STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review, the facility failed to provide privacy and dignity while providing care to 1 out of 3 residents reviewed (Resident #5). Staff provided care to Resident #5 while she was lying in bed. During the provision of care both upper and lower areas of Resident #5 were exposed to include her breasts, buttocks and genitals. The blinds on this resident's window were left open with a parking lot just outside of her window. The facility reported a census of 72 residents. Findings include: A Quarterly Minimum Data Set, dated dated dated [DATE], documented diagnoses for Resident #5 included bipolar disorder, muscle weakness and need for assistance with personal care. A Brief Interview for Mental Status documented a score of 15 out of 15, which indicated intact cognitive functioning. Resident #5 was dependent on 2 or more staff for toileting hygiene, showering/bathing, upper and lower body dressing and personal hygiene. On 5/5/25 at 12:26 p.m., Resident #5 stated that when staff do her cares they often leave the blinds to her window open, so anyone that is out there could see. On 5/5/25 at 1:15 p.m., Staff D, Certified Nurse Aide (CNA) and Staff E, CNA, went into Resident #5's room. They started providing cares to this resident. The window blinds were open. A car parked in an empty spot approximately 4 spaces away from this resident's window. A person got out of the car and walked away from, not toward the window. Directly following this observation, Staff D, when asked about the blinds being left open while they provided care, stated she should have shut them. When told a car pulled up, a person got out but that person didn't walk toward the window, Staff D nodded and repeated she should have shut them. On 5/6/25 at 3:35 p.m., the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), acknowledged the concern regarding the blinds not being drawn while cares were given. They acknowledged this was a dignity/resident rights issue. A Resident Rights Policy with the subject of Dignity and Privacy revised on 10/2024, directed the following: (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
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	POLICY: It is the policy of this facility that all residents be treated with dignity, respect, and privacy. PROCEDURES: 1. The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. 2. Schedules of daily activities allow maximum flexibility for residents to exercise choices about what they will do and when they will do it. Residents' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, and entertainment are elicited and respected by the facility. 3. Residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and be well groomed per their preference. 4. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. People not involved in the care of the Resident shall not be present without the resident's consent while they are being examined or treated. 5. Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene, except when staff assistance is needed for the Resident's safety. 6. Violations of the Resident's right to dignity and respect should be promptly reported to the Director of Nursing Services and/or the Administrator. HIGHLIGHTS: Dignity and respect, daily activity schedules, privacy, care and treatments, reporting violations and grievances

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
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** 40907 Based on observations, interviews and record review, the facility failed to have clear direction for their staff regarding code status for 1 of 1 resident reviewed (Resident #2). The facility had a doctor's order for a full code which directed that in the event Resident #2's heart and respirations should stop, CPR (Cardiopulmonary Resuscitation)(Chest Percussions and rescue breathing) (Full Code) was to be performed. The IPOST (Iowa Physician's Orders for Scope of Treatment) for this resident directed that this resident was to be a DNR (Do Not Resuscitate) in the event Resident #2's heart and respirations should stop this resident was not to have chest percussions nor was he to have rescue breathing given to him. The facility reported a census of 72 residents. Findings include: A Care Plan for Resident #2 had a focus area initiated on [DATE], directed that Resident #2 desired to be a DNR per IPOST. The Goal was that Advanced Directives will be honored by staff. The intervention directed that the IPOST document would be reviewed with each care conference and updated as needed. An IPOST dated [DATE], directed that resident was a DNR/Do Not Attempt Resuscitation. A Physician's Order dated [DATE], directed that Resident #2 was to have CPR/Full Code. On [DATE] at 11:47 a.m., Staff A, Certified Medication Aide (CMA), stated that on [DATE] Resident #2's eyes didn't look right and his respirations were high. Staff A asked 2 other staff to lay Resident #2 down. Staff A stated that the staff reported when they were laying this resident down, this resident started to turn blue. Staff A stated he called for a code blue overhead and everyone came down. Staff A stated he knew they (the nurses) were trying to work with the oxygen and they were trying to find out code status for Resident #2. Staff A stated that the papers they were going to send with the ambulance directed that Resident #2 was a DNR, but Resident #2 was listed as a Full Code in the facility's system. On [DATE] at 12:56 p.m., Staff B, Registered Nurse (RN), 2nd floor Unit Manager, stated that Staff A shouted down the hall to Staff B that they needed her. She stated that they called on the overhead speaker for assistance on the 2nd floor. She stated the overhead call was for a code. Staff B stated a code was not initiated as Resident #2 had a pulse and was breathing. He was pale in color. She stated then the EMS (Emergency Medical Services) arrived. Staff B stated that this resident was a DNR. She stated his IPOST directed that he was a DNR. Staff A stated she knew that in his chart there was a doctor's order for a full code. She stated the DNR/IPOST was signed around December (2024) and the doctor's order was written as a full code when Resident #2 returned around [DATE] from his prior hospitalization last month. Staff B stated she did not feel the team at this facility could have done anything differently then what they did, other than being sure the code status was aligned. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:36 p.m., Staff C, Nurse Practitioner, stated that she usually goes over code status when residents return from the hospital and Staff C wanted to talk with his son. Staff C stated that the hospital likely changed Resident #2 to a full code in order for them to perform a wound debridement procedure. Staff C stated that she thought Resident #2's son made Resident #2 a DNR when this resident was very first admitted to the facility. On [DATE] at 3:35 p.m., the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) , acknowledged the above concern regarding differing code status for Resident #2. They stated they became aware of this situation on the day it happened and have started to look further into this situation, including doing audits on the other residents. A Care and Treatment Policy with the subject Advance Directives revised on ,d+[DATE], directed the following: POLICY: It is the policy of this facility that a resident's choice about advance directives will be respected. PROCEDURES: 1. The care plan team will ask residents, and/or their family members, about the existence of any advance directives. 2. Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record. 3. The facility will work with the resident and their responsible party in completing an advanced directive if they choose and an IPOST to clarify their wishes to be documented for physician signature. 4. The facility has defined advanced directives as preferences regarding treatment options and are included, but not limited to: a. Living Will - A document that specifies a resident's preferences about measures that are used to prolong life when there is a terminal prognosis; b. Do Not Resuscitate -- Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health-care proxy, or representative (sponsor) have directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used; c. Do Not Hospitalize - Indicates that the resident is not to be hospitalized , even if he/she has a medical condition that would usually require hospitalization ; d. Feeding Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to be fed by artificial means (e.g., tube, intravenous nutrition, etc.) if he/she is not able to be nourished by oral means; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Medication Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to receive life-sustaining medications (e.g., antibiotics, chemotherapy, etc.); and f. Other Treatment Restrictions - Indicates that the resident, legal guardian, health-care proxy, or representative (sponsor) does not wish for the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusions, tracheotomy, respiratory incubation, etc. 5. If advance directive documents or IPOST are not available or signed by the resident (responsible party) and the physician, the facility will consider the resident a full code until clarification is obtained. 6. If advance directive documents were developed in another state, the resident must have such documents reviewed and revised by legal counsel in this state before the facility may honor such directives. 7. The care plan team will review periodically, at least quarterly, annually with the resident his/her advance directives to ensure that they are still the wishes of the resident. Such reviews will be made during the assessment process and recorded on the resident assessment instrument (MDS). 8. Changes or revocations of a directive must be submitted to the facility, in writing. The facility may require new documents if changes are extensive. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan. 9. The facility will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical records and plan of care. 10. Inquiries concerning advance directives should be referred to social services, and/or to the director of nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observation, interviews, and record and policy review, the facility failed to ensure safety risks were minimized for 1 of 1 resident observed (Resident #8). Resident #8 was observed being pushed in her wheelchair (w/c) by Staff F, Certified Nurse Aide (CNA) without her feet on w/c pedals. It was noted that the bottom of Resident #8's feet were skimming the floor while Staff F was pushing her. The facility reported a census of 72 residents. Findings include: A Minimum Data Set (MDS) dated [DATE], documented that diagnoses for Resident #8 included carpal tunnel syndrome bilateral upper limbs, repeated falls, and weakness. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, which indicated intact cognitive functioning. Resident #8 could wheel herself once seated in a manual wheelchair at least 50 feet and make 2 turns. It documented that this resident used a manual wheel chair and once seated she had the ability to wheel at least 150 feet in a corridor or similar space. Observation on 5/6/25 at 3:30 p.m., revealed Resident #8 was being pushed in her w/c by Staff F, CNA. There were no w/c pedals on the chair. This resident stated she asked Staff F to push her down the hall. Staff F said she knows to use w/c pedals when pushing residents. Staff F said this resident had asked Staff F to push her in her w/c. This resident said she did ask Staff F to push her down the hall in her w/c. When asked about her feet touching the floor, this resident lifted her feet way up. Staff F stated that Resident #8 normally wheels herself all over the place or walks behind the w/c. Staff H, Certified Nurse Aide (CMA) was standing at the medication cart. She said she didn't see this incident. Staff H said she was new to the facility. Staff H asked Staff F if most residents have bags on their w/cs to place w/c pedals. Staff F said she didn't know if Resident #8 even had any w/c pedals. Staff G, MDS Coordinator/nurse, stated understanding of this observation. Staff G acknowledged that no resident should be pushed in a w/c by staff without having the legs and w/c pedals on the wheelchair with the resident's feet on the pedals. When Staff F was asked if she knew why there was a concern with this situation, she stated yes, they could break their ankles. On 5/6/25 at 3:35 p.m., the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), when told about this observation, stated understanding of the concern and acknowledged it was a concern. The DON stated usually Resident #8 uses her feet to go all over the facility in her w/c. On 5/7/26 at 11:36 a.m., Staff C, Nurse Practitioner, stated that Resident #8 is alert and oriented times 3 (oriented to person, place, and time). Staff C stated that Resident #8 should not have been pushed with her feet skimming on the ground. A Quality of Life policy with a subject of Safety, Resident was reviewed on 10/2024. It directed the following: POLICY: It is the policy of this facility to create a safe environment for wheelchair mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165268	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Des Moines	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURES: 1. Assist resident to wheelchair as resident needs arise per resident's care plan. 2. Make sure the person is comfortable. 3. Position the patient's feet on the footrests of the wheelchair when needed per resident needs. 4. When transporting a resident in a wheelchair unlock the wheelchair brakes and transport the individual forward through an open doorway after checking for traffic. 5. When transporting the individual up to a closed door, open the door and back the wheelchair through the doorway. 6. Take the individual to their destination and ensure they are safe