

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2025
NAME OF PROVIDER OR SUPPLIER  University Park Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886</b></p> <p>Based on observation, record review, resident interviews, staff interviews and policy review, the facility failed to assure residents were treated with respect and dignity for 2 of 3 residents reviewed (Resident #84 and #54). The facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) for Resident #84, dated 1/21/25, Resident #84 scored 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. The resident was dependent on staff for toileting assistance and required substantial assistance for lower body dressing and chair to bed/chair transfer. The resident's diagnoses included a stroke.</p> <p>The Care Plan included Resident #84 had the potential for diversional activity due to cognitive impairment and/or physical assistance needed and the resident needed assistance to and from activities. Interventions included invite and encourage resident to attend activities and offer assistance for locomotion as indicated. The Care Plan further included the resident had a self-care deficit as evidenced by requiring assistance with</p> <p>Activities of Daily Living (ADLs), impaired balance during transitions requiring assistance and /or walking, incontinence. The resident required a one person staff assist with dressing/undressing and toileting and a two person staff assist with transfers with a sit to stand lift.</p> <p>During an observation 1/27/25 at 2:22 PM, Resident #84 was sitting upright in his reclining chair with his pants partway down his legs with a brief on. The brief was completely visible, initially it appeared the resident was sitting in his chair in his underpants. The door to his bedroom was open, his roommate was in the room, the curtain was open and the roommate was awake, the roommate could visually see the resident sitting in his chair with his pants down and the brief exposed. The resident could be observed sitting in his brief from the open doorway. The resident was observed sitting in his brief until 2:50 PM, when a staff placed blanket over his lower body.</p> <p>During an interview 1/27/25 at 2:25 PM, Resident #84 stated staff was just in his room, they needed to get another person for assistance and said they would return. The resident stated he was wanting to get into his wheelchair and go down to the activity that started at 2:00 PM.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 1/27/25 at 2:45 PM, Resident #84 stated he turned his call light on because no one came back to help him into his wheelchair. The resident stated he has been sitting in his chair with his pants partway down waiting for assistance to get into his wheelchair since 2:00 PM. He wanted to transfer to his wheelchair to go down to the activity on the lower level.</p> <p>During an interview 1/27/25 at 2:50 PM, Resident #84 stated he wanted to go downstairs for the activity, which was national cupcake day and get a cupcake, he has now missed this activity.</p> <p>During an observation 1/27/25 at 2:56 PM, staff brought Resident #84 a cupcake wrapped in a paper towel. The resident was still sitting upright in his reclining chair with a blanket over him, his pants were still not pulled up and he was still not transferred to his wheelchair.</p> <p>During an interview 1/29/25 at 2:45 PM, Staff D, Registered Nurse (RN), stated she was working on Monday, the 27th, on the 4th floor. She recalled being asked to go into Resident #84's room to assist him to pull up his pants, this was later in the afternoon, sometime around 3:00 PM or after. She stated the resident was sitting upright in his reclining chair with his pants down, he said he had been waiting for staff to help him with his pants and transfer him to his wheelchair. She helped him with his pants and then had to get another staff to assist with the transfer. Staff D stated another staff asked her to help the resident because he had been sitting for at least an hour in his chair waiting to have his pants pulled up and transferred to his wheelchair. She stated for dignity she would not leave a resident sitting in his chair with his pants down.</p> <p>During an interview 1/29/25 at 3:00 PM, Staff E, Assistant Director of Nursing (ADON) on the 4th Floor, stated an expectation staff cover a resident and not leave a resident in their chair with their pants pulled down and the door open to their room. ADON stated an expectation staff assist the resident immediately, and not leave them in an exposed condition. The ADON stated an expectation the resident be covered for dignity purposes. The ADON stated an expectation staff assist residents to activities and accommodate resident's choices to attend activities.</p> <p>Review of the facility policy Quality of Life-Dignity, revision date of August 2009, documented each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.</p> <p>50500</p> <p>2. The Quarterly MDS dated [DATE] revealed Resident #54 with a BIMS of 15, indicating intact cognition. Diagnoses included anxiety, diabetes, and depression with severely impaired vision. The MDS stated Resident #54 requires set-up assistance at meals with maximal assistance with transfers and self-cares.</p> <p>The Care Plan revealed Resident #54 had a self-care deficit, was at risk for falls and had visual impairment/blindness. Interventions include set-up assistance at meals, environment free of spills and personal items within reach. Resident #54 utilized a wheelchair that staff propels.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During breakfast observation on 1/28/25, the dining room was full with approximately 15 residents and 4 staff members (3 staff assisting residents to eat and 1 staff checking-in with residents throughout the meal). At 8:40 AM, Resident #54 accidentally dropped a bowl of oatmeal on the floor next to them creating a trail of oatmeal approximately 18-inches long. Staff did not immediately acknowledge or respond. At 8:48, an unknown therapy staff member picked-up the bowl, left the dining room and returned with towels to clean up. There was no interaction with the resident during this time. At 8:52 AM an unknown staff member cleaned-up the area further. The staff member did not interact with Resident #54, such as alerting to the spill/clean-up or offering another bowl of oatmeal. At 8:58 AM, when asked, Resident #54 indicated they were done with breakfast and staff began to clear off the table. At 9:08 AM staff escorted the resident back to their room.</p> <p>During an interview on 1/28/25 at 1:10 PM, Resident #54 indicated they were aware the oatmeal bowl fell to the floor. Resident #54 believes the bowl may have been moved accidentally and was not in its usual position. Resident #54 stated they would have liked another bowl of oatmeal if asked in a timely manner. However when staff asked if they were finished with the meal (18 minutes later), Resident #54 just wanted to return to their room.</p> <p>During an interview with Staff C, Assistant Director of Nursing, suspected staff overcompensated with the lack of interaction with Resident #54 as not to draw attention. Staff C would expect staff to address any food spills in a timely manner.</p> <p>The policy Quality of Life-Dignity, revised August 2009, stated staff shall keep the resident informed and oriented to their environment. Procedures shall be explained before performed.</p>		

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<p>F 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48886</p> <p>Based on observation, staff interviews and policy review, the facility failed to maintain resident living areas in good repair and provide a homelike environment. The facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>During an observation 1/27/25 at 12:00 PM, Resident #27 and #34's shared bathroom had wall damage on the floor board, a hole in the wall and the border coming off by the floor, with a large gap and hole in the wall.</p> <p>During an observation 1/27/25 at 12:58 PM, Resident #19 and #81's shared bathroom had a hole in the bathroom door in the middle, on the outside of the door. The bottom of the bathroom door was observed to be falling apart, with jagged edging and splintered wood. There was a hole along the floor board in the bathroom, by the sink.</p> <p>During an observation 1/29/25 at 12:30 PM, with the Administrator present, Resident #27 and #34's bathroom was observed, as well as Resident #19 and 81's bathroom. The Administrator advised she was not aware of the condition of the bathroom with damage to the walls in the bathrooms in more than one area and damage to the bathroom door. The Administrator stated the facility uses a tracking system called TELS to report, track and monitor repairs and maintenance issues. Staff are to use the TELS system to report repairs and maintenance issues. The Administrator pulls the report from TELS to see how timely repairs are fixed. The Administrator stated the damage to the floor and wall in the bathrooms is not homelike and stated an expectation this be repaired. The Administrator acknowledged the damage to the bottom of the door could be a safety concern with the wood being jagged and splintered. The Administrator is unaware if this damage was reported in TELS.</p> <p>During an interview 1/29/25 at 1:58 PM, the Administrator stated the damage to the bathrooms and doors were not reported in TELS and maintenance was not notified of the damage. The Administrator stated an expectation this damage be reported and be repaired.</p> <p>Review of the facility policy Quality of Life-Homelike Environment, with a revision date of May 2017, documented residents are provided with a safe, clean, comfortable and homelike environment.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>48886</p> <p>Based on record review, staff interviews, and policy review, the facility failed to ensure residents were free from misappropriation of resident property for 1 of 1 resident's reviewed (Resident #35). The facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>According to the Quarterly Minimum Data Set (MDS) for Resident #35, dated 1/22/25, a Brief Interview for Mental Status (BIMS) was not conducted as the resident is rarely/never understood. The resident had diagnoses to include Debility, Cardiorespiratory Conditions, heart failure, renal insufficiency and Non-Alzheimer's Dementia.</p> <p>The Care Plan for Resident #35, with a revision date of 8/7/24, included the resident had the potential for diversion activity due to cognitive impairment and/or physical assistance needed. Interventions included to encourage ongoing family involvement and provide for social interaction opportunities. The Care Plan further included Resident #35 was the recipient of an allegation of abuse: theft of cellphone, with a revision date of 11/7/24. Interventions included encourage visits with Social Services/designee to promote healing/recovery, notification to local Law Enforcement as required, replacement of items evaluated by facility, staff to provide for separation from perpetrator of the allegation. Staff member suspended and terminated. The facility has ordered a cellphone holder to be worn around neck if desired.</p> <p>During an interview 1/28/25 at 9:53 AM, Resident #35's daughter, who is the responsible party and emergency contact for the resident, stated the facility offered to replace the phone that was stolen. She advised they did not have a passcode on the phone that was stolen because it was easier for Resident #35 to use it without the passcode. The daughter stated the family did not want to have criminal charges pressed against the staff who stole his phone. The daughter stated they realized the phone was missing around the end of October when she tried to Facetime her father and he did not answer. She thought the phone was dead or just misplaced, but they could not locate the phone in his room or at the facility. About a week later the family decided to activate an old phone they had and used the same phone number as the phone that was missing/stolen. The daughter noticed some text messages coming through that she did not recognize. She gave the messages to the Administrator. She stated the facility handled the phone incident really well, she believed the facility conducted a thorough investigation and let the staff member go who was believed to have taken the phone.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 1/28/25 at 1:00 PM, the Administrator stated the facility made a referral to the Des Moines Police Department (DMPD), who said the family had to be the one to press charges. The family did not want to press charges. The facility offered to replace the missing cell phone, the family said they would replace the phone and did not want the facility to do this. The Administrator stated they realized the phone was missing when the family tried to Facetime the resident, this was around the first part of November, the family thought the phone was dead so they called the facility and the facility staff looked for the phone and could not find it. The family then activated another phone they had with the resident's phone number and when they did this, they noticed text messages on the phone. The facility thought it was Staff F, Certified Nursing Aide (CNA), who was using the resident's phone. Staff F did not admit to this and she did not show up for the 2nd interview they had scheduled with her. Staff F was terminated on 11/5/24.</p> <p>Review of the facility internal investigation report with regard to Resident #35's cell phone revealed on the night of Friday 10/25/2024, the daughter of Resident #35 messaged Staff E, Assistant Director of Nursing (ADON) to let her know that the resident's phone was dead and they were not able to facetime him like they wanted too. Staff E and other facility staff were not able to find the phone at this time. The daughter was notified and shared that she figured he lost it like he had in the past and it will come back like it has before. Staff continued to look for the phone. The daughter shared that the family decided to replace the phone because they believed that he had misplaced the phone, and it was in the facility somewhere. On Friday night 11/1/2024 the family of Resident #35 decided to activate an old phone that they had sitting at home. At this point they had turned on the new phone they saw messages from Friday the 1st that they did not know who they were from. The family then let the facility know that they believed the phone had been taken out of the facility by someone else. The facility worked with the family and received the cell phone from the family on Saturday night to be able to see if the facility knew any of the numbers that were messaged or called on the phone. A message that was received to the resident's new phone at 6:06 pm on Friday night was from Staff F stating that she was clocking out. This message was the only message sent to the phone from a staff member. The facility did call other numbers to see who they were and a lot of them were males that the facility did not have any correlation with. The facility then conducted interviews from all the staff that worked between 10/25/2024 to 11/1/2024. On 11/4/2024 when interviewing staff members the facility received the following responses, I have never seen the phone. I saw the phone a while ago but can not remember the last time. I saw the phone about 2 weeks ago sitting on the resident's mini fridge plugged in. The facility asked staff if they remember the color of the iPhone and the ones that have seen it stated that it was red. The color was verified by the family. The staff that typically work with the resident and on the fourth floor stated that they saw it approximately 2 weeks ago and on the mini fridge. The facility has been in contact with the family and let them know they believe they know who has taken the phone. The family still has stated that they will not be pressing charges but knows that it is their right to do so. The facility has also encouraged the family to change the resident's phone number so he does not receive messages from anyone who might have the old number.</p> <p>During a review of the text messages that came through to Resident #35's phone when the number was reactivated on 11/1/24, at 6:20 PM a text message was received on the resident's phone sent from a number stating I'm at Wayne's house. At 6:09 PM a text message was received that a Cricket update was completed. At 6:06 PM a text was received on the resident's phone number, this was a different number from the one received at 6:20 PM, it stated Clocking out.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 1/29/25 at 11:12 AM, the Administrator stated the phone number that sent the message I'm at Wayne's house was a number the facility did not know or recognize. The Administrator called that number and a male answered and did not say their name, she did not recognize the voice. The Administrator called the number that sent the message to Resident #35's cell phone number on 11/1/24 at 6:06 PM that said Clocking out and a female answered, said hello. The Administrator said who she was and asked to whom she was speaking with, the female did not say, and hung up. The Administrator said she recognized the voice and thought it was Staff F, who had worked at the facility for a year. The Administrator texted that number from her personal phone on the 1st of November, saying hey is this Staff F, it's the Administrator from UP? Staff F replied back to the Administrator on the 4th of November, saying yes, this is her, what's going on? The Administrator texted Staff F back on this number that sent a text to the resident's number, asking Staff F to come into UP, they have a situation that they need her help with. Staff F replied back saying okay, I can come in a sec, let me throw some sweats on, is it bad? This was on Monday, the 4th of November. Staff F came in for an interview with the Administrator on the 4th of November. Staff F admitted the phone number that sent a text message to Resident #35's cell phone number on the 1st of November saying clocking out was her number, she said she used a texting app phone number and it generated the number that she had used to send text messages. The Administrator asked Staff F who she was texting to Resident #35's number that she was clocking out. Staff F then said she didn't text that number, she said she didn't know who it was. The Administrator watched video footage when Staff F clocked out that day and she got in her own car and left, did not see her on her phone or get into anyone's car. Staff F worked on the 1st of November, from 6:00 AM to 6:00 PM. The Administrator stated they looked through other staff phone's and did not see Resident #35's number come up anywhere on their phones. The Administrator thought Staff F took Resident #35's phone and gave it to someone she knows, because she texted that number. Staff F was asked to come back in for a second interview on the 4th of November, Staff F initially said she would come in, then she did not show up for the interview or show up for work on her next scheduled shift. Staff F was terminated on 11/5/24 due to a violation of company policy regarding not working with the facility on an investigation and a no call no show for a scheduled shift on November 5th, 2024. Resident #35 had a different roommate at the time, the roommate had a low BIMS and was not interviewable.</p> <p>Telephone contact was attempted with Staff F on 1/29/25 at 11:26 AM, a voice message was left and a text message was sent requesting a return call.</p> <p>During an interview 1/30/25 at 11:00 AM, the Administrator stated an expectation residents are free from abuse and do not have their property stolen or misappropriated.</p> <p>Review of the facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting, updated 7/8/24, documented all residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50500</p> <p>Based on observation, family and staff interview, and policy review, the facility failed to ensure call light was within reach for 1 of 19 residents reviewed (Resident #68). The facility reported a census of 76.</p> <p>Findings include:</p> <p>The Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #68 with a Brief Interview for Mental Status score of 13 indicating intact cognition. Diagnoses included anemia, heart failure, hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body), hip fracture with presence of an artificial hip joint, and osteoporosis. The MDS stated Resident #68 used either a walker or wheelchair and requires moderate assistance with transfers.</p> <p>The Admission/Readmission Narrative Bundle, Section C-Falls, dated 12/19/24, assessed Resident #68 at risk for falls with a score of 14.</p> <p>The Care Plan revised on 1/15/25 revealed Resident #68 has self-care deficits. Interventions included staff assistance of one for transfers and walker mobility. The Care Plan also stated Resident #68 is a fall risk. Interventions included call light within reach, removal of wheelchair pedal while in the wheelchair to avoid self-transfers, and completion of Morse Fall Assessment quarterly and as needed.</p> <p>During a family interview on 1/27/25 at 2:00 PM, family reported seeing the call light out of reach for Resident #68 to use. This occurred when the resident was sitting in the recliner.</p> <p>During an observation on 1/29/25 at 1:30 PM, Resident #68 was in their room and seen sleeping in a recliner. The call light observed laying across the bed-side table which was over 3-feet away from the resident and out of their reach. During a return visit at 2:10 PM, Resident #68 remained asleep in the recliner with the call light on the bed-side table over 3-feet away.</p> <p>During an interview on 1/30/25 at 10:00 AM, Staff C, Assistant Director of Nursing, reported an expectation that staff should ensure call lights are within resident's reach.</p> <p>The policy titled Answering the Call Light, revised March 2021, stated when a resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>48886</p> <p>Based on observation, resident and staff interviews, record review and policy review, the facility failed to have sufficient nursing staffing to respond to resident's needs in a timely manner after a call light was activated. The facility reported a census of 76 residents.</p> <p>Finding include:</p> <p>1. According to the Minimum Data Set (MDS) for Resident #50, dated 11/15/24, Resident #50 scored 14 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. The resident was dependent on staff for toileting hygiene and required substantial assistance for lower body dressing. The resident's diagnoses included muscle weakness and other orthopedic conditions.</p> <p>During an observation 1/27/25 at 2:00 PM, upon entering the hallway, Resident #50's call light was activated above the door to the bedroom.</p> <p>During an observation 1/27/25 at 2:10 PM, Resident #50 was sitting on the toilet in the bathroom located in his bedroom, the call light above his door was on and activated. Resident #50 stated he pushed his call light at least 20 minutes prior and was waiting for staff to assist with toilet hygiene. Observed staff enter the resident's room at 2:10 PM and inquire what the resident needed and said they would return. Observed staff re-enter at 2:15 PM to assist the resident.</p> <p>During an interview 1/27/25 at 2:39 PM, Resident #50 stated he sat on the toilet for 45 minutes, he said he has his phone with him in his shirt pocket and said he pushed his light at 1:45 PM today. Resident #50 pulled his cell phone out of his shirt pocket, indicating he had this with him and it was on and working. Resident #50 stated he has sat on the toilet before for 25-30 minutes waiting for staff to help him wipe, he said he does not need assistance with transferring, he just needs assistance with wiping. He said his legs get sore from sitting on the toilet for so long. The resident stated this has happened a few times. He said they answer quickly when he pushes it while in his bed. The resident stated today when he sat for so long on the toilet he called down to the front desk to ask for someone to come up and help him. He said he has waited for 30-45 minutes for someone to come into the bathroom to assist him more than once.</p> <p>2. According to the MDS for Resident #84, dated 1/21/25, Resident #84 scored 15 on the BIMS, indicating intact cognition. The resident was dependent on staff for toileting assistance and required substantial assistance for lower body dressing and chair to bed/chair transfer. The resident's diagnoses included a stroke.</p> <p>During an observation 1/27/25, beginning at 2:22 PM, Resident #84 was sitting sitting upright in his reclining chair with his pants partway down his legs with a brief on and visible from the open doorway to his bedroom. Resident #84 was observed sitting in this position until 2:50 PM when a staff placed a blanket over the resident's legs. The resident's call light was observed to be activated at 2:45 PM. Observation from 2:22 PM to 2:49 PM revealed no staff member entering the resident's room to assist the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  University Park Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview 1/27/25 at 2:25 pm, Resident #84 stated staff was just in his room and little while ago, they needed to get another person for assistance. The resident stated he was wanting to get into his wheelchair and was a two person assist for transfers.</p> <p>During an interview 1/27/25 at 2:45 PM, Resident #84 stated no one came back to help him into his wheelchair so he put his call light back on, he said he has been sitting in his chair with his pants partway down waiting for assistance to get into his wheelchair since 2:00 PM.</p> <p>During an observation 1/27/25 at 2:56 PM, Resident #84 was still sitting upright in his reclining chair with a blanket over him, his pants were still not pulled up and he was still not transferred to his wheelchair.</p> <p>During an interview 1/29/25 at 2:45 PM, Staff D, Registered Nurse (RN), stated she was working on Monday, the 27th, on the 4th floor. She recalled being asked to go into Resident #84's room to assist him to pull up his pants, this was later in the afternoon, sometime around 3:00 PM or after. Staff D stated the resident was sitting upright in his reclining chair with his pants down, he said he had been waiting for staff to help him with his pants and transfer him to his wheelchair. She helped him with his pants and then had to get another staff to assist with the transfer. Staff D stated another staff asked her to help the resident because he had been sitting for at least an hour in his chair waiting to have his pants pulled up and transferred to his wheelchair. Staff D stated they normally answer call lights quickly, within 15 minutes. She said if staff need another staff to assist, they come back quickly, within a few minutes, she said they should not leave a resident for longer than 15 minutes waiting for assistance.</p> <p>During an interview 1/29/25 at 3:00 PM, Staff E, Assistant Director of Nursing (ADON), stated an expectation call lights are answered within 15 minutes, or sooner. If a staff responds to a call light and needs another staff to assist, they should return within a few minutes, no longer than 15 minutes. If it will take longer than just a few minutes, staff need to let the resident know and return within 15 minutes.</p> <p>Review of the facility Resident Council meeting minutes, dated 1/27/25, documented under Nursing, day shift slow to answer call lights.</p> <p>Review of the facility policy Answering the Call Light, revised March of 2021, documented the purpose of this procedure is to ensure timely responses to the resident's requests and needs.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49628</p> <p>Based on personnel document review, staff interviews, and facility policy review the facility failed to employ a clinically qualified nutrition professional by not having a certified dietary manager. The facility reported a census of 17 residents.</p> <p>Findings include:</p> <p>On [DATE] a request for documentation from the facility revealed the Dietary Director did not have the required certification.</p> <p>On [DATE] at 12:30 PM the Dietary Director confirmed he had been in the position for 3 weeks and had not completed the certification requirement yet. The Dietary Director stated he had previously held a Serve Safe Certification, but it had expired. The staff stated he was currently enrolled in the necessary coursework to complete the certification.</p> <p>On [DATE] at 1:20 PM the Administrator acknowledged the Dietary Manager was a new employee and had not completed his certification, but was currently taking the necessary coursework.</p> <p>The facility did not have a policy related to having a certified dietary manager.</p> <p>The Food and Drug Administration Food Code 2022 revealed the person in charge of the kitchen must be a certified food protection manager who has shown proficiency in required information through passing a test that is part of an accredited program.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49628</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on documentation review, staff interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility failed to document temperatures of food in the kitchen prior to distribution. The facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>Reviewed the kitchen meal temperature logs for 3 months. 4 meal temperatures out of 90 meals were not recorded in November. 8 meal temperatures out of 93 meals were not recorded in December. 25 meal temperatures out of 78 meals were not recorded in January</p> <p>On 1/29/25 at 12:30 PM the Dietary Director expected that all temperatures would be completed in the kitchen prior to distributing the food to the dining rooms, and completed in the dining rooms prior to serving. The Dietary Director stated he further expected that all temperatures were to be logged on the appropriate log forms whether the kitchen or dining rooms. The Dietary Director acknowledged with incomplete documentation it was unknown if the temperatures were taken prior to food distribution or serving, and the food had reached the required temperatures.</p> <p>On 1/29/25 at 1:20 PM the Administrator expected all food temperature logs be kept current to document temperatures taken in the kitchen and in the dining rooms. The Administrator concurred documentation is required to prove the food temperatures were taken prior to food distribution or serving.</p> <p>The facility policy, Food Preparation and Service, revised October 2017 revealed specific temperatures/times required for specific foods to be reached to inactivate pathogenic microorganisms. The document further revealed dietary staff would adhere to proper practices to prevent the spread of foodborne illness.</p> <p>The Food and Drug Administration Food Code 2022 revealed the person in charge of the kitchen should be provide daily oversight of the employees ' routine monitoring of the cooking temperatures.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49628</p> <p>Based on observations, staff interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with professional standards. The facility placed cooking utensils on countertops, and delivered drinks uncovered. The facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>Observation on 1/27/25 at 9:45 AM revealed the ice machine had a light pink substance throughout.</p> <p>Continuous observation on 1/28/25 at 9:53 revealed Staff A placed a scraper on a countertop without a barrier during the preparation of pureed meat. During the preparation of mashed potatoes Staff A placed the whisk on the countertop without a barrier.</p> <p>Continuous observation on 1/28/25 at 12:07 PM revealed room tray service initiated. A room service tray left the dining room with 3 drinks uncovered. During preparation of the second tray, Staff B, Certified Nursing Assistant (CNA), stated forgot to put lids on the drinks. Observed a tray with uncovered drinks leave the dining room and enter the hallway when the Registered Dietitian stopped the delivery, and directed the staff to return to the dining room to cover the drinks.</p> <p>During an interview 1/27/25 at 2:56 PM, Resident #84 stated he eats in his room. He said he wondered if the State was here today because his drinks had a cover over them for lunch and normally they do not, he said his drinks are served to him without a cover normally.</p> <p>On 1/29/25 at 12:30 PM the Dietary Director stated he was not aware of the ice machine needing to be monitored and cleaned as he was new to the position. The staff stated cooking utensils could be set on the countertops if the countertops were wiped off. The Dietary Manager stated he was not aware of when the last time the counters were wiped off prior to setting the utensils on them. The staff stated all liquids on room trays were to be covered prior to delivery.</p> <p>On 1/29/25 at 1:20 PM the Administrator stated she expected the ice machine to be kept in a clean manner and maintenance should be responsible for this. The Administrator stated she would be fine with utensils on counters if the counters had been wiped down, but could not guarantee when the counters had been wiped or if things had been set on them prior to staff setting utensils on them. The Administrator stated that cups should have lids on them prior to carrying them down the hall from the dining rooms on the floors.</p> <p>The facility policy, Ice Machines and Ice Storage Chests, revised January 2012 revealed the facility would have procedures for cleaning and disinfecting the ice machine adhering to the manufacturer's instructions. It further revealed the ice machine will be used and maintained to assure a safe and sanitary supply of ice.</p> <p>The facility policy, Food Preparation and Service, revised October 2017 revealed food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.</p>		