

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Rehabilitation Center of Des Moines		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Riverview 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434</b></p> <p>Based on clinical record review, policy review, and staff interviews, the facility failed to honor a resident's desire to be a Do Not Resuscitate(DNR) status by initiating cardiopulmonary resuscitation(CPR) for 1 of 4 residents(Resident #2) reviewed for advance directives(written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to the provision of health care when the individual was incapacitated). The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set(MDS) assessment tool, dated [DATE], listed diagnoses for Resident #2 which included heart failure, pneumonia, and wound infection. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The MDS documented the resident had diagnoses including heart disease, diabetes, kidney disease, and respiratory failure.</p> <p>The facility policy Nursing Administration with subject Advanced Directives revised ,d+[DATE], stated with admission paperwork, the care plan team would ask resident and family member about the existence of any advance directives and include a copy of the directives in the medical record.</p> <p>The resident's Initial Admission Record, effective date [DATE], stated the resident's advance directives wish was DNR.</p> <p>A hospital Discharge Summary, dated [DATE] listed the resident's code status at discharge as DNR.</p> <p>The resident's Care Plan did not address the resident's advance directive wishes.</p> <p>The resident's Initial Care Plan, dated [DATE], did not address the resident's advance directive wishes.</p> <p>The resident's electronic health record(EHR) Resident Dashboard stated no information found under the resident's Advance Directive.</p> <p>(continued on next page)</p>

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The untitled, undated facility summary of the event stated Staff A Registered Nurse(RN) walked by the resident's room and she quickly became non-responsive. At the moment, the resident did not have an Iowa Physician Orders for Scope of Treatment(IPOST-directed staff regarding advance directive wishes) so staff initiated CPR. The resident's daughter was contacted and directed staff to continue CPR. Staff contacted the hospital and determined the resident was a DNR status so CPR was terminated.</p> <p>On [DATE] at 12:29 p.m. via phone, Staff A Registered Nurse(RN) stated as he walked by the resident's room, she dropped something and he ran into the room and the resident could not speak. He told the nurse to call 911. He stated the electronic health record stated DNR but when they called the daughter she instructed them to continue CPR. He stated they initiated CPR and emergency medical services(EMS) arrived and took over. He stated EMS inquired as to her code status and called the hospital. The hospital reported that she was a DNR so they stopped CPR.</p> <p>On [DATE] at 1:17 p.m., Staff B RN stated she was at the nursing station and Staff A directed to call a code. She stated he initiated an emergency response and she followed him. In the EHR, it stated she was a DNR but the resident's daughter directed to carry out CPR. She stated they carried out CPR until EMS arrived. She stated there was a binder at the nursing station with resident code statuses but it did not contain one for Resident #2.</p> <p>On [DATE] at 1:40 p.m., the Director of Nursing stated upon admission, nurses should fill out code status paperwork. She stated with regard to Resident #2, there was confusion because she went to the hospital shortly after her arrival. She stated they did not have a signed IPOST at the time of the incident.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interviews, the facility failed to notify the resident's family of an increase in pain and the need for additional pain medication for 1 of 3 residents reviewed for a change in condition(Resident #1). The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set(MDS) assessment tool, dated 8/19/24, listed diagnoses for Resident #1 which included Alzheimer's disease, anxiety disorder, and depression. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15. The MDS documented the resident had diagnoses including Alzheimer's disease, arthritis, joint contracture, muscle weakness.</p> <p>The facility policy Notification, Physician or Responsible Party, dated 8/2007, stated the facility would inform the resident's family/responsible party when there was a significant change in the resident's physical status.</p> <p>A Care Plan entry, dated 5/2/23, stated the resident's had acute(short term)/chronic(long-term) pain.</p> <p>An 11/2/23 5:28 p.m. Secure Conversations entry stated the nurse reported to the Nurse Practitioner(NP) that the resident refused cares and refused to get out to bed and her Tramadol(a narcotic pain medication) was ineffective. The NP stated she would order Oxycodone(a narcotic pain medication) 5 milligrams three times daily.</p> <p>The facility lacked documentation of family notification of the resident's increased pain level and new order of Oxycodone.</p> <p>On 6/6/24 at 1:40 p.m., the Director of Nursing(DON) stated if a resident was in pain and required Oxycodone, this would warrant a call to the family.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to report an allegation of abuse to the State Agency within 2 hours for 1 of 1 residents reviewed for an allegation of abuse(Resident's #3). The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>The Admission Minimum Data Set(MDS) assessment tool, dated 2/28/24, listed diagnoses for Resident #3 which included anxiety, depression, and psychotic disorder, and listed her Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition.</p> <p>The facility policy Abuse: Prevention of and Prohibition Against, revised 12/20/23, stated all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator and the facility would notify the appropriate State or Federal agencies in the applicable time frames, as per this policy and applicable regulations. The policy stated the facility would immediately remove the employee from the care of any resident and suspend the employee during the pending of the investigation.</p> <p>A 2/23/24 Care Plan entry directed staff to approach the resident in a calm manner.</p> <p>The facility's undated self-report 5 Day Summary stated the resident reported to staff on 6/3/24 that a Certified Nursing Assistant(CNA) touched her face and told her to shut the [expletive] up on 6/2/24 at approximately 6:30 p.m. Camera footage revealed Staff D CNA exited the resident's room on 6/2/24 at approximately 6:30 p.m.</p> <p>A Grievance Resolution Form, dated 6/3/24 at 11:50 a.m. stated the resident reported at 6:30 p.m. on 6/2/24, a nurse aide grabbed her face and told her to shut the [expletive] up.</p> <p>A 6/3/24 4:28 p.m. Speech Therapy Treatment Encounter Note stated the resident's reported an incident with the night staff and the speech therapist(ST) filled out a grievance form and gave it to the Director of Nursing(DON).</p> <p>A Time Tracking: Daily Punch Details report documented Staff D worked the following hours:</p> <p>6/2/24 12:03 a.m. to 6:27 a.m. and 6:02 p.m. to 12:00 a.m.</p> <p>6/3/24 12:00 a.m. to 6:29 a.m. and 5:59 p.m. to 12:00 a.m.</p> <p>6/4/24 12:00 a.m. to 6:33 a.m.</p> <p>The facility lacked documentation they submitted the allegation of abuse to the State Agency prior to 6/3/24 at 4:20 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/24 at 10:27 a.m. Resident #1 stated that a staff member grabbed her by the jaw and shook her face and told her to shut the [expletive] up.</p> <p>On 6/5/24 at 11:50 a.m., the Director of Nursing(DON) stated after an allegation of abuse, the facility usually suspended the staff member alleged of abuse but in this cased they separated the staff member from the resident who made the accusation. She stated on 6/3/24, Staff D was assigned the other half of the resident's hall.</p> <p>On 6/5/24 at 2:01 p.m., Staff C Speech Therapist(ST) stated the resident reported to her that a staff member grabbed her face and told her to shut the [expletive] up. She stated she filled out a grievance form and this was around 11:40 a.m. on 6/3/24. She stated she gave the form to the DON later in the day.</p> <p>On 6/6/24 at 1:40 p.m. the DON stated if there was an allegation of abuse, she would want to know about it immediately. She stated with regard to Resident #2, she found out about it about 2 hours after the resident reported it. She stated Staff C wrote a grievance but did not turn it in at that time.</p> <p>On 6/6/24 at 2:00 p.m., the Administrator stated after an allegation of abuse, they would intervene immediately and if it was reportable, they would reach out to the State Agency. He stated they separated the accused staff member from that resident specifically but she continued to work on the floor with other residents. He stated it was his understanding this was acceptable.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>35434</p> <p>Based on clinical record review, policy review, and resident and staff interviews, the facility failed to separate an alleged perpetrator of abuse(Staff D) from other residents for 1 of 1 allegation of abuse reviewed(Resident's #3). The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>The Minimum Data Set(MDS) assessment tool, dated 2/28/24, listed diagnoses for Resident #3 which included anxiety, depression, and psychotic disorder and listed her Brief Interview for Mental Status(BIMS) score as 9 out of 15, indicating moderately impaired cognition.</p> <p>The facility policy Abuse: Prevention of and Prohibition Against, revised 12/20/23, stated all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator and the facility would notify the appropriate State or Federal agencies in the applicable time frames, as per this policy and applicable regulations. The policy stated the facility would immediately remove the employee from the care of any resident and suspend the employee during the pending of the investigation.</p> <p>A 2/23/24 Care Plan entry directed staff to approach the resident in a calm manner.</p> <p>The facility's undated self-report 5 Day Summary stated the resident reported to staff on 6/3/24 that a Certified Nursing Assistant(CNA) touched her face and told her to shut the [expletive] up on 6/2/24 at approximately 6:30 p.m. Camera footage revealed Staff D CNA exited the resident's room on 6/2/24 at approximately 6:30 p.m.</p> <p>A Grievance Resolution Form, dated 6/3/24 at 11:50 a.m., stated the resident reported at 6:30 p.m. on 6/2/24, a nurse aide grabbed her face and told her to shut the [expletive] up.</p> <p>A 6/3/24 4:28 p.m. Speech Therapy Treatment Encounter Note stated the resident's reported an incident with the night staff and the speech therapist(ST) filled out a grievance form and gave it to the Director of Nursing(DON).</p> <p>A Time Tracking: Daily Punch Details report documented Staff D worked the following hours:</p> <p>6/2/24 12:03 a.m. to 6:27 a.m. and 6:02 p.m. to 12:00 a.m.</p> <p>6/3/24 12:00 a.m. to 6:29 a.m. and 5:59 p.m. to 12:00 a.m.</p> <p>6/4/24 12:00 a.m. to 6:33 a.m.</p> <p>The facility lacked documentation they submitted the allegation of abuse to the State Agency prior to 6/3/24 at 4:20 p.m.</p> <p>On 6/5/24 at 10:27 a.m. Resident #1 stated that a staff member grabbed her by the jaw and shook her face and told her to shut the [expletive] up.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/24 at 11:50 a.m., the Director of Nursing(DON) stated after an allegation of abuse, the facility usually suspended the staff member alleged of abuse but in this case they separated the staff member from the resident who made the accusation. She stated on 6/3/24, Staff D was assigned the other half of the resident's hall.</p> <p>On 6/5/24 at 2:01 p.m., Staff C Speech Therapist(ST) stated the resident reported to her that a staff member grabbed her face and told her to shut the [expletive] up. She stated she filled out a grievance form and this was around 11:40 a.m. on 6/3/24. She stated she gave the form to the DON later in the day.</p> <p>On 6/6/24 at 1:40 p.m. the DON stated if there was an allegation of abuse, she would want to know about it immediately. She stated with regard to Resident #2, she found out about it about 2 hours after the resident reported it. She stated Staff C wrote a grievance but did not turn it in at that time.</p> <p>On 6/6/24 at 2:00 p.m., the Administrator stated after an allegation of abuse, they would intervene immediately and if it was reportable, they would reach out to the State Agency. He stated they separated the accused staff member from that resident specifically but she continued to work on the floor with other residents. He stated it was his understanding this was acceptable.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35434</p> <p>Based on clinical record review, policy review, and staff interview, the facility failed to ensure 1 of 1 residents reviewed for vehicle safety(Resident #8) was secured in a van during transport, causing the resident to fall out of her seat. The facility reported a census of 65 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set(MDS) assessment tool, dated 10/11/23, listed diagnoses which included diabetes, non-Alzheimer's dementia, and anxiety disorder and listed her Brief Interview for Mental Status(BIMS)score as 15 out of 15 indicating intact cognition.</p> <p>The facility policy Fleet Safety Program, revised 4/14/21, stated the driver and all occupants were required to wear safety belts at all times and the driver was responsible for ensuring all passengers were properly secured in the vehicle at all times.</p> <p>A 12/9/23 untitled incident report stated the resident was transported and was not properly fastened in the seat belt. The driver attempted to leave the parking lot and the resident's flew forward and landed on her stomach on the front of the vehicle. The resident was not properly fastened in the car seat which caused her to fall forward when the vehicle started moving. The resident was sore all over her body but had no visible bruising and could move all extremities without difficulty.</p> <p>A 12/9/23 11:30 a.m. Nursing Note stated the resident transferred to the ER due to fall.</p> <p>A 12/9/23 3:06 p.m. Nursing Note stated the resident returned to the facility and had no pain or discomfort at the time.</p> <p>A 12/11/23 provider Encounter Note stated the resident hit the right side of her head when she flew between the driver and passenger seat during a van trip. The resident went to the ER for evaluation and stated her head still hurt some, and her chronic shoulder and knee pains were worse.</p> <p>A 12/11/23 Nursing Note stated the resident's was sore but her pain medications helped.</p> <p>On 6/6/24 at 1:40 p.m., the Director of Nursing(DON) stated that residents should be strapped into vehicles securely. She stated the resident did not sustain a fracture but was assessed at the hospital.</p>		