STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49698 Based on clinical record review, staff interviews, and policy review the facility failed to notify the Long Term Care Ombudsman of discharge/transfer of residents as required for 5 of 5 residents reviewed who were discharged or transferred from the facility (Residents #5, #14, #23 #42, and #59). The facility reported a census of 79 residents. Findings include: 1. Review of the Minimum Date Set (MDS) assessment dated [DATE] revealed Resident #5 had an unplanned discharge to the hospital and reentered the facility on 10/16/23. The facility's Census List revealed Resident #5 hospitalized [DATE]-[DATE]. Review of the Notice of Transfer Form to the Long Term Care (LTC) Ombudsman lacked documentation of Resident #5's discharge to the hospital on 10/11/23 as required by federal regulation. 2. Review of the MDS assessment dated [DATE] and 1/3/24 revealed Resident #23 had unplanned discharges to the hospital and reentered the facility on 10/12/23 and 1/5/24. The facility's Census List revealed Resident #23 hospitalized [DATE]-[DATE] and 1/3/24-1/5/24. Review of the Notice of Transfer Form to the Long Term Care (LTC) Ombudsman lacked documentation of Resident #23's discharge to the hospital on 10/11/23 and 1/5/24 as required by federal regulation. 40905 3. The MDS for Resident #14 dated 1/9/24, included diagnoses of a seizure disorder and diabetes. A Brief Interview for Mental Status score of 14, indicated mild cognitive impairment. The facility Census List revealed Resident #14 admitted to the hospital 12/9/23 and returned to the facility 12/13/23. Review of the facility's Notice of Transfer Form to Long Care Term Ombudsman form for 12/2023 lacked documentation of Resident #14's transfer to the hospital. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34817 4. The MDS assessment dated [DATE] revealed Resident #42 had an unplanned discharge to the hospital and reentered the facility on 1/16/24. The Census List on the facility's computer software program used for electronic medical record documentation revealed Resident #42 hospitalized [DATE] to 1/16/24, and 2/8/24. Review of the E-interact transfer form revealed Resident #42 transferred to the hospital on 1/10/24, 2/1/24, and 2/8/24. Review of the Notice of Transfer Form to the LTC Ombudsman lacked documentation of Resident #42's discharge to the hospital on 1/10/24, 2/1/24, and 2/8/24 as required by federal regulation. 5. The MDS assessment dated [DATE] revealed Resident #59 had an unplanned discharge to the hospital and reentered the facility on 2/2/24. The Census List on the facility's computer software program used for electronic medical record documentation revealed Resident #59 hospitalized [DATE] - 2/2/24. Review of the Notice of Transfer Form to the Long Term Care (LTC) Ombudsman lacked documentation of Resident #59's discharge to the hospital on 1/27/24 as required by federal regulation. In an interview 3/20/24 at 3:15 PM, Staff E, ADON, stated the Administrator reported the resident discharges to the LTC Ombudsman. In an interview 3/21/24 at 8:45 AM, the Administrator reported the facility did not have policy for reporting to the LTC Ombudsman. The Administrator reported she sent a report to the LTC Ombudsman when residents discharged or transferred from the facility. In an interview 3/21/24 at 9:30 AM, the Administrator reported she pulled a report from the electronic software program but the report did not include some of the residents who discharged from the facility. She found another report that pulled all of the resident's discharged and/or transferred to the hospital. She planned to use this report now and in the future to provide a report to the LTC Ombudsman.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on observations, clinical record review, staff interview and facility policy review the facility failed to ensure each resident received necessary respiratory care and services in accordance with professional standards of practice by providing oxygen (O2) without a physician's order and not changing oxygen tubing for 1 of 1 resident (Resident #73) reviewed. The facility reported a census of 79 residents. Findings include: A Minimum Data Set, dated dated dated [DATE] for Resident #73, included diagnoses of chronic obstructive pulmonary disease and received O2 therapy. A Brief Interview for Mental Status score of 12 indicated mild cognitive impairment. On 3/18/24 at 3:06 PM, observed the resident sitting in a wheelchair with O2 on at 2.5 Liters (L) per nasal cannula (NC) and O2 tubing with no date marked on it. On 3/19/24 at 1:48 PM, observed the resident sitting in a wheelchair with O2 on at 2.5 L per NC and tubing remained without a date. Resident's Order Summary Report with active orders as of 3/19/24 lacked a physician's order for O2. The facility policy, Respiratory Therapy revised 11/2011 instructed to change the oxygen cannula and tubing every 7 days. Interview on 3/20/24 at 11:56 AM, Staff E, Assistant Director of Nursing confirmed the resident did not have a physician's order for O2 and expectation is to have an order and change the O2 tubing weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40905 Based on observations, clinical record review, staff interviews and facility policy review, the facility failed to provide a sanitary environment to help prevent the spread of communicable disease and infections. The facility failed to perform hand hygiene, don gloves, change gloves and use a barrier under a graduate during catheter drainage for 3 of 3 residents reviewed (Resident #51, #11 and #61). The facility reported a census of 79 residents. 1.The Minimum Data Set (MDS) assessment for Resident #51 dated 1/3/2024, included diagnoses of non-Alzheimer's dementia and obstructive uropathy (condition that blocks the flow of urine). The MDS documented the resident had an indwelling catheter (tube to drain urine from the bladder). The MDS documented a Brief Interview for Mental Status (BIMS) score of 8 completed, indicating moderate cognitive impairment for decision-making. During an observation on 3/19/24 at 2:50 PM, Staff D, Certified Nurse Aide (CNA) entered Resident #51's room, did not perform hand hygiene and applied gloves. Staff D drained the catheter bag into a graduate and placed the graduate directly on the floor, not placing a barrier under the graduate. Facility policy, Emptying a Urinary Drainage Bag revised 10/2010 instructed to place a paper towel on the floor beneath the drainage bag and position the measuring container under the drainage bag. Interview on 3/20/24 at 11:53 AM, Staff E, Assistant Director of Nursing (ADON) stated expectation is to complete hand hygiene before completing care and place a barrier between the graduate and floor. 34817 2. On 3/18/24 at 12:43 PM, observed Staff C, Environmental Services, wear gloves and push a cleaning cart onto the elevator. Staff C used her gloved hand and pushed the buttons on the wall inside the elevator. Staff C continued to wear the gloves as she rode the elevator to the next floor and then proceeded to push the cleaning cart off the elevator. 3. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had diagnoses of multiple sclerosis, cerebrovascular accident, and hemiplegia (paralysis on one side of the body). The MDS indicated the resident had incontinence, and had total dependence on staff for toileting, dressing, and personal hygiene. The Care Plan revised 1/26/24 revealed the resident had incontinence and at risk for skin impairment, urinary tract infections, and skin irritation in the peri-area. The Care Plan also indicated the resident required assistance with activities of daily living (ADL's). Staff directives included check and change the resident's brief and provide peri-care with every incontinence episode and as necessary. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/24 at 1:13 PM, observed Staff A, certified nursing assistant (CNA) and Staff B, CNA, don a pair of gloves. Staff A removed the resident's brief, then took disposable wipes and cleansed Resident #11's groin and perinea. Staff B assisted the resident to roll onto her left side. Staff A removed the brief from the resident's backside which had a large amount of stool present. Staff A took disposable wipes and cleansed between the buttocks front to back, then removed the soiled brief. Staff A changed gloves, then took additional wipes and cleansed the buttocks area again. Staff A then tucked a clean brief under the resident, rolled the resident onto her back, pulled the brief up, and attached the tabs on the brief. In an interview 3/21/24 at 11:50 AM, Staff E, Assistant Director of Nursing (ADON) reported she expected staff changed gloves in-between going from dirty to clean tasks. 4. The MDS assessment dated [DATE] revealed Resident #61 had diagnoses of dementia and mild intellectual disability. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severely impaired cognition. The MDS revealed the resident had total dependence on staff for toileting. The Care Plan revised on 9/10/22 revealed the resident had incontinence and required assistance with ADL's. The Care Plan directed staff to provide peri-care with every incontinent episode. On 3/19/24 at 1:44 PM, observed Staff A, CNA, and Staff B, CNA, use a mechanical lift and transfer Resident #61 from a wheelchair to the bed. Staff A and Staff B wore gloves during the transfer. Staff A and Staff B removed the sling under the resident, then removed the resident's pants and soiled brief. Staff A took disposable wipes and cleansed the resident's groin and penis. Staff B rolled the resident onto his left side. Staff A opened the back of the brief, which contained a moderate amount of stool. Staff A took disposable wipes and cleansed between the resident's buttocks, and then removed the soiled brief under the resident. Staff A placed a clean brief under the resident, rolled the resident onto his back, and attached the brief tabs. Staff A wore the same gloves during cares. The facility's Handwashing/Hand Hygiene policy (version 2.2) revealed an alcohol-based hand rub or soap and water used before moved from a contaminated body site to a clean body site during resident care, and after gloves removed. The facility's Personal Protective Equipment -Using Gloves policy revised 9/2010 lacked direction as to when gloves needed changed. The facility's Perinea Care policy revised 2/2018 revealed the following procedural steps: a. Wash hands. b. Put on gloves. c. Wash perinea area, wiping from front to back. d. Turn resident on side. e. Wash the rectal area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165272	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing & Rehabilitation Center	233 University Avenue Des Moines, IA 50314

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Remove gloves. g. Wash hands. In an interview 3/21/24 at 11:50 AM, Staff E, ADON, reported she expected staff changed gloves in-between going from dirty to clean tasks.