| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165268 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rehabilitation Center of Des Moines | 701 Riverview<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic record review (EHR), staff interviews, policy review, and guidance from the 2024 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual the facility failed to accurately complete the Minimum Data Set (MDS) Assessment for 5 of 18 resident. Residents #1, #3, #6, and #13 were not coded correctly regarding pneumococcal vaccinations and Resident #3 and #13 were not coded correctly regarding the use a Code Alert (wander guard) bracelet. The facility reported a census of 72. Findings include: 1.The MDS Assessment completed on 7/10/25 revealed Resident #1 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS indicated Resident #1's pneumococcal vaccination was not up to date and it was offered and declined. Physician's Order dated 9/9/23 directed staff to administer pneumonia vaccination with informed consent. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24. Resident #1 signed the document and consented to received the pneumococcal vaccine according the Centers for Disease Control and Prevention (CDC) recommended schedule. The EHR Progress Notes lacked documentation Resident #1 received a pneumococcal vaccine. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. 2.The MDS Assessment completed on 8/1/25 revealed Resident #3 with a BIMS score of 5 indicating severely impaired cognition. Diagnoses on the MDS include non-Alzheimer's dementia, post traumatic stress disorder, and a psychotic disorder (other than schizophrenia). Resident #3 noted to be independent with use of a manual wheelchair and without use of a wander/elopement alarm. The MDS indicated Resident #3's pneumococcal vaccination was not up to date and it was offered and declined. Physician Order Summary Report, obtained on 9/11/25, listed the following orders: Check Code Alert for proper functioning every shift; Start Date 9/8/24.Check Code Alert placement every shift; Start Date 9/8/24.Code Alert expires 12/2026. Change Alert on or before expiration date; Order Date 9/8/24.Administer pneumonia vaccination with obtained consent; Start date 6/19/24. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/9/24. Resident #3's Power of Attorney (POA) provided verbal consent for the resident to receive the pneumococcal vaccine according the Centers for Disease Control and Prevention (CDC) recommended schedule. The EHR Progress Notes lacked documentation Resident #3 received a pneumococcal vaccine. The Care Plan, last updated 8/15/25, included a Focus Area related to wandering/elopement risk. Interventions include to monitor wander guard placement (right wrist). During an observation on 9/11/25 at 11:15 AM, Resident #3 seen with a Code Alert bracelet on their right ankle. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. 3.The MDS Assessment completed on 6/13/25 revealed Resident #6 with a BIMS score of 4 indicating severely impaired cognition. The MDS indicated Resident #6's pneumococcal vaccination was up to date. Physician's Order dated 9/25/23 directed staff to administer pneumonia vaccination with informed consent. The EHR Clinical Immunizations tab indicated Resident #6 received the Prevnar13 (PCV13) pneumococcal vaccination<br>(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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | on 4/25/22 and no further pneumococcal vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24. Resident #6's POA provided verbal consent for the resident to receive the pneumococcal vaccine according the Centers for Disease Control and Prevention (CDC) recommended schedule. The EHR Progress Notes lacked documentation Resident #6 received an updated pneumococcal vaccine. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #6 was eligible to receive the PCV20 or PCV21 pneumococcal vaccine as of 4/25/23 to be considered up to date. 4.The MDS assessment dated [DATE] revealed Resident #8 with a BIMS of 13 indicating intact cognition. The MDS indicated Resident #8's pneumococcal vaccination was up to date. Physician Order dated 1/24/24 directed staff to administer pneumonia vaccination with informed consent. The EHR Clinical Immunizations tab indicated Resident #8 received PPSV23 (pneumococcal polysaccharide vaccine) on 8/26/20 and no further pneumococcal vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24. Resident #8's POA provided verbal consent for the resident to receive the pneumococcal vaccine according the Centers for Disease Control and Prevention (CDC) recommended schedule. The EHR Progress Notes lacked documentation Resident #8 received an updated pneumococcal vaccine. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #8 was eligible to receive the PCV20, PCV21, or the PCV15 pneumococcal vaccine as of 8/26/21 to be considered up to date. 5.The MDS assessment dated [DATE] revealed Resident #13 with a BIMS score of 12 indicating moderately impaired cognition. Diagnoses include anxiety disorder, schizophrenia, and traumatic brain injury. Resident #13 noted to be independent with use of a manual wheelchair and without use of a wander/elopement alarm. MDS indicated Resident #13's pneumococcal vaccination was not up to date and it was offered and declined. Physician Order Summary Report, obtained on 9/11/25, listed the following orders: Administer pneumonia vaccination with obtained consent.Check Code Alert for proper functioning every shift; Start Date 5/28/24.Check Code Alert placement every shift; Start Date 5/28/24. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24. Resident #13 signed the document and consented to receive the pneumococcal vaccine according the Centers for Disease Control and Prevention (CDC) recommended schedule. The EHR Progress Notes lacked documentation Resident #1 received a pneumococcal vaccine. The Care Plan, last updated 8/22/25, included a Focus Area related to wandering/elopement risk. Interventions include to monitor wander guard placement (right wrist). During an observation on 9/10/25 at 2:30 PM, Resident #13 seen with a Code Alert bracelet on their right wrist. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #13 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. During an interview on 9/9/25 at 4:45 PM, the Facility Administrator stated pneumococcal vaccinations were not offered as part of the October 2024 vaccination clinic. During an interview on 9/15/25 at 12:45 PM, the MDS Coordinator acknowledged the lack of coding for the Code Alert bracelets for Residents #3 & #13. They believed the bracelets were considered a restraint and therefore not coded. The RAI Manual coding instructions documented the following after determining if the resident up to date on pneumococcal vaccinations: Question O0300ACode 0, no, if the vaccination is not up to date or cannot not be determined. Proceed to item O0300B, if pneumococcal vaccine not received, state reason. Code 1, yes, if the vaccination is up to date. Question O0300BCode 1, not eligible, if the resident is not eligible due to medical contraindications.Code 2, offered and declined if the resident or responsible part/legal guarding had been informed of what is being offered and chooses not to accept.Code 3, not offered, if the resident not offered the vaccination. After determining whether or not an item listed in P0200 (alarms), which included a wander/elopement alarm, was used during the 7-day look-back period, code the frequency of use:Code 0, not used, if the device was not used during the 7-day look-back period.Code 1, used less than daily, if the device was used less than daily.Code 2, used daily, if the device was used on a daily basis during the look-back<br>(continued on next page) |

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| Rehabilitation Center of Des Moines | 701 Riverview<br>Des Moines, IA 50316 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | period. The definition per the RAI of a wander/elopement alarm: Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and policy review the facility failed to vaccinate an eligible resident with the pneumococcal vaccine for 5 of 5 resident reviewed, (Residents #1, #3, #6, #8 and #13). The facility reported a census of 72 residents.Findings include: 1.The Minimum Data Set (MDS) assessment for Resident #1 dated 8/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, coronary artery disease (CAD - arteries that supply blood to the heart muscles), diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, and chronic obstructive pulmonary disease (COPD). It indicated the resident had not received a pneumococcal vaccination. The resident's most recent MDS, dated [DATE], additionally documented the resident to be not up to date on pneumococcal vaccination. It coded the vaccine was offered and declined. Physicians Orders dated 9/9/23 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The Electronic Health Record (EHR) included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident consented to receive the pneumococcal vaccination. The Progress Notes did not include any documentation the resident received a pneumococcal vaccination. On 1/13/25, an X-Ray result indicated the resident had midlung consolidation for pneumonia. The Care Plan dated 1/13/25 and resolved 2/26/25 indicated the resident had pneumonia. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. 2. The MDS assessment for Resident #3 dated 9/03/24 revealed a BIMS score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, CAD, kidney failure, non-Alzheimer's dementia, and COPD. It indicated the resident had not received a pneumococcal vaccination. The most recent MDS of Resident #3, dated 8/1/25, additionally documented the resident to be not up to date on pneumococcal vaccination. It coded the vaccine was offered and declined. Physicians Orders dated 6/19/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's Power of Attorney (POA) consented to the resident receiving the pneumococcal vaccination. The Clinical Immunizations tab lacked a documented pneumococcal vaccination. The Progress Notes did not include any documentation the resident received a pneumococcal vaccination. The Care Plan revised 10/14/24 included a resolved intervention to ensure all immunizations were up to date. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. 3. The MDS assessment for Resident #6 dated 9/28/24 revealed a BIMS score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, CAD, heart failure, diabetes mellitus, non-Alzheimer's dementia, and morbid obesity. It indicated the resident's pneumococcal vaccination was not up to date. The most recent MDS of Resident #6, dated 6/13/25, coded the resident was up to date on pneumococcal vaccination, although an updated vaccination had not been administered. Physicians Orders dated 9/25/23 directed staff to administer influenza vaccination every year during flu season if no allergy to eggs or egg products and administer pneumococcal vaccine -PPSV 23 per CDC guidelines if indicated and consented. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's POA consented to the resident receiving the pneumococcal vaccination. The Clinical Immunizations tab indicated the resident received the Prevnar13 (PCV13) pneumococcal vaccination on 4/25/22 and no further pneumococcal vaccinations. The Progress Notes did not include any documentation the resident received a pneumococcal vaccination. The Care<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Plan did not include any documented vaccinations. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #6 was eligible to receive the PCV20 or PCV21 pneumococcal vaccine as of 4/25/23. 4. The MDS of Resident #8 dated 8/01/24 revealed a BIMS score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, seizure disorder, and schizophrenia. It indicated the resident was offered and declined a pneumococcal vaccination. The most recent MDS of Resident #8, dated 6/25/25, coded the resident was up to date on pneumococcal vaccination, although an updated vaccination had not been administered. Physicians Orders dated 1/24/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The Clinical Immunizations tab indicated the resident received the PPSV23 (pneumococcal polysaccharide vaccine) on 8/26/20. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's POA consented to the resident receiving the pneumococcal vaccination. There were no pneumococcal vaccination declination forms in the EHR. The Clinical Immunizations tab indicated the resident received the PPSV23 (pneumococcal polysaccharide vaccine) on 8/26/20. The Progress Notes did not include any documentation the resident received a pneumococcal vaccination. The Care Plan did not include any documented vaccinations. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #8 was eligible to receive the PCV20, PCV21, or the PCV15 pneumococcal vaccine as of 8/26/21. 5. The MDS assessment for Resident #13 dated 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, schizophrenia, and traumatic brain injury (TBI). It indicated the resident had not received a pneumococcal vaccination. The most recent MDS of Resident #13, dated 8/29/25 documented the resident remained out of date for pneumococcal vaccination. Physicians Orders dated 2/21/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident consented to receive the pneumococcal vaccination. The Clinical Immunizations tab lacked a documented pneumococcal vaccination. The Progress Notes did not include any documentation the resident received a pneumococcal vaccination. The Care Plan did not include any documented vaccinations. A CDC document titled Pneumococcal Vaccine Timing for Adults dated 3/2025 indicated Resident #1 was eligible to receive the PCV20, PCV21, or the PCV15 followed by the PPSV23 at least one (1) year later. On 9/9/25 at 4:45 pm the Administrator stated she had verified the Covid and Pneumonia vaccines had not been administered, only flu shots. She stated the facility had a vaccine clinic scheduled to get the residents up to date on other vaccines as well. The facility policy Immunizations - Residents, review date 7/2023, documented the following: Policy: It is the policy of this facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine(s) and obtaining consent. Eligibility to receive the vaccines may include, but is not limited to current vaccine status, season/time of year, medical contraindications, or resident preference/choice.Procedure:1. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines, to receive the influenza, pneumococcal, and/or COVID-19 vaccine(s). 2. Before offering any vaccine and to ensure a resident's right to choose, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.3. Each eligible resident is offered a seasonal influenza immunization unless the immunization is medically contraindicated or the resident has already been immunized. 4. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.5. Each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated or the resident has already been immunized. 6. The resident or the<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident's representative has the opportunity to decline any or all immunization(s). 7. Information related to education provided regarding the benefits and risks of each immunization and the administration or refusal of or medical contraindications to the vaccines will be documented in the resident's medical record.a. Document that the resident either received the influenza and/or pneumococcal and/or COVID-19 immunization or did not receive the influenza and/or pneumococcal and/or COVID-19 immunization due to medical contraindications or declination. b. Documentation will also include any adverse effects experienced by the resident related to vaccination(s). (Electronic health record/immunization tab/progress notes) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interview, and guidance from the Centers for Disease Control and Prevention (CDC), and policy review, the facility failed to offer and provide the recommended COVID-19 vaccine to eligible residents for 5 of 5 resident reviewed for vaccines (#1, #3, #6, #8, and #13). The facility reported a census of 72 residents.Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #1 dated 8/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, coronary artery disease (CAD - arteries that supply blood to the heart muscles), diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, and chronic obstructive pulmonary disease (COPD). It did not indicate the resident received a COVID-19 vaccination. The resident's most recent MDS, dated [DATE], coded the resident remained out of date for COVID-19 vaccinations. Physician's Orders dated 9/08/23 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The resident's chart failed to reveal an order for administering COVID-19 vaccinations. The Electronic Health Record (EHR) included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident consented to receive the COVID-19 vaccination.The Clinical Immunizations tab lacked documentation of a COVID-19 vaccination after 10/31/23. The Progress Notes failed to reveal any documentation that the resident received a COVID-19 vaccination. The Care Plan did not include any documented vaccinations. 2. The MDS assessment of Resident #3 dated 9/03/24 revealed a BIMS score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, CAD, kidney failure, non- Alzheimer's dementia, and COPD. It did not indicate the resident received a COVID-19 vaccination. The most recent MDS of Resident #3, dated 8/1/25, coded the resident remained out of date for COVID-19 vaccinations. Physician's Orders dated 6/19/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The resident's chart failed to reveal an order for administering COVID-19 vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's Power of Attorney (POA) consented to the resident receiving the COVID-19 vaccination. The Clinical Immunizations tab lacked a documented COVID-19 vaccination after 9/23/21. The Progress Notes failed to reveal any documentation the resident received a COVID-19 vaccination. The Care Plan revised 10/14/24 included a resolved intervention to ensure all immunizations were up to date. 3. The MDS assessment for Resident #6 dated 9/28/24 revealed a BIMS score of 07 out of 15 which indicated severely impaired cognition. It included diagnoses of anemia, CAD, heart failure, diabetes mellitus, non-Alzheimer's dementia, and morbid obesity. It did not indicate the resident received a COVID-19 vaccination. The resident's most recent MDS, dated [DATE], coded the resident remained out of date for COVID-19 vaccinations. Physician's Orders dated 9/5/23 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The resident's chart failed to reveal an order for administering COVID-19 vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's POA consented to the resident receiving the COVID-19 vaccination. The Clinical Immunizations tab lacked a documented COVID-19 vaccination after 10/19/23. The Progress Notes failed to reveal any documentation the resident received a COVID-19 vaccination. The Care Plan did not include any documented vaccinations. 4. The MDS assessment for Resident #8 dated 8/01/24 revealed a BIMS score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, seizure<br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | disorder, and schizophrenia. It did not indicate the resident received a COVID-19 vaccination. The resident's most recent MDS, dated [DATE], coded the resident remained out of date for COVID-19 vaccinations. Physician's Orders dated 1/24/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The resident's chart failed to reveal an order for administering COVID-19 vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident's POA consented to the resident receiving the COVID-19 vaccination. The Clinical Immunizations tab lacked a documented COVID-19 vaccination after 11/15/21. The Progress Notes indicated the resident was evaluated on 8/31/24 for confirmed COVID-19 diagnosis. However, notes failed to reveal any documentation that the resident received a COVID-19 vaccination after 3-months post-recovery. The Care Plan did not include any documented vaccinations. 5. The Minimum Data Set (MDS) assessment for Resident #13 dated 8/29/24 revealed a BIMS score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anemia, schizophrenia, and traumatic brain injury (TBI). It did not indicate the resident received a COVID-19 vaccination. The resident's most recent MDS, dated [DATE], coded the resident remained out of date for COVID-19 vaccinations. Physician's Orders dated 2/21/24 directed staff to administer influenza vaccination annually with obtained consent and administer pneumonia vaccination with obtained consent. The resident's chart failed to reveal an order for administering COVID-19 vaccinations. The EHR included a document titled Resident Consent for Influenza, Pneumococcal, and COVID-19 Vaccination dated 10/09/24 indicated the resident consented to receive the COVID-19 vaccination. The Clinical Immunizations tab lacked a documented COVID-19 vaccination. The Progress Notes indicted the resident tested negative for COVID-19 infection. It also did not include any documentation the resident received a COVID-19 vaccination. The Care Plan did not include any documented vaccinations. On 9/9/25 at 4:45 pm the Administrator stated she had verified the Covid and Pneumonia vaccines had not been administered, only flu shots. She stated the facility had a vaccine clinic scheduled to get the residents up to date on other vaccines as well. A CDC document titled Recommended Adult Immunization Schedule 2025 indicated adults age [AGE] years and older who received a COVID-19 vaccination prior to the 2024-2025 vaccine period should receive two (2) COVID-19 vaccines 2 to 6 months apart for the 2024-2025 vaccination season. The facility policy Immunizations - Residents, review date 7/2023, documented the following: Policy: It is the policy of this facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine(s) and obtaining consent. Eligibility to receive the vaccines may include, but is not limited to current vaccine status, season/time of year, medical contraindications, or resident preference/choice.Procedure:1. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC/ACIP guidelines, to receive the influenza, pneumococcal, and/or COVID-19 vaccine(s). 2. Before offering any vaccine and to ensure a resident's right to choose, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.3. Each eligible resident is offered a seasonal influenza immunization unless the immunization is medically contraindicated or the resident has already been immunized. 4. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized.5. Each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated or the resident has already been immunized. 6. The resident or the resident's representative has the opportunity to decline any or all immunization(s). 7. Information related to education provided regarding the benefits and risks of each immunization and the administration or refusal of or medical contraindications to the vaccines will be documented in the resident's medical record.a. Document that the resident either received the influenza and/or pneumococcal and/or COVID-19 immunization or did not receive the influenza and/or pneumococcal and/or COVID-19 immunization due to medical contraindications or declination. b. Documentation will (continued on next page) |

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|---|---|---|---|
| | 165268 | A. Building<br>B. Wing | 09/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Rehabilitation Center of Des Moines | 701 Riverview<br>Des Moines, IA 50316 |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | also include any adverse effects experienced by the resident related to vaccination(s). (Electronic health record/immunization tab/progress notes) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record review (EHR), staff interviews, and policy review, the facility failed to complete and document resident neurological exams (neurochecks) as scheduled for 2 of 2 residents reviewed for falls (Residents #3 and #8.) The facility reported a census of 72. Findings include: 1. Minimal Data Set (MDS) Assessment completed on 8/1/25 revealed Resident #3 with a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition with continuous disorganized thinking and inattentive. Diagnoses on the MDS include non-Alzheimer's dementia, post-traumatic stress disorder, and a psychotic disorder (other than schizophrenia). Resident #3 required staff supervision for transfers and noted independent with use of a manual wheelchair. The MDS documented a resident fall with injury (skin tears/abrasions, lacerations, bruises, hematomas, sprains) since the last assessment. The Care Plan, last updated on 8/15/25, included Focus Areas related to fall risk and impaired cognitive function. The Progress Note dated 6/10/25 at 1:33 AM documented an unwitnessed fall with left knee injury for Resident #3. The Progress Noted dated 8/5/25 at 1:38 AM documented an unwitnessed fall with no visible injuries for Resident #3. The EHR lacked documentation neurochecks were initiated and/or completed for the duration of the scheduled timeframe for Resident #8 after the unwitnessed falls on 6/10/25 and 8/5/25. 2. The Minimum Data Set (MDS) Assessment completed 6/25/25 revealed Resident #8 with a BIMS of 13 indicating intact cognition. Diagnoses include anxiety disorder, depression, malnutrition, non-Alzheimer's dementia, dysphasia (swallowing difficulty), seizure disorder/epilepsy, and schizophrenia. Resident #8 requires maximum staff assistance for transfers. Resident #8 utilizes a manual wheelchair and noted to be independent for short distances (at least 50 feet) but dependent on staff for longer distances (at least 150 feet). The MDS documented a resident fall with no injury since last assessment. The Care Plan, last updated 3/26/25 included Focus Areas related to fall risk and impaired cognitive function. The Progress Note dated 12/15/24 at 7:50 AM documented a fall with Resident #8 hitting the back of their head on the floor. No visible injuries. The Progress Note dated 12/16/24 at 11:00 AM documented Resident #8 was transported to the emergency room. This was related to continued swelling and pain to the left wrist. The Progress Note dated 12/17/24 at 12:44 AM documented Resident #8's return to the facility from the emergency room with a diagnosis of fractures to the left distal radius and ulna. The Progress Note dated 12/19/24 at 5:37 PM indicated the fall with fracture occurred on 12/16/24. The Progress Note dated 4/28/25 at 2:15 PM documented an unwitnessed fall with no visible injuries. The document Neurological Evaluation was initiated for Resident #8 on 12/16/24 at 5:00 AM. The scheduled neurochecks for the first hour after the fall lacks documentation for the final 15-minute check. Neurochecks were not resumed upon Resident #8's return from the emergency room on [DATE] at approximately 12:45 AM. The neurocheck form lacked documentation for all of 12/17/25. Neurocheck documentation resumed on 12/18/24 and noted with an incomplete assessment noted for 2nd shift scheduled check (no level of consciousness, pupil size, pupil response, hand grasp documented). The last scheduled neurocheck on 12/19/24 for 2nd shift lacked documentation. The document Neurological Evaluation was initiated for Resident #8 on 4/28/25 at 2:15 PM. The scheduled neurochecks for every 2 hours for 8 hours had 1 documented assessment out of 4. The scheduled neurochecks for every 4 hours for 12 hours had 1 documented assessment out of 3. The scheduled neurochecks for every shift for 48 hours lacked documentation. During an interview on 9/16/25 at 8:45 AM, Staff I, Registered Nurse (RN), recalled events of Resident #3's unwitnessed fall on 8/5/25. Staff I explained neurochecks were initiated and completed as scheduled for the remainder of their shift. Assessments were documented on the neurocheck form. Once their shift was over the form documenting the checks was handed off to the day shift. During an interview on 9/16/25 at 9:15 AM, Staff J, RN, was unable to recall events of Resident #3's unwitnessed fall on 6/10/25, Staff J acknowledged neurochecks are initiated with head injuries and unwitnessed falls. Staff J explained<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | neurochecks are documented on paper and then on the computer. During an interview on 9/15/25 at 4:30 PM the Facility Administrator reviewed neurocheck forms and acknowledged the lack of documentation for Resident #3 and the inconsistent documentation for Resident #8. The Administrator would expect staff to complete neurochecks as scheduled. Neurochecks should have been resumed after Resident #8 returned from the hospital unless further testing had been completed to rule out a brain bleed. On 9/16/25 at 835 AM the Facility Administrator confirmed Resident #8 did not have any additional testing at the hospital to rule out a brain bleed. The policy Neuro Policy revised 4/2022 outlined the following:Complete full neuro assessments with any unwitnessed fall or fall with resident hitting their head.Licensed nurse will complete an initial neuro assessment at time of the incident and in the assigned increments of time: Q15 minutes x1 hour, Q30 minutes x1 hour, Q hour x2 hours, Q4 hours x12 hours, and Q shift x48 hours or as instructed by the provider. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>Based on electronic health record review (EHR), staff interviews, and policy review, the facility failed to coordinate nutritional care with the dialysis unit for 1 of 2 residents reviewed for dialysis (Resident #2). The facility reported a census of 72.Findings include: The Minimum Data Set (MDS) Assessment completed on 6/16/25 revealed Resident #2 with a Brief Interview for Metal Status score of 15 indicating intact cognition. Diagnoses include end stage renal disease (receiving dialysis), diabetes, heart failure, hyperkalemia (high blood potassium levels), and respiratory failure. The MDS did not indicate a therapeutic diet (such as low sodium diabetic) was in place. The Care Plan, last revised 6/26/25 included a Focus Area related to nutrition due to end stage renal disease, hyperkalemia (high blood potassium), and fluid overload. Interventions include a liberalized regular textured diet with thin liquids and to honor resident rights to make personal dietary choices. Physician Order Summary report, obtained on 9/11/25, listed the diet order as liberalized regular textured diet with thin liquids. The EHR included Nursing Dialysis Communication Records from May 2025 to September 2025. On 13 different occasions, dialysis staff documented on the communication sheet to offer a low potassium or renal diet due to high potassium levels. The EHR lacked documentation regarding communication between the facility's Registered Dietitian (RD) and the dialysis center's RD. During an interview on 9/15/25 at 10:15 AM the Certified Dietary Manger (CDM) reported they have not received any communication (written or verbal) for the dialysis center or the facility regarding diet. The CDM has not received any directive to offer a low potassium diet from facility staff or the RD. During an interview on 9/15/25 at 10:45 AM, the RD reported they had reviewed the Nursing Dialysis Communication Records and aware of the low potassium/renal diet request. However Resident #2 is resistant to change and feels a renal diet is too restrictive. The RD explained they have not reached out to dialysis staff, including the dialysis RD, to update that the resident declines dietary restrictions. The RD noted they do not have dialysis RD contact information. If needed, the RD reported the facility could provide a low potassium diet if Resident #2 agreed. During an interview on 9/15/25 at 11:45 AM the dialysis RD acknowledged Resident #2's high potassium levels and the requests for a low potassium/renal diet. Monthly lab work is faxed over the facility with contact information attached. The dialysis RD explained calling the facility on July 30, 2025. Facility staff answering the phone confirmed Resident #2 was on a renal diet. As far the dialysis RD knows, a renal diet was in place. information. During an interview on 9/15/25 at 1:00 PM, the Administrator acknowledged Resident #2's high potassium levels. They were not aware of any specific labs or faxes from the dialysis unit has they are faxed to the floors directly. The Administrator noted Resident #2 has moved floors since facility admission in May 2025. When discussing the dialysis RD call on July 30th, the Administrator noted the person who they were talking with may have been a resident. The name the dialysis RD provided does not match up with any staff member but with a resident. Any diet specific items should be addressed by the facility RD. The Administrator believed the current RD would be reaching out to the dialysis center as per past facility RDs. The policy Dialysis (Renal), Pre and Post Care, revised 4/2025, noted the following:Staff to participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.Notify Registered Dietitian of any dietary concerns. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on electronic health record review (EHR), observations, staff interview, and policy review, the facility failed to provided oxygen (O2) therapy as ordered by the physician for 1 of 1 residents reviewed for respiratory care (Resident #2). The facility reported a census of 72. Findings include: The Minimum Data Set (MDS) Assessment completed on 6/16/25 revealed Resident #2 with a Brief Interview for Metal Status score of 15 indicating intact cognition. Diagnoses include end stage renal disease (receiving dialysis), diabetes, heart failure, respiratory failure and seizure disorder. The Order Summary Report, obtained on 9/11/25, noted an order for continuous O2 at 2L/min via nasal cannula to keep O2 saturation (amount of oxygen in the blood) above 90% every shift; Start date 7/11/25. The Medication Administration Record for September 2025 showed O2 saturation (sats) levels are monitor three times per day. The EHR clinical O2 Sats summary tab lacked consistent documentation of the O2 setting when O2 sats obtained when the use of O2 via nasal cannula noted. No O2 settings were documented in August or September with 2 settings documented in July after the order initiated. These were documented at 3L (liters). During an observation on 9/8/25 at 1:40 PM, Resident #2's O2 concentrator was set at 4L. The EHR lacked documentation regarding the increased O2 setting. During an observation on 9/11/25 at 3:20 PM, the O2 concentrator was turned off. Resident #2 turned it on and the setting was noted at 4L. The EHR lacked documentation regarding the increased O2 setting or why the O2 concentrator was off. During an observation on 9/15/25 at 8:15 AM, Resident #2's O2 concentrator was set at 3L. The EHR lacked documentation regarding the increased O2 setting. During an interview on 9/11/25 at 3:20 PM, Resident #2 voiced the need for O2 therapy especially when sleeping. Resident #2 acknowledged they may remove and/or adjust the O2 settings as needed but would not set it above 3L. During an interview on 9/11/25 at 3:50 PM, Staff F, Certified Medication Aide (CMA), explained CMAs cannot adjust a resident's O2 setting. Only nurse may do so. Staff F noted they may not routinely look at O2 settings when taking vitals, which include O2 sats. Staff F explained the 3rd floor nursing needs currently split between the 2nd and 4th floor nursing. During an interview on 9/11/25at 4:00 PM, Staff G, Registered Nurse, acknowledged Resident #2 use of O2 and believed settings were ordered at either at 2L or 3L; Was unsure without referring to EHR. Staff G aware of Resident #2 adjusting levels on their own but had not seen it set higher than 3L. Staff G confirmed they are scheduled to cover the 2nd floor as well as half of the 3rd floor at this time. During an interview on 9/15/25 at 8:20 AM Staff H, Licensed Practical Nurse, voiced being familiar with Resident #2. They were unsure of Resident #2's O2 setting order without referring to the EHR. Staff H explained vitals obtained either by nursing staff or the aides. They may not routinely chart O2 setting when obtaining O2 sats. Should the resident need an increase in O2 (above what is ordered), Staff H explained a physician order would be needed. Staff H confirmed they are scheduled to cover the 2nd floor as well as half of the 3rd floor at this time. During an interview on 9/15/25 at 1:00 PM, the Administrator confirmed Resident #2's current O2 order at 2L. Staff should be documenting O2 settings in the EHR. The Administrator noted Resident #2 does take off their O2 when going to smoke, as required. The policy Oxygen Administration, revised 12/2017, noted the following the resident's clinical record will include:That oxygen is to be administered.When and how often oxygen is to be administered.The type of oxygen device to use (i.e., mask, nasal).Charting and documentation related oxygen use. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, policy review, and guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to implement infection control practices to prevent cross contamination by staff failing to perform appropriate hand hygiene during medication administration for 1 of 4 residents reviewed for medication administration (Resident #2). The facility reported a census of 72 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] indicated that Resident #2 had a diagnosis of chronic pain syndrome. The Care Plan initiated on 5/6/25 revealed that Resident #2 is on pain medication for chronic pain syndrome. During an observation on 9/10/2025 at 8:56 AM Staff A, CMA gave Resident #2 her oral medications. Staff A, CMA did not perform hand hygiene after giving the oral medications. Resident #2 then asked for her pain patches to her back. Staff A, CMA told her to go to her room and he would be down to apply the patches. At 9:01 AM, Staff A, CMA documented the oral medications and took the patches out of the medication cart. Gloves were donned and Staff A, CMA applied the patches to Resident #2's back. He then doffed his gloves and charted the medications. He did not perform hand hygiene before donning or doffing of his gloves. Medication observation was competed for Resident #2. At the conclusion of the observation of Resident #2, Staff A, CMA continued to be observed preparing medications and entering another Resident's room with them. Hand hygiene was not completed between Resident #2 and the next resident. In an interview on 9/11/2025 at 10:00 AM Staff B, RN stated hand hygiene should be performed when removing gloves, after touching a resident and between residents. In a document titled Hand Hygiene, it stated to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: 1. Before and after direct contact with residents. 2. Before preparing or handling medications. 3. After removing gloves. According to the CDC document Clean Hands dated 2/27/24, hand hygiene should be performed immediately before touching a patient, immediately after glove removal, before exiting a patient room and if moving from care on one patient to another patient. This document can be found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.htm |