STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospitalization record review, facility policy review, resident and staff interviews, the facility failed to safely discharge 1 of 3 residents (Resident #1) reviewed for discharge planning, by discharging the resident to a location that did not meet his health and safety needs. On 4/21/26, Resident #1 with a history of a traumatic brain injury and cognitive impairment was assisted by nursing staff to sign an Against Medical Advice form after the resident became upset when reminded of the facility smoking policy and stated he would just leave. Resident #1 signed the AMA form, took his belongings and left the facility via a cab. Resident #1 went to a homeless shelter without his medication and was unable to tell the shelter staff where he came from or how he arrived at the shelter. Resident #1 was then taken to a local hospital and admitted on a court order. The State Agency (SA) informed the facility of the Immediate Jeopardy (IJ) situation on 04/28/2026 at 02:56 PM. The IJ began on 4/21/26 at 1:09 PM and the SA confirmed the immediate removed on 4/28/2026 by implementing the following actions: a. Assessing all residents in the facility to determine if there were residents at risk for improper AMA discharge.b. Educating the Interdisciplinary team and all Nurses on the process for AMA discharges to ensure there are safeguards in place to prevent cognitively disabled residents from unsafe discharges.c. Reviewing all discharges including AMA discharges to assess facility practices and the appropriateness of the transfer.The scope lowered from J to D at the time of the survey after ensuring the facility implemented staff education and procedures.The facility reported a census of 66.Findings include: The admission Minimum Data Set (MDS) for Resident #1, completed on 04/06/2026, documented the resident's Brief Interview for Mental Status (BIMS) score was 9 out of 15, which indicated a moderate cognitive impairment. The MDS list of diagnoses included: cirrhosis of the liver, renal insufficiency (kidney failure), seizure disorder or epilepsy, traumatic brain injury (TBI), anxiety disorder, depression, asthma or chronic obstructive pulmonary disorder (COPD), other lack of coordination, muscle weakness, unspecified mood (affective) disorder, other symptoms and signs with cognitive functions and awareness, restlessness and agitation. The MDS documented Resident #1 prescribed antidepressants, diuretics (water pills), opioids, antiplatelet, and anticonvulsant medications. The MDS revealed Resident #1 required prompting and supervision to complete oral care, showering or bathing, personal hygiene, toileting hygiene, dressing lower part of body, and putting on or taking off shoes. The MDS indicated Resident #1 admitted to the facility on [DATE], after a short hospital stay. Review of [Name of hospital redacted] hospitalization records sent to the facility on March 9, 2026 at 11:03 AM prior to Resident #1's admission to the facility revealed: Date of admission (to hospital): 2/24/26. History.admitted with a chief complaint of inability to care for himself. Active Hospital Problems Diagnosis: inability to return to living situation, traumatic brain injury with loss of consciousness, generalized anxiety disorder, tobacco abuse, alcohol abuse, stage 3a chronic kidney disease, gastroesophageal reflux disease, seizure disorder and cognitive deficits. Assessment and Plan, in part:a. Neurocognitive disorder with inability to care for himself. Patient has a history of traumatic brain injury. Family unable to care for himself as well. He needs safe placement. b. History of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	polysubstance abuse and alcoholismc. Agitation. Secondary to his neurocognitive disorder and mental instability and psych issues given his history of polysubstance abuse as well as traumatic brain injury. Atarax (antianxiety medication) p.r.n (as necessary).d. Thrombocytopenia (low platelets, affecting blood clotting) secondary to liver disease and alcohol use.e. History of smokingf. Seizure disorder on Keppra (antiseizure medication).g. Generalized anxiety disorderh. History of liver cirrhosis.Review of records obtained by the State Agency for the hospitalization from February 18, 2026 to March 30, 2026 revealed:a. admission date: 2/18/26. discharge date : [DATE]. Chief Complaint: Psychiatric Evaluation (Dual committal. Affidavit's reports frequent alcohol use and violence.). The Disposition section revealed, in part: 2/19/26 1824 (6:24 PM) .substance abuse court order has been dropped. Mental Health court order remains with search for placement.2/23/26 0715 (7:15 AM) .it was clarified with nursing staff that both the mental health and substance abuse court orders have been dropped. Given concerns about patient's cognitive baseline due to underlying prior traumatic brain injury, consideration of placement continued. However, patient is now requesting discharge home. Social worker has spoken with patient. Appropriate resources and referrals have been provided. Patient is currently deemed competent to make his medical decision and does not have a guardianship. As such per his request we have no indication to keep him here against his will and he will be discharged .b. (Re)-admission date: 2/24/26. Chief Complaint: Failure to Thrive (Recently here for mental health. Hx (history) of TBI's (traumatic brain injury) and confusion due to this. Visit Diagnosis, in part: Cognitive deficient (primary), Inability to return to living situation, and Traumatic brain injury with loss of consciousness. History of Present Illness section.Patient was discharged yesterday after social worker attempted to give appropriate resources and referrals for being at home independently. Patient was deemed competent to make medical decisions at that time and he has his own guardianship.Only a few hours later, he returned to the ER with his son who stated he could not care for the patient and that he was unable to be his guardian. Social work spoke with administration on-call and was advised that the patient be assessed for competence. [Name of Behavioral Health consultant service redacted] states the patient is not capable of making healthcare decisions in own best interest.Review of the facility electronic health record (EHR) admission Note entered on 3/30/26 at 4:26 PM Note text: [no text entered] Review of Resident #1 Care Plan revealed the following Focus areas:a. DISCHARGE PLANNING-LONG TERM: Requires the support/services of the LTC (long term care) setting. The stay is presently identified as Long-Term. Initiated: 4/9/26.b. The resident has impaired cognitive function or impaired thought processes r/t (related to) Long term memory loss, Neurological symptoms, Psychotropic drug use. Short term memory loss. Interventions included, in part: Cue, reorient and supervise as needed; and Present just one thought, idea, questions or command at a time. Initiated: 3/31/26.c. Resident is a Level 2 PASRR for Serious Mental Illness. Time approved through 9/7/26. Interventions included, in part: Resident will receive appropriate specialized services to attain or maintain his/her highest practicable psychological, physical, functional and psychosocial well-being; and As indicated, refer to following Care Plan focus Mood State, Psychiatric Disorders, At risk Substance Use, Discharge Planning Return to Community Referral. Initiated: 3/31/26.Review of the April 2026 Medication Administration Record (MAR) revealed Resident #1 prescribed the following medications, in part, prior to the 4/21/26 discharge: a. Furosemide (a diuretic, often called a water pill) Oral Tablet 20 MG (milligrams) - give 40 mg [2 tablets] by mouth in the morning related to CHRONIC KIDNEY DISEASE STAGE 3 A. D/C (discharged date): 4/21/26 at 1:55 PM. MAR documented the last dose administered during the scheduled 7:00 AM to 9:00 AM medication pass. b. Sertraline HCL Oral Tablet 50 MG - give 50 mg by mouth in the morning related to DEPRESSION. D/C date: 4/21/26 at 1:55 PM. MAR documented the last dose administered during the scheduled 7:00 AM to 9:00 AM medication pass.c. Levetiracetam Oral Tablet 500 MG - give 500 mg by mouth two times a day related to EPILEPSY. D/C date: 4/21/26 at 1:55 PM. MAR documented the last dose administered during the scheduled 7:00 AM to 9:00 AM medication pass. Resident #1 discharged prior to the 7:30 PM to 10:00 PM medication pass. d. Buspirone HCL tablet 5 MG - give 1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tablet by mouth three times a day related to GENERALIZED ANXIETY DISORDER. D/C date: 4/21/26 at 1:55 PM. MAR documented the last dose administered during the scheduled 7:00 AM to 9:00 AM, and the 12:00 PM to 1:00 PM medication passes. Resident #1 discharged prior to the 7:30 PM to 10:00 PM medication pass. e. Gabapentin Oral Tablet 600 MG - give 600 MG by mouth three times a day related to POLYNEUROPATHY, UNSPECIFIED. D/C date: 4/21/26 at 1:55 PM. MAR documented the last dose administered during the scheduled 7:00 AM to 9:00 AM, and the 12:00 PM to 1:00 PM medication passes. Resident #1 discharged prior to the 7:30 PM to 10:00 PM medication pass. Review of the EHR revealed a Nurses Note entered on 4/21/26 at 1:09 PM: Resident [Resident #1] was smoking in his room. ED was made aware and asked this resident to turn over his lighter in which this resident refused and made the comment he would just leave. AMA (Against medical Advice) was signed and the resident took his belongings and went to the front door. Review of a document titled Against Medical Advice (AMA form) revealed Resident #1 signed the form on 4/21/26. The form documented, in part: Have not been deemed Incompetent/Incapable by my physician or court of law, therefore, I am competent to make my own decisions. The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks. Review of the EHR revealed the following:a. Nurses Note entered on 3/30/26 at 3:50 PM: admitted with a lighter in his pocket, the admission coordinator attempted to place it with smoking materials. He refused. This writer also attempted to get him to give his lighter to staff for safety, he adamantly refused.b. Social Service Note entered on 3/30/26 at 3:58 PM: Called Placed to Son informing him of his dad's wish to leave AMA. Son indicated he is currently displaced.Son is listed as the primary contact but an unequivocal No as far as being his caregiver.c. Nurses Note entered on 4/3/26 at 2:11 PM: Around 1300 [1:00 PM] heard back door alarming sounding. [Name reacted, Resident #1] was outside in the smoke area smoking a cigarette. Requested he return inside and give the cigarettes and lighter to this writer. He stated F*** you, they are mine.he came back into the building. When informed that he could not keep the smoking items he stated, then I'm leaving. Attempted to talk him down and get him to stay by telling him that he would get his meals, have somewhere to sleep, get his medications and have medical care. He stated he wanted to leave. Discussed with him that he would need to sign the AMA paperwork and that would mean that he would have to leave and could not return.d. Nurses Notes entered on 4/16/26 at 1:09 PM: Resident stated he wanted to leave, offered resident AMA paperwork, resident stated he wanted to talk to his son first.Resident stated that on Monday he will talk to the lady with the money and get the rest of his money and then he will leave.e. Behavior Note entered on 4/18/26 at 5:23 PM: This resident walked out setting off the door alarm on North. Staff intervened and was able to persuade him to come back inside. This resident was upset d/t the fact that at smoke break only one cigarette is given. The rules and policy were discussed and he said that he was not having anyone tell him when and how may he could smoke. He was educated on signing AMA if he wanted to leave.f. Nurses Note entered on 4/19/26 at 3:39 PM: This resident made the comment that he was bored and was going to run out the back door of the North Nursing unit. This writer discussed the risks of doing such things and reminded this resident that if he did not want to be here anymore that he was free to sign the AMA form and that was explained to him as well. Resident calmed down. g. Social Service Note entered on 4/22/26 at 9:14 AM: Admin reached out to residents' son to notify him that [name redacted, Resident #1] was non-compliant with smoking. He previously signed the smoking policy and continued to want to smoke all hours of the day, and has stated he wants to leave so he can smoke. Residents' son stated he wanted him to go to a homeless shelter but couldn't take care of him at this time. Administrator notified APS (Adult Protective Services) of his location, and diagnosis and current living situation.Cab came to pick up resident. State Agency will be notified of AMA on transfer/discharge notice form for the month of April.Review of records from [name of homeless shelter redacted] revealed Resident #1 entered the shelter on 4/21/26. A review of the Coordinated Intake Shared Client Notes section revealed, in part:a. Note added on 4/21/26: This writer met with [Name redacted, Resident #1] for [name of shelter redacted] intake. [Name (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	redacted, Resident #1] was very confused on the questions asked. [Name redacted, Resident #1] kept talking about his car and going back to [NAME], Tennessee. This writer asked [Name redacted, Resident #1] over and over where he came from that brought him to the shelter.b. Note added on 4/27/26: This writer met with [Name redacted, Resident #1] and [shelter name redacted] Advocate. Advocate stated that she had concerns about [Name redacted, Resident #1] as he was able to remember where he came from before checking into [shelter name redacted] the night before. The Shelter manager [name redacted] stated that [Name redacted, Resident #1] was dropped by a taxi on 7/20/26 [although this note stated 7/20/26, the note entered on 4/27/26] the evening before at about 5:30 PM. At that time, he did not know what his name was or where he just came from.This writer called and spoke to [name redacted] Administrator of [facility name redacted]. He stated that he asked [Name redacted, Resident #1] to leave because he smoked a cigarette. This writer asked how [Name redacted, Resident #1] chose to come to [shelter name redacted] and how he paid for the taxi. [Name redacted, facility Administrator] stated he signed himself out on his own. This writer called [initials of the state adult protective services] to make a report of a dependent adult as it was clear that [Name redacted, Resident #1] still could not say where he was, he did not know what day or year it was and he was not able to state his name.This writer and [name redacted, shelter advocate] went to the local court house and filed a Mental Health Committal. It was approved by the judge. The county sheriff department picked up [Name redacted, Resident #1] and he was taken to [name of psychiatric unit redacted]. On Monday 4/27 [2026] a mental health hearing took place. The inpatient psychiatrist that evaluated [Name redacted, Resident #1] did agree that [Name redacted, Resident #1] had a severe past head trauma and had dementia. It was her testimony that [Name redacted, Resident #1] need to stay in the hospital until appropriate placement was found for him. The judge agreed with this. [Name redacted, Resident #1] will stay in-patient until they find appropriate placement. Review of [name of psychiatric unit redacted] hospitalization notes, dated 4/24/26 revealed, in part: [Name redacted, Resident #1] admitted to behavioral health unit on 4/23/26. SOAP Narrative: [Name redacted, Resident #1] .with a history of traumatic brain injury and suspected dementia and seizure disorder, presenting on a mental health court order filed by [shelter name redacted] staff based on observations of disorientation and inability to care for himself following voluntary discharge from long term, memory care facility. Current presentation is notable of significant cognitive impairment, including disorientation to place and situation, markedly impaired short-term memory, limited insight, and poor executive functioning as evidenced by inability to articulate a safe or realistic plan for meeting basic needs (food, shelter, medications) .Diagnoses: Neurocognitive disorder.a Reevaluation #2 dated 4/23/26 at 01:48 [AM] documented, in part.Patient inappropriately discharged form nursing home. Patient has dementia secondary to TBI. Not competent to make decisions and patient signed out AMA. Patient sent to a homeless shelter. Homeless shelter ordered the patient here. No SI (suicidal ideation) or HI (homicidal ideation). Psychiatry aware.likely will need to involve legal department. During an interview on 04/23/2026 at 03:16 PM, the Administrator, explained the details of Resident #1's discharge was as follows: Resident #1 had threatened to leave multiple times because he wanted to smoke at will against facility policy. The facility had members of their team reapproach him and had calm him down on a number of occasions, and had previously been successful at preventing him from leaving the facility. On 04/21/2026 at 01:09 PM the Resident was caught smoking in his room, it was believed he pocketed his cigarettes and a lighter while outside smoking with staff supervision. He was asked to hand over his cigarettes and lighter and reminded he could not smoke in his room. The Resident became belligerent and refused to hand over the cigarettes and lighter, stating he wanted to smoke when he wanted. A family member of Resident #1 was contacted, and the Family member informed the facility he wanted nothing to do with Resident #1's care. The Administrator stated he was told to send him to a local homeless shelter by the family member. AMA paperwork was presented to the resident, the resident signed the AMA paperwork, was given his belongings, and left through the front door. The resident left (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility in a cab that he called and paid for on his own.During an interview on 04/28/2026 at 9:36 AM, Staff A, Licensed Practical Nurse (LPN), stated she had a good rapport with Resident #1. She stated he had made comments about leaving the facility since entering, but was redirectable and could be calmed down. She stated she did not believe Resident #1 had the capacity to make choices for himself, was forgetful and often confused. She stated staff were told to contact Social Services when Resident #1 became agitated and Social Services would redirect and calm him down. She stated she worried about the resident being discharged to a homeless shelter because she did not believe he could meet his needs there. She stated she does not believe Resident #1 should have been allowed to leave AMA without further assessment.During an interview on 04/28/2026 at 9:50 AM, Staff B, LPN, stated she was the nurse who assisted Resident #1 in checking out Against Medical Advice. She stated she did not believe Resident #1 was impaired, but did not know his diagnoses. She stated he had been non-compliant with their smoking policy on the day of 04/21/2026, and she made an initial effort to redirect the resident but he stated he wanted to leave the building and she believed he could.During an interview on 04/30/2026 at 01:34 PM, the Social Services Director (SSD) stated he was present in the building the day of Resident #1's discharge, but was not contacted until after the resident had already been signed out AMA. He stated he was not contacted that day to attempt to deescalate Resident #1. The SSD stated he believes he could have redirected and deescalated Resident #1, it would have just taken time. He stated Resident #1 needed support making decisions due to his poor short-term memory and minimal recall.During an interview on 5/05/2026 at 8:25 AM, Staff C, LPN stated in her scope as a nurse, when a cognitively disabled resident wanted to check out AMA she would first contact the family and doctor to attempt to prevent an unsafe discharge, then contact outside agencies like local hospitals if they could not prevent the resident from leaving. She stated this is how she has always done things as a nurse.During an interview on 4/28/2026 at 2:25 PM, the Administrator stated he provided Resident #1 with a telephone number for a cab service after Resident #1 signed out AMA. He stated Resident #1 was able to dial the cab number independently, and paid for the cab with his own money. The number to this cab service was provided at this time. He stated he did not contact the corporate nurse or physician prior to Resident #1's discharge, but did contact them after. He stated he did not contact the Homeless Shelter.During an interview on 04/30/2026 at 11:11 AM, the SA contacted the cab service number provided to Resident #1 and the SA by the Administrator. The number went to a personal cell number, and was answered by the former owner of a cab service. In the interview, he explained he used to operate a cab service, but had not operated a cab service in three years. He stated he had not provided transportation for anyone at all since then, and now owns and operates a business in a different sector.During an interview on 4/28/2026 at 11:45 AM, a family representative of Resident #1 stated Resident #1 only knows how to call him [family representative] on his cell phone. He disputed Resident #1's ability to place calls or dial numbers on a cell phone independently. He stated he doesn't have the memory recall to perform such tasks and hasn't for at least two years. He stated he did tell the facility to take Resident #1 to a homeless shelter, but stated that he suggested a hospital first. He was upset Resident #1 was allowed to leave AMA and did not understand how they could allow an incompetent resident to leave on their own. He denied paying for a cab for Resident #1.During an interview on 04/27/2026 at 01:03 PM, the Shelter Director stated Resident #1 arrived at the homeless shelter at an unknown time and was discovered near the doors of the building around 5:30 PM on 04/21/2026. She stated a coworker completed Resident #1's initial assessment, and she [Shelter Director] provided a follow-up assessment. She stated that when she arrived to perform the follow-up assessment Resident #1 was incapable of using his cell phone independently, did not know who he was or how he arrived at the shelter, and did not know where he had come from.During a phone interview on 04/28/2026 at 11:34 AM, Resident #1 stated he thought he was in prison and could not say how he ended up in the hospital. During an interview on 04/28/2026 at 02:03 PM, the Shelter Manager stated she completed the initial assessment for Resident #1. She stated Resident #1 had been found outside of the shelter (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165202	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Park Place	2401 East Eighth Street Des Moines, IA 50316

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	around 05:30 PM on 04/21/2026. The Shelter Manager explained the shelter had been at capacity at this time, and they did not have room for Resident #1, but the resident did not seem to be alert. She performed the assessment and found the Resident could not reliably give his name, did not know who he was, where he had come from, or how he had arrived at the shelter. The Shelter Manager stated the assessment revealed the resident could not perform basic self-care, and due to his confused state, she made the decision to house him in the lounge with staff oversight. She stated that during the night the Resident did not sleep, and spent his time wandering. The Shelter Manager stated Resident #1 soiled himself twice and had no awareness that he had soiled himself or that he needed to be cleaned up. She reported he required assistance cleaning himself up. The Shelter Manager added when the resident was found outside of the shelter he was carrying a basket of belongings, but was only wearing one shoe and one sock. She stated he did not have any paperwork on him, and after her initial assessment she knew Resident #1's needs could not be met at the shelter.During an interview on 04/27/2026 at 03:14 PM, the Psychiatric provider for Resident #1 for his on-going, current hospitalization stated she completed the initial assessment of Resident #1 when he arrived from the shelter on 04/23/2026. She stated Resident #1 was able to identify who he was at the time of her assessment, but was unable to identify what state he was in, where he was from, how he had arrived at the hospital. The Provider stated Resident #1 had been consistently incontinent and required assistance for most tasks. She stated her assessment revealed even immediate recall failed for the resident and she was able to piece together the resident had severe dementia secondary to a TBI (traumatic brain injury) in the past. She stated the resident was not capable of using a cell phone independently, and was not competent to make decisions about his care. The Provider stated she had reviewed the records from Resident #1 hospitalization from February 2026 to March 2026 at a different local hospital, and noted the records indicated Resident #1 had been found to not be competent to make his own decisions. During an interview on 04/28/2026 at 12:27 PM, the current Hospital Medical provider stated in her dealings with the resident he does not know who he is or where he is most of the day and should not have been released to a homeless shelter.During an interview on 05/04/2026 at 03:34 PM, the facility Clinical Nurse Consultant stated she had not been present at the time Resident #1 discharged AMA. She stated the facilities AMA discharge policy speaks to ensuring proper notifications and calling additional agencies as indicated.Review of a facility policy provided document titled Discharging a Resident without Physician's Approval, revised March 2025 and March 2026 revealed a Policy Statement which declared A physician's or provider's order is obtained for discharges, unless a resident or representative requests the discharge against medical advice. The Policy Interpretation and Implementation section directed, in part:1. Should a resident, or the representative (sponsor), request a discharge earlier than outlined in the care plan and without the approval of the physician or provider (against medical advice), the resident's attending physician or provider is notified.3. If a resident or representative requests to be discharged to a setting that does not appear to meet the resident's post-discharge needs, or appears unsafe, the facility will treat this situation similarly to refusal of care and will:a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident or representative is choosing that location;b. Determine if a referral to Adult Protective Services or other state entity charged with investigating abuse and neglect is necessary. The referral should be made at the time of discharge.