

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 10/17/2024
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513</p> <p>Based on observation, staff interview and policy review, the facility failed to ensure dignity was provided, resident pulled to shower room backwards down the hall covered with only a blanket for 1 of 3 residents reviewed for dignity (Resident #51). The facility reported a census of 66 residents.</p> <p>Findings include:</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had a Brief Interview for Mental Status (BIMS) of 15 which indicated intact cognition. The MDS further documented the resident had diagnoses included traumatic brain injury, schizophrenia and bilateral lower leg amputation. The resident required substantial/maximal assistance with bathing.</p> <p>The Care Plan dated initiated 2/21/24 revealed a focus area for Resident #51 Activity of Daily Living (ADL) self-care performance deficits related to traumatic brain injury and double below knee amputation. Interventions included substantial/maximum assistance with bathing/showering 2 times a week and as necessary, dependent on staff to dress lower body.</p> <p>In an observation on 10/14/24 at 12:21 PM Certified Nursing Aide (CNA) Staff A pulled resident in a wheeled shower chair through the hall while resident sat with back to staff A. Resident observed covered with a blanket, head uncovered, lower legs partially covered displayed both legs were amputated.</p> <p>In an Interview on 10/16/24 at 5:30 PM The Director of Nurses (DON) acknowledged concerns regarding Resident</p> <p>#51 dignity, relayed ongoing work is in process to ensure resident dignity is maintained.</p> <p>Facility policy titled Dignity and Privacy Revised May 2007 documented all residents be treated with dignity, respect and privacy. Residents shall be examined and treated in a manner that maintains the privacy of their bodies.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on clinical record review, observations, staff interview, and policy review, the facility failed to revise and update a comprehensive person-centered care plan for 2 of 21 residents reviewed (Residents #27 and #61). The facility reported a census of 66 residents.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The Minimal Data Set (MDS) assessment dated [DATE] recorded Resident #27 had diagnoses including cancer, anemia, coronary artery disease, hypertension, renal insufficiency, obstructive uropathy, history of urinary tract infections, and diabetes. Other diagnoses verified by the primary care provider include chronic osteomyelitis (unspecified site), difficulty walking (not elsewhere classified), type 2 diabetes with diabetic polyneuropathy, and acquired absence of left leg below the knee amputation (BKA). The MDS documented Resident #27 does not have any type of a urinary catheter. <p>Resident #27's Care Plan, with target completion date of 11/1/24, revealed inconsistent amputation sites and presence of a urinary catheter with the following Focus area statements:</p> <ol style="list-style-type: none"> a. Activities of Daily Living (ADL) self-care performance deficit related to recent myocardial infarction, left BKA, adult failure to thrive b. Has a risk for urinary retention related to benign prostatic hyperplasia (BPH) with obstruction. I know have a Foley catheter c. Has indwelling catheter related to BPH d. At risk for falls related to confusion and recent amputation of right foot e. Potential fluid deficit related to history of infection to amputated left BKA f. Has acute/chronic pain related to right foot amputation <p>The Change in Condition progress notes completed by nursing staff revealed the following:</p> <p>On 7/16/2024 at 5:39 PM, Symptoms or signs noted of Condition change: Other change in condition Blood in urine. foley catheter d/c. Voiding trial.</p> <p>Notifications: Reported to primary care clinician:</p> <p>Date and time of clinician notification: 07/16/2024 3:00 PM</p> <p>On 7/16/24 at 5:48 PM, Blood in urine. Foley d/c. Voiding trial initiated.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Current Conditions: Resident noted with blood in his urine and also blood from his penis. Resident denies pain/discomfort. Respiration even, unlabored. No s/s of acute distress noted. VSS. Nurse Practitioner on unit and she made aware. Order received for labs. BMP, CBC, UA/C&S. CBC and BMP labs obtained. Pending results. Order also received to keep foley catheter out after it dislodge. Check VS every shift. Voiding trial initiated. Resident voids large amount of urine mixes with blood. Care plan ongoing.</p> <p>On 7/17/24 at 8:15 AM, Change in Condition: Symptoms or signs noted of Condition change: Falls Other change in condition Ok to send to the hospital to eval/treat d/t hematuria, lethargic and generalized weakness. Notifications: Reported to primary care clinician.</p> <p>On 10/14/24 at 10:00 AM. Resident #27 observed sitting at the edge of his bed wearing a short-sleeved shirt and an incontinent brief (no shorts or pants). No urinary catheter visualized.</p> <p>On 10/16/24 at 11:25 AM. Resident #27 verbalized and confirmed an amputation to his left leg due to an infection. The resident's right foot visualized and did not show signs of an amputation. No urinary catheter tubing or bag visualized.</p> <p>During an interview on 10/17/24 at 8:15 AM, Staff H, Registered Nurse, confirmed Resident #27 returned without a urinary catheter when hospitalized in July. Resident #27 remains without urinary catheter.</p> <p>2. The Quarterly MDS assessment dated [DATE] revealed the Brief Interview for Mental Status could not be completed on Resident #61. Diagnoses on the MDS included stroke, aphasia, hemiplegia or hemiparesis, depression, and dysphagia. The MDS indicated Resident #61 experienced one fall since admission or prior assessment. The MDS indicated the use of an antidepressant.</p> <p>Resident #61's Care Plan, with target completion date of 9/26/24, indicated a fall with an intervention to utilize a fall mat (date initiated 7/18/24).</p> <p>Room observations completed on 10/15/24, 10/16/24, and 10/17/24. Resident #61 found sleeping during each visit with no fall mat present visualized next to the bed.</p> <p>During an interview on 10/17/24 at 8:15 AM, Staff H voiced Resident #61 did not have any specific fall preventions in place. Staff H denied current use of or need for a fall mat. Staff H explained Resident #61 brought out to the nurse's station after meals and encouraged to remain upright for 30 minutes. This additional oversight indicated due to history of Resident #61 scooting himself down to laying position. Staff H also explained his room door is kept open most of the time for increased resident visualization.</p> <p>The Care Plan failed to indicate the above fall interventions and contained an intervention not being utilized.</p> <p>The Order summary Report documented Sertraline HCl 100 milligrams by mouth in the morning for depression with the start date of 7/30/24.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review indicated Resident #61 receiving counseling services thru Flowstate Health for treatment of his depression. The Social Services Summary progress note from 9/27/24 at 11:28 AM states, [NAME] is a resident at a Long Term Care Facility (LTC) which remains appropriate for his LOC needs as he is dependent for most ADLs. He is cognitively impaired and has some signs and moderate symptoms of depression. BIMS 9 PHQ 15. Agreeable to continue individual therapy sessions. Family would like to see him move to a facility closer to their home, but he has not been accepted elsewhere. The clinic record showed scanned counseling session notes from the Flowstate Health therapist</p> <p>During an interview on 10/17/24 at 8:50 AM, Staff L, Social Services, confirmed Resident #61 received counseling. Services began 6/7/24 with Flowstate Health. Staff L indicated social services personnel would update resident care plans to reflect mental health services.</p> <p>During an interview on 10/16/24 at 3:30 PM, the Director of Nursing (DON) explained unit managers were responsible for care plan updates up until August of this year. The DON or the MDS coordinator are primarily responsible to update care plan.</p> <p>The policy Care Planning, with a review date of November 2022, revealed the following:</p> <ul style="list-style-type: none"> a. The comprehensive care plan will be developed by the Interdisciplinary Team (IDT) within seven days of the completion of the resident's MDS> and will include needs identified in the comprehensive assessment, any specialized services, resident goals/outcomes, and preferences for future discharge plans b. The comprehensive care plan will be reviewed and/or revised by the IDT after each assessment and updated as appropriate c. The care plan will be reviewed as needed for order changes or resident changes in condition and interventions will be implemented as appropriate. 		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500</p> <p>Based on clinical record review and staff interviews the facility failed to obtain follow-up blood work in the timeframe ordered by the Primary Care Provider (PCP) laboratory (Resident #49) and the resident was eventually hospitalized with 1 of 3 residents reviewed. The facility reported a census of 66 residents.</p> <p>Findings include:</p> <p>1. The Admission Minimal Data Set (MDS) assessment dated [DATE] indicated Resident #49 could not complete the Brief Interview for Mental Status. Diagnoses on the MDS included: renal insufficiency/renal failure/or end stage renal disease, diabetes, aphasia, stroke, hemiplegia/hemiparesis, and respiratory failure. The MDS revealed the presence of a feeding tube and the resident received tracheostomy care.</p> <p>Laboratory blood work obtained on 8/6/24, revealed a low potassium level of 3.1 mEq/L (reference range 3.4-5.0mEq/L) and a sodium level of 142 (reference range of 135-15mEq/L). On 8/8/24, the PCP ordered a potassium supplement and to recheck labs in one week (8/13/24). The order was noted by the facility's registered nurse on 8/8/24 and placed on the laboratory treatment administration sheet for 8/15/24.</p> <p>The clinical record revealed the follow-up blood draw was not completed until 8/20/24, five days after it was initially scheduled. There is no indication in the clinical record that staff notified the PCP of the missed and delayed lab work. On 8/22/24, the PCP notified of results which included a potassium level of 3.8mEq/L (within acceptable parameter) and an elevated sodium level of 154mEq/L. Orders to increase free water flushes and to recheck labs next week noted by the facility's registered nurse on 8/22/24.</p> <p>The Progress Note dated 8/27/24 11:43 AM documented a critical sodium 161mEq/L with Resident #49 tired and lethargic. Per orders from the PCP, Resident #49 transported to the emergency room and was subsequently admitted for hyponatremia (elevated sodium level).</p> <p>During an interview on 10/17/24 at 8:15 AM, Staff H, Registered Nurse explained routine, non-emergent blood work completed on Tuesdays. Those labs which are considered emergent are obtained per timeframe ordered by the PCP. Facility staff will contact the PCP if labs were not obtained, as ordered, for any reason.</p> <p>During an interview on 10/17/24 at 12:30 PM, the Director of Nursing (DON), voiced the expectation of staff obtaining Resident #49's blood work on 8/15/24, as ordered by the PCP. The DON acknowledged lab work was missed and lacked documentation which indicated the PCP was notified. The DON explained labs were obtained as soon as the oversight noticed, which was on 8/20/24.</p> <p>During an interview on 10/17/24 at 1:55 PM, Staff I, Advanced Registered Nurse Practitioner, unable to recall if the facility staff notified of the missed lab work from 8/15/24. Staff I unable to determine if the delay in obtaining the lab work on 8/15/24 would have prevented the hospitalization for hyponatremia.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513</p> <p>Based on resident interview, staff interview, clinical record review and facility policy the facility failed to ensure specialist referral for 1 of 3 residents reviewed for referrals. Resident #38 complained of worsening vision. The facility reported a census of 66 residents.</p> <p>Findings include:</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #38 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated intact cognition. The MDS included resident diagnoses, heart and respiratory disease, non-Alzheimer's dementia, anxiety, depression, post-traumatic stress and depression.</p> <p>The Care Plan dated 4/2/22 identified Resident #38 medications included the following types psychoactive drugs, antidepressants, antipsychotics and antianxiety medications and directed to observe for side effects which included blurred vision.</p> <p>A Progress Note dated 6/27/23 from the Nurse Practitioner, Staff C documented, detailed exam included for vision, seen today as a new patient, Resident #38 has blurry vision in his left eye that isn't new onset.</p> <p>A Progress note dated 11/2/2023 revealed Resident #38 reported that he has a hard time seeing out of his left eye and that its been getting worse over the last month or so, this nurse spoke with resident and social services and an appointment will be made for the optometrist, reported Nurse Practitioner, Staff C notified as well.</p> <p>In an interview on 10/15/24 08:59 AM Resident #38 relayed needs to see an eye doctor, could not see out of left eye, had told staff and continued to worsen since February 2024.</p> <p>In an interview on 10/16/24 at 5:17 PM Director of Nurses, DON relayed was not aware of Resident #38 had eye trouble, would check into further.</p> <p>In an interview on 10/17/24 09:16 AM Social Services, Staff B relayed several options for vision care nearby without regard to funding source. Relayed was not aware until this week that resident expressed change in vision, reported Resident #38 now has an appointment for tomorrow.</p> <p>In an Interview on 10/17/24 at 1:39 PM with the DON reported the expectation if a resident complained of vision changes, the resident would be referred to the optometrist.</p> <p>In a telephone interview on 10/17/24 at 01:15 PM Nurse Practitioner Staff C relayed did not recall resident complaining of blurred vision and If a resident complained would write an order, patient needs to be seen by an optometrist, also would alert the facility nurses. Relayed is no longer contracted to work at this facility, cannot access notes and could not recall Resident #38 complaining of any vision complains. Discussed note in resident electronic recorded by this NP dated 6/27/23 documented, Resident #38 has blurry vision in left eye that isn't new onset, Staff C relayed had just begun working at the facility at that time likely one of the first notes and could not recall.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled, Procedure Referrals dated May 2022 documented, If the facility does not employ a qualified professional to furnish a specific service ordered by the physician, the facility will make necessary arrangements for services to be furnished to the resident by a person or agency outside the facility.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>40905</p> <p>Based on observation, clinical record review, and staff interview the facility failed to ensure an emergency tracheostomy kit was at the resident's bedside for 1 of 3 residents reviewed (Resident #57). The facility reported a census of 66 residents.</p> <p>Findings include:</p> <p>The Annual Minimum Data Set (MDS) for Resident #57, dated 7/19/24, included diagnoses of anoxic brain damage (due lack of oxygen) and respiratory failure. The MDS documented resident was totally dependent on staff for all cares, had a tracheostomy (surgical opening in neck to provide for obstruction of breathing) and required oxygen.</p> <p>Observation on 10/14/24 at 11:54 AM, resident in room reclined in a wheelchair with a tracheostomy, with an oxygen (O2) mask over the tracheostomy, and O2 at 4.5 liters. No emergency tracheostomy kit available at the resident's bedside.</p> <p>Resident's Care Plan initiated 6/30/23, documented resident had a tracheostomy related to impaired breathing mechanics and intervention to keep a tracheostomy tube and obturator (medical device to hold tracheostomy tube in place) at bedside.</p> <p>Interview on 10/15/24 at 1:50 PM, Staff D Registered Nurse confirmed she was unable to find an emergency tracheostomy kit in the resident's room.</p> <p>Interview on 10/15/24 at 3:02 PM, the Director of Nursing confirmed no emergency tracheostomy kit in the resident's room and stated her expectation of an emergency tracheostomy kit should be at the bedside for any resident with a tracheostomy.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905</p> <p>Based on observation, clinical record review, staff interview and family interview, and policy review, the facility failed to maintain infection control standards due to not wearing Personal E(PPE) of gown and gloves while providing high contact care activity for a resident required to be on Enhanced Barrier Precautions (EBP) (an infection control intervention requiring staff to wear designated PPE to reduce transmission of organisms for designated residents) for 3 (Resident #49, #119, and #219) of 3 residents reviewed and not completing proper hand hygiene with cares for 1 (Resident #52) of 1 reviewed. The facility reported a census of 66 residents.</p> <p>Findings include:</p> <p>1. The Quarterly Minimum Data Set (MDS) for Resident #119, dated 8/9/24, included diagnoses of osteomyelitis (bone infection) of vertebra, Stage 4 (full thickness of skin wound) pressure ulcer of right buttock, and septicemia (infection in blood) and documented the resident had a Foley catheter (tube to empty urine from the bladder) and colostomy (opening in the abdominal wall from the colon to the outside of the body).</p> <p>Observation on 10/15/24 at 3:00 PM, Staff E, Certified Nurse Aide (CNA) and Staff F, CNA entered Resident #119's room and applied gloves. Staff E and Staff F transferred the resident from the bed to a wheelchair with a full body mechanical lift, holding the catheter tubing while transferring. Staff E and Staff F removed their gloves and exited the resident's room without completing hand hygiene. No EBP signage on resident's door and no PPE supplies available at doorway.</p> <p>Interview on 10/14/24 at 2:09 PM, a resident's wife stated she visited daily. The wife stated the staff always wear gloves, but do not wear a gown, when providing care for her husband who had a tracheostomy (surgical opening in neck) and gastrostomy tube (surgical opening into stomach to provide nutrition).</p> <p>Observation and interview on 10/14/24 at 3:04 PM, no EBP signs on ant residents' doors in the 200 hall. Staff J, CNA stated did have EBP signs on the residents' doors back in July and August but have not had for a while. Staff J stated his understanding of EBP was to wear a gown and gloves with cares with residents with wounds or lots of tubes and he stated staff do not to that consistently. Staff J confirmed there were no EBP signs on the residents' doors in the 200 hall. Staff J stated PPE supplies are available at the nurse's station and not outside doors or inside rooms.</p> <p>Observation on 10/15/24 at 10:AM, EBP signs on 9 residents' doors in the 200 hall.</p> <p>Facility policy for Standard and Transmission-Based Precautions revised 3/2024 directed EBP used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities. Examples of high-contact resident care activities requiring gown and glove use include: dressing, transferring, providing hygiene, device care (indwelling catheters, feeding tube, tracheostomy).</p> <p>46513</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. The Quarterly MDS dated [DATE] for Resident #52 documented diagnoses including, wound infection, pneumonia, schizophrenia and bipolar disorder. Skin conditions included surgical wound and open lesions. Resident #52 required surgical wound care, application of ointments and medications.</p> <p>The Care Plan focus dated 9/30/24 indicated resident had infection to the right knee that required intravenous antibiotics. Also indicated impairment to skin integrity on left ankle and directed to maintain standard precautions when providing resident care.</p> <p>The Treatment Administration Record, October 2024 for Resident #52 directed treatments as follows:</p> <p>a. cleanse right knee with normal saline and cover with (absorbent dressing to treat large wounds, or wounds that require a lot of absorption) ABD pad secure with any tape of choices, one time a day for surgical area</p> <p>b. Cleanse wounds on the left lateral leg with normal saline and gauze, cover wound bed with triad then cover with 4 inch x 4 inch Mepilex border (dressing). Perform wound cares every other day and as needed for saturation of dressing. in the morning, Tuesday, Thursday, Saturday.</p> <p>During an observation on 10/14/24 at 8:27 AM, Registered Nurse (RN) Staff #B entered resident #52's room. Staff B set up supplies needed for dressing change on a barrier, gowned and gloved appropriately for the procedure. Staff B removed the right knee dressing, cleansed the wound and covered with a dressing. Staff B took off the gloves and put on new gloves, did not sanitize hands after removing gloves and proceeded on to complete the left leg wound care.</p> <p>In an interview on 10/16/24 at 8:51 AM followed dressing change, RN Staff B acknowledged he did not complete hand hygiene after removing gloves and putting on new gloves as continued on for wound care to resident's other leg.</p> <p>On 10/16/24 at 5:30 PM the Director of Nursing (DON) acknowledged hand hygiene should be performed after removing gloves and new gloves for infection control. DON also, acknowledged Enhanced Barrier Precautions (EBP) needed improvements for compliance, had struggled with EBP process since this is resident's home and felt EBP conflicted with resident dignity by wearing gowns for some procedures.</p> <p>In an interview with 10/16/24 02:00 PM with Registered nurse, Staff K, acknowledge EBP signs were posted on resident doors earlier this week and reported work needed to be done to ensure compliance. Staff K reported not receiving education about the EBP and would look into this.</p> <p>50500</p> <p>3. The Admission Minimal Data Set (MDS) assessment dated [DATE] indicated Resident #49 could not complete the Brief Interview for Mental Status. Diagnoses on the MDS included: renal insufficiency/renal failure/or end stage renal disease, neurogenic bladder, Multidrug-Resistant Organism (MDRO), diabetes, aphasia, stroke, hemiplegia/hemiparesis, and respiratory failure. The MDS revealed the presence of a feeding tube and receiving tracheostomy care.</p> <p>(continued on next page)</p>		

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 10/17/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Care Plan initiated on 6/24/24 revealed Resident #49 with self-care performance deficit due to impaired mobility. The Care Plan noted the need for a tracheostomy related to impaired breathing mechanics. A jejunostomy tube present for daily tube feedings due to dysphagia. A gastric tube present for drainage with the drainage bag emptied daily.</p> <p>During observation on 10/16/24 at 9:00 AM, Staff E, Certified Nursing Assistant, and Staff H, Registered Nurse, completed hand hygiene & donned a pair of gloves upon room entry. Both staff members completed pericare with hand hygiene and glove changes completed throughout. Once pericare were completed, Staff H washed hands and initiated tracheostomy cares. All Supplies laid out on a bedside table with a barrier. A new pair of gloves obtained from the tracheostomy suction kit. Suctioning completed. Staff H transitioned to changing out the tracheostomy annual. Hand hygiene completed with a new pair of gloves obtained from the cannula kit. The cannula changed out with Staff H completing hand hygiene and glove change afterwards. Staff H did not wear a gown during tracheostomy cares. An enhanced barrier protection sign present on the door with supplies available in the hallway.</p> <p>4. The Care Plan initiated on 10/3/24 revealed Resident #219 admitted to the facility with two stage three pressure Injuries to bilateral hips requiring daily dressing changes. The Care Plan documented that Resident #219 had and infection to the buttocks that required antibiotic therapy.</p> <p>During wound care observation on 10/15/24 at 3:25 PM, Staff H, Registered Nurse completed hand hygiene and donned a pair of gloves upon room entry. Wound supplies laid out on bedside table with a barrier. Staff H explained Resident #219 had a shower earlier where the left hip wound dressing was removed. Wound cleansed with gauze pre-soaked with normal saline and then pat dry. Staff H completed hand hygiene and changed gloves. Triad paste and dressing applied. Staff H completed hand hygiene and changed gloves to initiate wound cares to the right hip. After the old dressing removed, hand hygiene completed and gloves changed. Wound cleansed with gauze pre-soaked with normal saline and then pat dry. Staff H completed hand hygiene and changed gloves. Triad paste and dressing applied. Hand hygiene complete after all cares were finished. Staff H did not wear a gown during wound cares. An enhanced barrier protection sign present on the door with supplies available in the hallway.</p>		