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	06/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interviews, nurse practitioner interview, and facility policy. The facility failed to follow up on progress notes from the nurse practitioner with orders for premarin vaginal cream (a prescription medication that contains estrogen used to treat certain types of urinary incontinence) 1 of 3 residents. (Resident#1). The facility reported a census of 70. The Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated cognition intact for Resident#1 (R1). The Care Plan initiated 12/10/25 instructed staff that R1 had incontinence and to check as required for incontinence. Change clothing as needed after incontinence episodes. The Progress Note dated 4/29/26 by the Nurse Practitioner documented R1 was seen for complaints of urinary incontinence. Urinary frequency has been ongoing for the last few months and started to feel mild burning with urination. Urinary symptoms overall are getting worse. Recheck UA to r/o infection. Start premarin cream, vaginally at night for two weeks, then two times a week.The Progress Note dated 5/12/26 signed by the Nurse Practitioner ([NAME] Payne) documented Resident #1 was seen for a follow up visit. The Resident was reporting dysuria last month, with orders for UA recheck but does not appear was completed. Was also ordered to start premarin vaginal cream but does not appear this has been put in yet either. Continues to have urinary incontinence, poor bladder control, with evident skin breakdown today. Continue with good pericare, frequent toileting. Start premarin cream, vaginally at night for two weeks, then two times a week. Observation on 6/1/26 at 12:57 PM, revealed Resident #1 had her call light on. Certified Nursing Assistant (CNA) answered her call light. The resident requested to be changed as she was incontinent of urine. The CNA assisted with change of incontinent brief, perineal cleansing, and change of a bath blanket on the resident's recliner. The blanket was saturated with urine but was not soaked through the blanket as her recliner was still dry. The resident's room smelled odorous, like urine. On 6/1/26 at 1:05 PM the resident indicated she had been incontinent for 4-6 months and didn't know if it was because of her hysterectomy with laser therapy, or because she had 8 bladder infections after the surgery. I don't know what they are doing for the incontinence. They were supposed to put me on a cream and do another urine test but that hasn't happened yet. They didn't do any urine tests or put me on a cream. On 6/1/26 at 1:50 PM with Staff, B RN indicated the nurses working put in the new orders after the doctors round on the residents. The doctors wrote the orders on sheets or on lab sheets. The nurses placed orders to the pharmacy and then complete assessments each shift. She was not aware if the NP wrote orders for premarin cream. On 6/1/26 at 3:30 PM, the Director of Nursing, (DON). Confirmed the progress notes from the NP documented orders to start premarin cream and obtain another UA to rule out infection. Also confirmed the progress notes from the NP which documented the premarin and UA were not started.On 6/1/26 at 3:41 PM Administrator acknowledged and indicated that he would expect if a NP placed an order it should be completed. Also indicated that they were not able to find any hard copies of the orders.The Progress Note dated 6/2/26 at 2:42 PM, the Director of Nursing (DON) documented the doctor reviewed the Nurse Practitioners progress notes related to premarin cream. Received new orders to administer (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	premarin cream 2 grams vaginally at bedtime x 14 days. The pharmacy was notified. The Care Plan initiated on 6/2/26 documented the resident has intermittent cream for bladder strengthening and incontinence. The Treatment Administration Record for June 2026 documented premarin vaginal cream 0.625 mg/gm, insert 2 gram vaginally at bedtime for 14 days related to disorder of the urinary system. Order date 6/2/26 with a start date of 6/3/26.In an interview on 6/3/26 at 11:35 AM the doctor stated that he saw Resident #1 yesterday, reviewed the Nurse Practitioners notes, and acknowledged that she indeed needed the premarin cream treatment as the urinalysis was negative. In an interview on 6/4/26 at 12:20 PM, the Nurse Practitioner (NP) acknowledged that she had seen Resident #1 on 4/29/26 and 5/12/26. The NP reported she wrote orders and gave them to the charge nurses working those days. The NP was unsure what nurses were that she gave them to. She also indicated that she did not order another urinalysis on 5/12/26 because the resident was no longer having the burning with urination. However she was still experiencing frequent incontinence. The Facility Policy and Procedure for Medication Administration dated 7/25 instructed the following:1. Only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medication administration. 2. Medications must be given in accordance with the resident's plan of care. 3. Medications must be administered in accordance with the written orders of the attending physician. 4. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR). 5. Topical medications used in treatments should be recorded on the resident's medication administration record (MAR). 6. Identification of the resident must be made prior to administering medication to the resident. 7. Unless otherwise specified by the resident's attending physician, routine medications will be administered per the facility time ranges. This is to promote the continuance of a home like environment for our residents. 8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the next resident's medication. 9. When PRN medications are administered, the nurse or medication technician must record the date and time administered, and later the results achieved from the PRN medication as appropriate. 10. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule don the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interviews, and review of the facility policy. The facility failed to administer Levothyroxine and Acyclovir per physicians orders for (Resident #7) 1 of 3 Residents reviewed. The facility reported a census of 70. The Minimum Data Set (MDS) dated [DATE] for Resident #7 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The physician signed a written order for Acyclovir (an antiviral medicine used to manage and treat viral infections like cold sores, genital herpes, shingles, and chickenpox) 800 mg 1 tablet 5 times daily by mouth for 7 days on 6/1/26. On 6/2/26 at 7:25 AM, Resident #7 indicated she was having some pain and had something that was like chicken pox. An observation on 6/2/26 at 7:30 AM revealed that Staff A, Certified Medication Aide (CMA) administered Levothyroxine. Staff A, CMA gave Resident #7. Resident #7 asked Staff A, CMA what the medication was after she swallowed the Levothyroxine. Staff A, CMA told her that it was her thyroid medication that she was supposed to get early in the morning. The resident received pain medication for complaints of pain related to shingles. The June 2026 Medication Administration Record (MAR) revealed the Levothyroxine was scheduled to be given at 5:00 AM and nursing staff failed to chart administration for 6/1/26 and 6/2/26. The June MAR also revealed staff had failed to chart administration of Acyclovir on 6/1/26 at 9:00 PM, 6/2/26 at 5:00 AM, and 6/2/26 at 9:00 AM. On 6/2/26 at 9:15 AM Staff A, CMA reported he could not administer the resident's Acyclovir because they have not received the supply from the pharmacy yet. On 6/2/26 at 9:15 AM Staff C, Registered Nurse (RN) indicated he called the pharmacy to see why they haven't sent in the supply yet. Also indicated when they receive an order in the evenings after the pharmacy is closed, we don't always get the supply right away. On 6/2/26 at 9:39 AM Staff C, RN indicated he called the pharmacy, they said they delivered the medication and this mornings dose was at the facility and she has now received her first dose this morning. Also informed he would revise the order to start today to assure she receives the full course of antibiotics. He provided written warning to Staff A, for not calling the pharmacy to locate the medication. Per policy CMA's are supposed to notify the nurse or call the pharmacy to locate the medication. Also informed the Acyclovir was found in the medication cart but in a different area. On 6/2/26 at 11:52 AM the Director of Nursing acknowledged the nurse had to place a new order for Acyclovir as the order was not given on 6/1/26 or early this morning. Also indicated she would have expected the Resident received her first as ordered on 6/1/26.The Facility Policy and Procedure for Medication Administration dated 7/25 instructed the following:1. Only licensed medical and nursing personnel or other lawful authorized staff members may prepare, administer, and record medication administration. 2. Medications must be given in accordance with the resident's plan of care. 3. Medications must be administered in accordance with the written orders of the attending physician. 4. All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR). 5. Topical medications used in treatments should be recorded on the resident's medication administration record (MAR). 6. Identification of the resident must be made prior to administering medication to the resident. 7. Unless otherwise specified by the resident's attending physician, routine medications will be administered per the facility time ranges. This is to promote the continuance of a home like environment for our residents. 8. The nurse or medication technician administering the medication must record such information on the resident's MAR before administering the next resident's medication. 9. When PRN medications are administered, the nurse or medication technician must record the date and time administered, and later the results achieved from the PRN medication as appropriate. 10. Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule don the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.