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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Nursing and 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** Based on observations, clinical record review, staff interview, and policy review the facility failed to disinfect a mechanical lift after use between 2 of 2 residents (#37, #55) and failed to use appropriate Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) and enteric isolation precautions for 2 of 2 residents (#13, #75). The facility reported a census of 74 residents. Findings include:During a continuous observation that began on 3/03/2026 at 6:37 AM, Staff K, Certified Nurse Aide (CNA) transported a mechanical lift from a storage room to Resident #54's room.At 6:40 AM, Staff K transported the mechanical lift from Resident #54's room to Resident #55's room. The mechanical lift was not sanitized between resident use.At 6:50 AM, Staff J, CNA transported the mechanical lift from Resident #55's room and took it to Resident #37's room. The mechanical lift was not sanitized between resident use.At 6:56 AM, Staff J transported the mechanical lift from Resident #37's room and placed it in the shower room. The mechanical lift was not sanitized after resident use.At 7:02 AM, Staff J stated the mechanical lifts should be sanitized before and after resident use. She also stated should've sanitized the mechanical lift between residents but didn't. 2. Resident #75's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of hemiplegia (one-sided body paralysis caused by brain or spinal cord damage), asthma, and enterocolitis (inflammation of the small intestines and colon) due to clostridium difficile (C-diff - toxin producing bacteria that sheds spores). It revealed he required setup assistance with eating, supervision with oral hygiene, moderate assistance with bathing, sitting-to-lying, and lying-to-sitting, maximal assistance with footwear, bed mobility, sit-to-stand, and car and shower transfers, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It further revealed the resident received an antibiotic during the 7-day look-back period.The Electronic Health Record (EHR) revealed the resident was receiving a daily antibiotic dated 2/04/26 for C-diff.The Care Plan revised 1/21/26 indicated the resident was on enteric isolation due to C-diff and directed staff to post appropriate signs outside of room to ensure visitors check with nursing prior to entering.During a continuous observation that began on 3/02/26 at 8:26 AM, Staff L, Registered Nurse (RN) entered Resident #75's room to administer medications without putting on PPE. She stated he was still receiving antibiotics and being seen by an Infectious Disease physician.At 8:32 AM, Staff M, Activities Director (AD) entered the resident's room without PPE and delivered his mail. She exited his room and entered the next resident's room.An Enteric Contact Precautions (infection control measures for pathogens spread by feces) sign was attached at the resident's room entrance. It directed staff to wear a gown and gloves upon entry and to wash hands with soap and water. 3.Resident #13's MDS dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of obstructive uropathy (urine flow blockage), seizure disorder, and ulcerative colitis (bowel inflammation that causes ulcers). It indicated she required supervision with eating, moderate assistance with all forms of non-ambulatory mobility, and maximal assistance with all other ADLs and ambulatory mobility. It further revealed she had a urinary catheter and a feeding tube.On 3/04/26 at 7:00 AM, Staff N, Registered Nurse (RN) entered Resident #13's room to disconnect the feeding tube (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and administer medications. She performed hand hygiene in the resident's room and donned gloves. She stopped the tube feeding and disconnected it. She used a 50ml plunger and performed an air test for placement. She flushed the tube with 30 milliliters (mL) water. She attempted to administer medications through the feeding tube but could not get the medications through the tube. She removed the gloves, performed hand hygiene and notified the DON. She did not put on any other PPE throughout the process. An Enhanced Barrier Precautions (EBP) sign was attached to the resident's door.At 7:25 AM, Staff N stated she believed the EBP was for the other resident who shared Resident #13's room.On 3/04/26 at 2:15 PM, the Director of Nursing (DON) stated staff should sanitize equipment before and after resident use and should follow isolation precautions.A policy titled Infection Prevention and Control Program Policy and Procedure dated 1/01/26 indicated all staff are responsible for following all policies and procedures related to the program. It also indicated all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.A policy titled Management of C. Difficile Infection dated 2025 indicated all staff are to wear gloves and a gown upon entry into the resident's room and while providing care for the resident with C. difficile infection. It also indicated hand hygiene shall be performed by handwashing with soap and water in accordance with facility policy for hand hygiene.The EBP sign directed staff to wear gloves and a gown for the followingHigh-Contact Resident Care Activities.DressingBathing/ShoweringTransferringChanging LinensProviding HygieneChanging briefs or assisting with toiletingDevice care or use: central line, urinary catheter, feeding tube, tracheostomyWound Care: any skin opening requiring a dressing

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on clinical record review, staff and resident interview, and facility policy review, the facility failed to provide showers for dependent residents in 1 of 18 resident's reviewed for activities of daily living (ADLs) (Resident #58). The facility reported a census of 74. Findings include: The Minimum Data Set (MDS) for Resident #58, completed on 02/25/2025, recorded the resident's Brief Interview for Mental Status (BIMS) score as 14, which indicated intact cognition. It documented the following relevant diagnoses: Diabetes Mellitus (diabetes), and arthritis. It documented the resident was a below-the-knee amputee and had reduced mobility and a need for assistance with personal cares. It documented the resident entered the facility on 11/28/2025. The Care Plan for Resident #58, last revised on 03/02/2026, documented the resident required two-person assistance for bathing and showering, and instructed staff members to encourage the resident to bathe or shower twice weekly. Review of bath and shower records from 12/01/2025 through 03/01/2026 revealed the following: Resident #58 had a bed bath as requested on 12/05/2026From 12/06-12/14 there is no documentation about refusals, and no documentation to show the resident received a bath, shower, or bed bath in this timeframe. Resident #58 had a shower on 12/15/2025From 12/16/2025 through 01/11/2026 there is no documentation about refusals, and no documentation to show the resident received a bath, shower, or bed bath in this timeframe. Resident #58 was given a shower on 01/15/2026 Resident #58 refused a shower on 01/19/2026Resident #58 refused a shower on 01/26/2026. There are no documented showers or refusals from 01/19/2026 until 01/26/2026. Resident #58 was given a shower on 02/02/2026From 02/09/2026 through 03/01/2026 there is no documentation about refusals, and no documentation to shower the resident received a bath, shower, or bed bath in this timeframe. A review of the Kardex Plan of Care (POC) Response history with a lookback period of the last 30 days documented only one day in the last 30 days. 02/20/2026, and documented the resident did not receive a shower or bath on this date. Review of the Nursing Progress Notes from 11/28/2025 through 03/05/2026 documented two bath or shower refusals, once on 12/05/2025 in which the resident asked for a bed bath, and once on 01/19/2026. In an interview on 03/01/2026 at 02:07 PM with Resident #58, he stated he had only been offered and given two showers and one bed bath since he entered the facility. In an interview on 03/05/2026 at 09:47 AM with the Assistance Director of Nursing (ADON), she stated the facility had given surveyors all of the documentation they were aware of regarding baths and showers on 03/04/2026 and again on 03/05/2026. She stated refusals might also be documented in the nursing progress notes. In an interview on 03/05/2026 at 10:28 AM with Staff O, Certified Nurse Aide (CNA), she stated bath and shower sheets are how the facility and CNAs keep track of showers for residents. When a resident has a bath or if they refuse they document on the shower sheets. Nurses sign off on the shower sheets and then enter a nursing progress note if there was a refusal. She stated Resident #58 is supposed to be showered twice a week, but does refuse. She stated if there is no shower sheet, there is no way to prove the resident refused or received a shower. In an interview on 03/05/2026 at 10:39 AM with Staff P, CNA, she stated the nurses and CNAs sign off on the bed bath sheets to document if a resident got or refused a shower. She stated she doesn't know if the nurse documents anything after signing the sheet. She stated they do not use the Kardex or Pocket Plan of Care, they use bath sheets. She stated it is expected of her that she fill out and sign a bath sheet every time she offers a resident a bath, even if they refuse, because she documents the refusal on the sheet. In an interview on 03/05/2026 at 10:46 AM with Staff Q, Licensed Practical Nurse (LPN), she stated refusals and baths are documented on the bath sheets. She confirmed both nurses and CNAs are required to sign off on the bath sheets. She stated that if she did not see a bath sheet for a resident her assumption is that a bath was not offered. In an interview on 03/05/2026 at 10:01 AM with the Director of Nursing (DON), she stated her expectations for staff members is that they fill out a bath sheet for every bath, shower, or refusal. She stated if it isn't documented the facility cannot prove a resident was given or (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused a shower. She stated when she questioned staff members they admitted they had been forgetting to fill out refusals for Resident #58. Review of a facility provided document titled Resident Showers, with no known implementation or review date, stated Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. It contained no information regarding shower sheets or how to document refusals.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy review, the facility failed to correctly position a resident in a mechanical lift during transfer for 1 of 3 residents (#14), failed to lock the wheelchair during resident transfers for 2 of 3 residents (#44, #55), and failed to attach foot pedals on the wheelchair while transporting a resident for 1 of 1 resident (#69). The facility reported a census of 74 residents.Findings include:1.Resident #14's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of hemiplegia (one-sided body paralysis caused by brain or spinal cord damage), diabetes mellitus, and a stroke. It revealed he was independent with eating and oral hygiene, was dependent with toileting, and required maximal assistance with all other Activities of Daily Living (ADLs) and all forms of mobility.The Care Plan initiated 10/24/24 directed staff to transfer the resident with an EZ Stand (mechanical device used to transfer a resident in a standing position).On 3/01/26 at 10:15 AM, Staff D, Certified Nursing Aide (CNA) and Staff E, CNA transferred Resident #14 in an EZ Stand. Staff E positioned the EZ Stand in front of the resident's wheelchair, opened the EZ Stand legs, positioned the sling around the resident's back, and fastened it to the EZ Stand. The resident's knees were not touching the shin pads as Staff D raised the resident from his wheelchair.2.Resident #44's MDS assessment dated [DATE] identified a BIMS score of 00 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia and Down Syndrome. It revealed he required supervision with walking 10 feet, moderate assistance with eating, lying-to-sitting, and sitting-to-lying, maximal assistance with all other ADLs, toilet and shower transfers, and bed mobility, and was dependent with sit-to-stand and chair-to-chair transfers.The Care Plan revised 2/11/26 directed staff to use a mechanical lift for resident transfers.On 3/02/26 at 8:40 AM, Staff F, CNA and Staff G, contract staff transferred Resident #44 in a mechanical lift from his bed to his Broda chair (specialized chair with enhanced support features). Staff F held the resident's support sling while Staff F lowered the resident onto the Broda chair. Staff F pressed her foot down on the mechanical lift frame to stabilize it then locked it as the resident got closer to the chair. The Broda chair was unlocked throughout the transfer process.On 3/02/26 at 9:23 AM, Staff F and Staff G transferred Resident #44 from his Broda chair to a recliner in front of the nurses' station. The Broda chair's rear right wheel was not locked during the resident's transfer.3.Resident #69's MDS assessment dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, seizure disorder, and mild intellectual disabilities. It revealed he required supervision with eating and was dependent in all other ADLs and mobility.The Care Plan revised 9/10/22 revealed the resident did not ambulate but used a wheelchair that he can self-propel.On 3/01/26 at 2:42 PM, Staff H, CNA transported Resident #69 in his wheelchair without foot pedals. Staff H and Staff I, CNA transferred the resident from his wheelchair to his bed with a mechanical lift. The wheelchair was unlocked during the transfer process.Staff H and Staff I stated the wheelchair should be locked when transferring a resident to or from it. Staff H also stated they did not notice the wheelchair was unlocked. She further added the resident should not have been transported in his wheelchair without his foot pedals.4.Resident #55's MDS assessment dated [DATE] identified a BIMS score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of hemiplegia, diabetes mellitus, and chronic obstructive pulmonary disease (COPD). It revealed she required supervision with eating and was dependent with all other ADLs and mobility.The Care Plan revised 12/17/25 directed staff to use a mechanical lift with 2-person assistance for resident transfers.On 3/03/26 at 6:43 AM, Staff J, CNA and Staff K, CNA transferred Resident #55 with a mechanical lift from her bed to a wheelchair. Staff K raised the resident in the mechanical lift sling while Staff J positioned the wheelchair between the mechanical (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lift's legs. Staff K lowered the resident into the wheelchair. The wheelchair was unlocked throughout the transfer process.At 7:02 AM, Staff J stated the wheelchair should be locked when transferring a resident in or out of it but she forgot to lock it.At 7:05 AM, Staff K stated wheelchairs should be locked when transferring residents in or out of them.A policy titled Mechanical Lift Policy and Procedure dated 9/01/25 directed staff to perform a test lift before full transfer by raising the resident 2 inches off the surface to check sling fit, attachment security, and weight distribution.The facility did not provide a policy regarding locking wheelchairs or transferring residents in a wheelchair without foot pedals.On 3/04/26 at 2:15 PM, the Director of Nursing (DON) stated staff should lock the brakes on wheelchairs during resident transfers and follow the policy with resident transfers.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, electronic health record (EHR) review, staff interviews, and policy review, the facility failed to assure a medication error rate of less than 5%. A total of 27 ordered medications were reviewed with two errors, an error rate of 7.4%. The facility reported a census of 74. Findings include: During an observation on 3/4/26 at 7:55 AM, Staff B, Licensed Practical Nurse, prepared at total of 8 different medications for Resident #33. Staff B obtained one Omeprazole 20 milligrams (mg) pill from the resident's medication card as well as one Omeprazole 20mg pill from an over-the-counter floor stock bottle. Staff B also obtained two Vitamin D3 125 micrograms (mcg)/500 International Units (IU) pills from an over-the-counter floor stock bottle. These medications along with 6 others were administered to Resident #33. During reconciliation of the observed medication pass with current Physician Orders for Resident #33, the following was noted: 1.Omeprazole 20mg ordered for 1 capsule daily; 2.Vitamin D 1.25mg (50,000 IU) ordered for 1 capsule one time a week. In an interview at 3/4/26 at 8:30 AM, Staff B confirmed Resident #33's Omeprazole order at 20mg (1 pill). Upon further discussion, Staff B realized they should have administered the pill from the medication card only and not also from the stock bottle. In an interview on 3/4/26 at 10:25 AM, Staff C, Pharmacist, confirmed the Vitamin D order at 1.25mg weekly. Staff C explained this is sent via a resident-specific medication card.In a follow-up interview on 3/4/26 at 10:45 AM, Staff B acknowledged the Vitamin D pill should have been from the medication card and not the stock bottle. The undated policy Medication Administration noted the following: 1.Ensure the six rights of medications administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 2. Review the Medication Administration Record (MAR) to identify medication to administer 3. Compare the medication source (bubble pack, bottle, etc) with the MAR to verify resident name, medication name, form, dose, route, and time 4. Administer medication as ordered in accordance with manufacturer specifications