m. to 2:05 p.m. with Staff C, Dietary Aide, she revealed she had worked at the facility since October 2025 and part of her duties included sanitizing the dining room tables after the residents' mealtimes. Observation of this process revealed Staff C used a red six-quart bucket, placed a Quix Plus sanitizing towel in the red bucket and filled the bucket with three quarts of tap water. After filling the bucket with water, she then put on a pair of disposable gloves and left the kitchen to enter the main dining room. She had not squeezed the towel that had been pre-treated with sanitizing chemicals to release the sanitizing chemicals in the water. In the main dining room were seven square-top tables. At 1:35 p.m., Staff C reached into the bucket filled with water for the first time after filling the bucket with water, took the sanitizing towel in her hands and wrung the towel out once to remove the excess water from the towel and cleaned the dining room tables, chair arms and seats, salt and pepper shakers, condiment trays, and vases. Throughout the process, she placed the towel back into the water in the red bucket and wrung out the cloth to wipe another table, dining room chairs, and items in the center of each table. At 1:57 p.m., (continued on next page)

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.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff C placed the towel back into the water in the red bucket and wrung out the cloth for the tenth time. Staff C was informed at this point that she had wrung out the sanitizing cloth ten times after wiping five of the dining room tables, chairs, and items in the center of those tables. Staff C agreed with that observation. Staff C then continued her process to wipe the remaining two dining room tables, dining room chairs, and the items in the center of those two tables. After she completed wiping the dining room tables she returned to the kitchen with the red bucket. During an observation and interview on 3/31/26 at 2:07 p.m. with Staff C, Dietary Aide, she was asked to review the Quix Plus Sanitizing Towel label's directions which were on the box of towels used to wipe the dining room tables in the kitchen's store room. The Quix Plus Sanitizing Towel's Directions for Use revealed Prepare a 200 ppm [parts per million] active quaternary sanitizing solution by the immersion of one sanitizing towel in one gallon of water . Squeeze 10 times to activate the cleaning and sanitizing solution which, used as directed, will sanitize. hard non-porous surfaces. She agreed that she had not squeezed the sanitizing towel ten times prior to using the cloth to sanitize the dining room tables. A test of the Quix Plus Sanitizing Towel's sanitizing solution when placed in the water of the red bucket could not be completed due to the expired chemical sanitizer test strips. In an interview on 3/31/26 at 2:12 p.m. with the Dietary Manager, he revealed he was not able to find any sanitizer test strips with labels other than the expired sanitizer test strips with the 1/1/25 expiration date. When asked how long they had been using those expired sanitizer test strips, he stated he was unsure how long they had been using the expired sanitizer test strips. The Dietary Manager stated he had placed an order for new sanitizer test strips that day which should arrive tomorrow, 4/1/26. In an interview on 4/1/26 at 10:20 a.m. with the Dietary Manager, he revealed the sanitizer test strips had been received and revealed those sanitizer test strips' label had an expiration date of 1/15/28. Observation of the sanitizer test strip's label revealed Exp [DATE]. During an observation and interview on 4/1/26 at 10:25 a.m. in the kitchen with the Dietary Manager, he filled a red six-quart bucket with one gallon of water and placed a Quix Plus sanitizing cloth in the water. The Dietary Manager placed a sanitizer test strip in the water for approximately 10 seconds and then compared the color of the test strip to the color chart on the test strip's label which indicated the solution was at 150 ppm. The Dietary Manager agreed the water was at 150 ppm and had not reached the 200 ppm sanitizing solution indicated on the Quix Plus product label. The Dietary Manager then squeezed the Quix Plus cloth ten times and tested the sanitizing solution with a sanitizer test strip which tested at 400 ppm. In an interview on 4/1/26 at 10:40 a.m. with the Executive Director, she agreed that staff were not able to ensure a sanitizing solution's ppm by using sanitizing test strips that were expired. She agreed that staff should follow the Sanitizing Towel's directions for use by squeezing the towel ten times in one gallon of water to activate the cleaning and sanitizing solution to sanitize surfaces. The Executive Director agreed that the solution used to wipe the dining room tables after yesterday's noon meal was initially not sanitizing the surfaces wiped as the cloth had not been squeezed 10 times as the directions stated. She stated the consultant dietitian had recommended using those Quix Plus sanitizing towels. She was aware that sanitizer test strips were received that day with an expiration date of 1/15/28. She was not sure how long the dietary staff had been using the expired sanitizer test strips. Review of the Quix Plus Water Release Surface Sanitizing Towel's Product Label revealed These towels are pre-treated with sanitizing chemicals for use in restaurants and other food service establishments to sanitize the following hard non-porous food contact surfaces. When activated by immersion in water, they create a sanitizing solution for use on cleaned and rinsed hard non-porous food contact surfaces. These towels must be immersed in water and squeezed 10 times to activate the special sanitizing solution that will kill and control bacteria on precleaned food contact surfaces, when used as directed. DIRECTIONS FOR USE: Prepare a 200 ppm active quaternary sanitizing solution by the immersion of one sanitizing towel in one gallon of water. Squeeze 10 times to activate the cleaning and sanitizing solution which, used as directed, will sanitize the following precleaned hard non-porous surfaces. Remove all gross food particles and soil from surfaces to be sanitized by a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pre-flush, pre-soak or pre-scrape treatment. Wash surfaces thoroughly with a good detergent or compatible cleaner fallowed by a potable water rinse. Store towels/wipers in the sanitizing solution between uses. Prepare a fresh solution daily or more often if the solution becomes diluted or soiled. Dispose of used towels when discarding solution. Test solution regularly with quaternary test strips to confirm ppm activity. Review of the undated facility policy Dining Room and Table Sanitation revealed The facility is committed to maintaining a clean, sanitary, and safe dining environment for all residents, staff, and visitors. To prevent the spread of infection and foodborne illness by ensuring proper cleaning and disinfection of dining room tables and surfaces before and after each meal service. The policy's procedure documented: Use an EPA (Environmental Protection Agency)-approved food-contact surface sanitizer.Follow manufacturer's instructions for proper dilution. Allow tables to air dry. Immediately after meal service:Remove all food debris and dishware Clean tables using detergent or approved cleaner Disinfect all table surfaces, including edges and undersides if soiled Chairs, high-touch areas, and assistive dining devices must also be cleaned and disinfected. Use dedicated cloths or disposable wipes for dining surfaces

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and facility policy review the facility staff failed to perform appropriate hand hygiene with preparation, and administration of medication to four of four residents observed for medication administration (Resident #4, #17, #24, and #27). The facility reported a census of 40 residents. Findings include: During a continuous observation on 4/1/26 from 7:28 a.m. to 8:25 a.m. with Staff D, Certified Medication Aide (CMA), failed to clean and sanitize her hands prior to preparing thirteen medications for Resident #4. Staff D then knocked on Resident #4's room door and gave Resident #4 her medication cup filled with twelve of those oral medications, an oral inhaler medication, and a glass of water. After Resident #4 took her medications, Staff D returned to the medication cart and documented the resident's medication administration in the facility's electronic medical record (EMR) and documented the narcotic medication given in the narcotic binder located on the medication cart. Continued observation; Staff D, CMA failed to clean and sanitize her hands prior to preparing six oral medications for Resident #17. She then knocked on Resident #17's room door and assisted the resident with taking her medications and held the resident's water mug while the resident sipped the water through the straw. After Resident #17 took her medications, Staff D returned to the medication cart and documented the resident's medication administration in the facility's electronic medical record (EMR) and documented the narcotic medication given in the narcotic binder. Further observation; Staff D, CMA failed to clean and sanitize her hands prior to preparing five oral medications for Resident #27. She then wheeled Resident #27 in a wheelchair to the medication cart and placed a blood pressure monitor on the resident's left upper arm and took the residents blood pressure (BP). Staff D then used a plastic spoon and placed each pill in the resident's mouth and assisted the resident to take a sip of water through a straw in the glass of water she provided. Staff D then documented the resident's medications and blood pressure (BP) in the facility's EMR. Continued observation; Staff D, CMA failed to clean and sanitize her hands prior to preparing six oral medications for Resident #24. She then walked into the dining room and gave Resident #24 the medication cup with the six oral medications, and assisted the resident to take the pills with a plastic spoon and a glass of water. Staff D then documented the resident's medication administration in the facility's EMR, and documented the narcotic medication given in the narcotic binder. In an interview on 4/1/26 at 8:27 a.m. with Staff D, CMA, agreed that she had failed to clean and sanitize her hands during the medication administration for Residents #4, #17, #24, and #27. In an interview on 4/1/26 at 10:05 a.m. with the Director of Nursing (DON), stated her expectation was for staff to wash their hands or use a hand sanitizer while administering medications. She stated that staff should wash their hands prior to a resident's medication administration. Observations of that morning's medication pass with Staff D, CNA/CMA were discussed with the DON which included that Staff D had not completed any hand hygiene during my observations. She stated she should have used the hand sanitizer on the medication cart between the residents. The DON was informed that there was no hand sanitizer observed on the med cart. During an interview on 4/2/26 at 8:19 a.m. with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP), Observations of 4/1/26's morning medication administration with Staff D, CNA/CMA, was discussed. The ADON/IP agreed that Staff D should have used a hand sanitizer between the residents who received medications. The facility policy Administration of Medication dated 7/9/24 instructed licensed nursing personnel and/or certified medication aides to Wash hands or use hand sanitizer before and after each administration of medication.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure code status between the Iowa Physician Orders for Scope of Treatment (IPOST), the electronic health record (EHR) and the Care Plan were congruent for 1 of 1 residents reviewed for advanced directives (Resident #46). The facility reported a census of 40 residents. Findings include: Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had a Brief Interview for Mental Status (BIMS) of 6 indicating severe cognitive impairment. Review of the IPOST dated [DATE] revealed Resident #46 had an order for cardiopulmonary resuscitation (CPR) signed by the physician and the resident's responsible party. Review of the EHR for Resident #46 revealed a physician's order with revision date of [DATE] documented as follows; CPR; limited additional interventions; no artificial nutrition by tube. Review of the Care Plan for Resident #46 with a focus area of advanced directives initiated [DATE] and revised [DATE] revealed a code status of do not resuscitate (DNR). During an interview [DATE] at 1:06 PM Staff A, Registered Nurse (RN)/Quality Assurance (QA) acknowledged the Care Plan code status of DNR documented in Resident #46's Care Plan did not match the IPOST order or the electronic health record (EHR) order of CPR. Staff A revealed she would expect code status to match word for word in all areas. During an interview [DATE] at 1:13 PM Staff B, Licensed Practical Nurse (LPN) revealed she would review a resident's code status as needed in their chart, their IPOST and their EHR including their Care Plan. Review of facility policy titled, Iowa Jewish Senior Life Center, dated [DATE] revealed upon determination that a resident is in cardiopulmonary or respiratory arrest, CPR will be immediately initiated by nursing staff and 911 called for advance cardiac life support unless one of the exceptions applies: a. When the resident or surrogate has indicated that resuscitation is not desired and the attending physician has insured a written do not resuscitate (DNR) order that is maintained in the facility's clinical record. During an interview [DATE] at 11:22 AM the Director of Nursing (DON) revealed she would expect code status to match in all areas of the clinical record. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #46 had a Brief Interview for Mental Status (BIMS) of 6 indicating severe cognitive impairment. Review of the IPOST dated [DATE] revealed Resident #46 had an order for cardiopulmonary resuscitation (CPR) signed by the physician and the resident's responsible party. Review of the EHR for Resident #46 revealed a physician's order with revision date of [DATE] documented as follows; CPR; limited additional interventions; no artificial nutrition by tube. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan for Resident #46 with a focus area of advanced directives initiated [DATE] and revised [DATE] revealed a code status of do not resuscitate (DNR). During an interview [DATE] at 1:06 PM Staff A, Registered Nurse (RN)/Quality Assurance (QA) acknowledged the Care Plan code status of DNR documented in Resident #46's Care Plan did not match the IPOST order or the electronic health record (EHR) order of CPR. Staff A revealed she would expect code status to match word for word in all areas. During an interview [DATE] at 1:13 PM Staff B, Licensed Practical Nurse (LPN) revealed she would review a resident's code status as needed in their chart, their IPOST and their EHR including their Care Plan. Review of facility policy titled, Iowa Jewish Senior Life Center, dated [DATE] revealed upon determination that a resident is in cardiopulmonary or respiratory arrest, CPR will be immediately initiated by nursing staff and 911 called for advance cardiac life support unless one of the exceptions applies: a. When the resident or surrogate has indicated that resuscitation is not desired and the attending physician has insured a written do not resuscitate (DNR) order that is maintained in the facility's clinical record. During an interview [DATE] at 11:22 AM the Director of Nursing (DON) revealed she would expect code status to match in all areas of the clinical record.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and the Resident Assessment Instrument (RAI) manual, the facility failed to complete a significant change Minimum Data Set (MDS) assessment after a resident's hospice level of care was discontinued for 1 of 2 residents reviewed for change of condition (Resident #25). The facility reported a census of 40 residents. Findings include: The census in the Electronic Health Record (EHR) revealed on 9/24/25 Resident #25 transitioned from hospice private care to private-pay status. Review of Advance Beneficiary Notice of Non-coverage (ABN) dated 9/22/25 revealed hospice services for Resident #25 would end 9/24/25. Review of the MDS assessment dated [DATE] revealed Resident #25 was not receiving hospice services. Review of the MDS assessment dated [DATE] revealed Resident #25 was not receiving hospice services. Review of the MDS tracking schedule for Resident #25 lacked a significant change assessment following the discontinuation of hospice services. During an interview 3/31/2026 at 1:06 PM, Staff A, Registered Nurse (RN)/Quality Assurance (QA) acknowledged a significant change MDS had not been completed as expected after Resident #25 discontinued hospice level of care. Staff A revealed she would have expected a significant change would have been completed and that the facility followed the Resident Assessment Instrument (RAI) manual for completion of significant changes. The Long-Term Care Facility RAI 3.0 User's Manual, version 1.20.1 dated October 1, 2025, revealed the MDS assessment must be completed no later than 14 calendar days after the determination of a significant change in the resident's status. The manual defined hospice enrollment as a significant change. During an interview 4/1/2026 at 11:25 AM the Director of Nursing (DON) revealed she would expect a significant change MDS be completed if a resident discontinued hospice level of care. The DON revealed the facility does not have a policy for MDS significant changes as they follow the RAI manual.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and Maximus Preadmission Screening and Resident Review (PASRR) policies and procedures, the facility failed to submit a Level II PASRR evaluation for 1 of 1 residents reviewed with a new mental health diagnosis (Resident #4). The facility reported a census of 40 residents. Findings include: A Level 1 PASRR screening completed by a local hospital prior to admission dated [DATE] revealed Resident #4 had a diagnosis of depression/depressive disorder and a Level II evaluation was not required. The Level 1 PASRR evaluation lacked additional mental health diagnoses and revealed if new information refuted the findings, a new screen must be submitted. The admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #4 revealed a diagnosis of post traumatic stress disorder (PTSD). The MDS further revealed the resident received antidepressant and antianxiety medication during the 7 day look back period. The Care Plan initiated [DATE] indicated Resident #4 had a history of trauma/life events with actual/potential for PTSD as one daughter committed suicide, one daughter was in Iraq with PTSD, and her husband died when the resident was [AGE] years old. Review of the medical diagnoses dated [DATE] for Resident #4 included a diagnosis of PTSD. A Level II PASRR screening dated [DATE] revealed Resident #4 had diagnoses of major depression and anxiety disorder. The screening lacked the diagnosis of PTSD. On [DATE] at 2:27 PM the Administrator revealed the facility did not have a PASRR policy as they followed the guidelines provided by Maximus. During an interview [DATE] at 12:29 PM the Director of Nursing (DON) acknowledged a Level II PASRR evaluation should have been submitted with Resident #4's PTSD diagnosis. The DON further revealed her focus on Level II PASRR evaluations had been on medication changes rather than diagnosis changes.