STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via of Des Moines	4911 SW 19th Street Des Moines, IA 50315

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on observation, clinical record review, documentation from the facility self-report, staff interviews and facility policy the facility failed to provide an environment free from sexual abuse for 1 of 2 residents reviewed for sexual abuse. (Resident #1). Resident #2, the aggressor was well known for sexual behavior and comments toward other females. Resident #1 experienced unwanted sexual touching on 3/16/24. On 4/23/24, Resident #2 was observed sitting by Resident #4 who had poor cognitive status, and was unsupervised by staff for over two minutes. A serious adverse outcome was likely to occur as the facility failed to provide proper supervision of Resident#2, which put Resident#4 and any other vulnerable residents at risk for unwanted sexual advances. There was an immediate need for the facility to take steps to ensure all residents were protected from the risk of abuse. The facility reported a census of 78 residents. On April 23rd, 2024 at 5:45 p.m., the Iowa Department of Inspections, Appeals, and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff determined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on April 24th after the facility staff completed the following: 1. On 4/23/24, a motion alarm was installed on Resident #2's door to ensure staff are notified when Resident exits the room. 2. On 4/23/24, staff education was initiated to ensure staff are aware of the motion alarm on Resident #2's door and to ensure the whereabouts are being monitored. 3. On 4/24/24, all interview-able residents will be interviewed by staff to ensure any abuse-related concerns have been addressed appropriately. 4. On 4/24/24, a silent alarm will be procured to place in Resident #2's chair while they are out of the room to ensure their activity is monitored. This intervention will be reviewed weekly for appropriateness. 5. On 4/24/24, a silent alarm will be procured to Resident #2 door to ensure staff are notified when exiting the room. Once the alarm sounds the charge nurse will be responsible to ensure resident whereabouts and summon nursing staff to provide intervention such as toileting, snacks, ambulation and activities. (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: 165273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Via of Des Moines		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 SW 19th Street Des Moines, IA 50315	

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

6. On 4/24/24, Resident #1 and Resident #2 were moved rooms to decrease the potential interaction between Resident #1 and Resident #2.

7. The facility will continue with medication management and psychosocial services for Resident #2 as previously implemented.

8. The facility will continue with psychosocial services for Resident #1 as previously implemented.

9. Any concerns will be reported to the administrator immediately and addressed in facility Quality Assurance.

The scope was lowered from an IJ to a G at the time of the survey.

Finding include:

1. The Minimum Data Set (MD'S) assessment with a reference date of 12/29/23 for Resident #2 documented a score of 4 on the Brief Interview for Mental Status (BIMS) test which indicated severe cognitive impairment. The resident had diagnoses that included diabetes mellitus, Alzheimer disease, anxiety and depression and required supervision to touching assistance with transfers and ambulation with a walker. The MDS revealed the resident had no physical behavioral symptoms directed towards others (grabbing, abusing other sexually).

Review of Facility Self-Report dated 3/16/24,

Timeline of Incident:

*On 3/16/24 at approximately 3:56 p.m., Executive Director, was notified by Infection Prevention and Quality Nurse, that Resident #1 had reported to Certified Nurses Aid (CNA), that Resident #2 had touched Resident #1 inappropriately. This was reported to Department of Inspections Appeals and Licensing (DIAL) on 3/16/24 at approximately 4:11 p.m.

*On 3/16/24 at approximately 3:30 p.m., CNA had reported to Registered Nurse (RN) that Resident #1 wanted to speak with a nurse at Resident #1 bedside. The RN stated that Resident #1 reported that That man was in here and touched me. RN asked where and Resident #1 pointed to her private area under the covers and stated He went away and went to go sit on the bed over there. I then noticed Resident #2 was having trouble getting up, so I pushed the call light, and that CNA, came in here and helped him up. RN asked Resident #1 how she was feeling, and Resident #1 stated I am ok, I just want Resident #2 to stay out of my room. RN told Resident #1 that she would notify the management team, family, and providers and Resident #1 stated she was fine.

The Care Plan with initiated date 4/8/22 documented a focus area of increase in mood/behavior as evidence by diagnoses of dementia without behavioral disturbances, anxiety, and depression. The resident would wander the hallways putting him at risk for elopement. The resident had times of inappropriate sexual behavior including verbal comments to females, and exposing himself. The resident could be easily angered, become verbally, and physically abusive. (The following documentation was removed with a revision of the Care Plan along with the words physically abusive on 4/20/22, and then added back to the Care plan on 6/16/23; The resident would attempt to punch, kick, slap staff and other residents).

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The following Care Plan interventions were in place at the time of the incident on 3/16/24;

-Redirect the resident from female residents when he is sexually inappropriate. initiated 4/8/2022

-The resident is not able to give consent for sexual encounters. Monitor and redirect the other party immediately. Any encounter with another resident must follow resident to resident guidelines and be reported to the DON and or Administrator immediately along with a completion of an incident report 6/6/2022

-An attempt to conduct an evaluation for sexual consent was attempted with the resident on 6/6/22. Power of Attorney (POA) gave approval for the evaluation. The resident refused cooperation with the evaluation, and did not remember the sexual incident that took place with another female in his room on 6/5/22.

A Care Plan intervention with initiated date of 4/8/22 documented as follows; Behavior management referral will be made to Deer Oaks Psychiatry and Bridges Community Services, this was discontinued prior to the incident, but another referral was made on 3/16/24.

The Primary Care (physician visit notes) documented the following;

-Visit dated 9/1/23, Seroquel (antipsychotic) added recently for hypersexual behaviors and delusions. The resident is oriented to place and time, but does have memory loss, becomes easily agitated.

- Visit dated 10/27/23, Resident with increased hypersexual behaviors, exposes self to female resident, becomes agitated easily.

-Visit 11/3/23, Depression. Takes sertraline and Cymbalta. Followed by Deer Oaks. Denies symptoms today. Seroquel for hypersexual behaviors and delusions. Dose recently increased, becomes easily agitated.

-Visit 12/29/23, Depression. Takes sertraline and Cymbalta. Followed by Deer Oaks. Denies symptoms today. Seroquel for hypersexual behaviors and delusions. Dose recently increased, becomes easily agitated, but able to redirect.

- Visit 2/12/24, Depression. Takes sertraline and Cymbalta. Followed by Deer Oaks. Denies symptoms today. Seroquel for hypersexual behaviors and delusions. Dose recently increased, becomes easily agitated, but able to redirect. Continue to monitor behaviors.

-Visit 2/26/24, Seroquel dose decreased due to increased sleepiness and falls. Depression. Takes sertraline and Cymbalta. Followed by Deer Oaks. Seroquel for hypersexual behaviors and delusions. Dose recently decreased. No increase in behaviors at this time. Becomes easily agitated but able to redirect. Continue to monitor behaviors and follow up with Deer Oaks.

Deer Oaks Psychiatric Subsequent assessment dated [DATE] documented the following;

=Per staff on 1/5/23 resident asked another female resident to have sex, resident was redirected. Assessment/Plan directed staff to monitor mood and behaviors, provide supportive care and safe environment to meet resident's needs.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	=Deer Oaks Psychiatric Subsequent assessment dated [DATE] documented the following; Reason for referral at staff request the resident had aggressive behaviors difficult to redirect. Per staff resident seen in females' rooms- difficult to redirect, worsening agitation, verbally aggressive, physically aggressive, hit staff nurse, and roommate. Plan; Increase Seroquel, risk outweighs benefits as resident is danger to self and others. If Seroquel makes resident too sleepy, plan to cross taper Risperdal. Monitor mood and behaviors. Provide supportive care, safe environment to meet resident's needs. =9/28/23 Per staff resident makes inappropriate sexual comments at times. No behaviors. = 10/26/23 Per staff: Resident with recurrent falls. Resident inappropriate sexual behaviors and comments. Per chart on 10/24/23; resident found by CNA in a female resident room, with his pants around his ankles, and exposing his penis to the females in the room. Resident was made aware that it was inappropriate, assisted in pulling his pants, up, and was walked out of the room to a safe location. Resident had made in appropriate sexual comments toward staff. =3/5/24 Per staff resident impulsive and restless at time. Resident will change clothing multiple times per day, ambulates without walker, unsteady gait. No concern with inappropriate sexual behaviors. The Progress Notes documented on these dates and times the following behaviors: *6/5/22 at 5:40 p.m., Incident Note: Incident report complete due to inappropriate behavior with another resident. Physician notified, and family notified of incident. *6/6/22 at 8:44 a.m., Note Text: Message for, Advanced Registered Nurse Practitioner (ARNP) with Deer Oaks psych nurse manager regarding behaviors and incident on Sunday 6/5/22. She has sent over orders to increase med's and obtain labs. Noted in chart. Daughter to be notified by social worker when she contacts her regarding the incident. *6/6/22 at 2:09 p.m., Note Text: Administrator attempted to complete sexual consent assessment evaluation with resident to determine if resident is able to consent to sexual contact. Resident refused to answer questions asked by administrator. Administrator asked resident if he would prefer to be interviewed by a male staff member and he refused. Social Worker was present for attempted interview. *6/6/22 at 7:41 p.m., Note Text: resident observed sitting in lounge area trying to convince female resident, to come in to his room. This nurse reminded both residents that they cannot be alone in residents' room. *6/9/22 at 3:19 a.m., Note Text: Inappropriate behavior noted between resident and another resident. Educated on appropriate behavior and not to enter employee only exits. *6/10/22 at 12:25 p.m., Note Text: At the request of the family this writer attempted to do a second Sexual Consent; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Assessment with the resident. The resident did agree to the assessment. This writer provided the resident with reassurance that all the information would be kept confidential and reminded him that the questions are sexually explicit. He voiced understanding and wanted to continue. This writer asked the first question, and the resident provided a yes answer but refused to provide the second part to those questions and asked to proceed to the next question. This writer asked him the second question he responded yes. Again, when this writer asked him the second part to that question he refused to answer and stated We are done with these questions. I am not going to answer any more. This writer asked the resident do you understand what that means, he stated Yes, and I do not want to talk about it. This writer voiced understanding and left the resident. *8/3/23 7:58 p.m. Health Status Note documented as follows; the resident being aggressive to another resident in lounge area. Verbal disagreement between this resident and a female resident. Resident#2 stood with walker and walked past another resident and said, What you gonna do about it? and ran his walker into the other residents' wheelchair. There were words between the two residents and then staff intervened to separate the resident. The incident was witnessed by CNA staff and this nurse. *10/24/23 7:13 p.m. Behavior Note documented Resident was found by CNA in a female resident room, with his pants around his ankles, and exposing his penis to the females in the room. Resident was made aware that it was inappropriate, assisted in pulling his pants up, and was walked out of the room to a safe location. The CNA then came and told this RN about the incident. *10/25/24 5:26 p.m. Behavior Note documented CNA assisting resident with hallway ambulation and resident made inappropriate sexual comments to female CNA. Physician office notified. *10/26/23 10:06 a.m. Health Status Note documented Fax received from physician related to exposing self to peer with no new orders, continue to monitor and report persistent behaviors. Provider to follow up with next visit. *3/16/24 at 5:25 p.m., Note Text: Certified Nursing Assistant (CNA), reported to nurse that a female resident is requesting nurse at bedside. This nurse at bedside. Nurse asked female resident how can we help her and she said, That man was in here and he touched me. She then said, He had trouble getting up by himself on that bed over there so I pushed my call light and the CNA girl came in and helped him up. Registered Nurse (RN) found resident's CNA and asked her if she helped resident up and staff member said, Yes, female resident called and said he needed help getting up. She then asked me to get a nurse. RN went to go see male resident next. RN found male resident laying down in his bed. RN asked male resident if he went into female resident room and male resident said, Yes, I went in there to say hi to her. RN asked male resident if he touched female resident at all and male resident said, No, I would not do that. RN assessed resident male resident head to toe and obtained vital signs. RN asked resident if he was having any pain, questions or concerns and resident said, No, I am fine. INTERVENTION: 15- minute checks started at 3:30 p.m. stat. RN stepped out of male residents' room and called On-call nurse to update her on recent incident, also notified Director of Nursing (DON) as soon as possible (ASAP). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*3/22/24 at 3:43 p.m., Note Text: resident walking with staff in hall way. Resident made comment regarding breasts and attempted to touch staff member over clothes on her breast. Incident reported to this nurse and DON. *3/24/24 at 3:10 a.m., Note Text: CNA reported to this nurse that resident made sexually inappropriate comments to her. This RN reported to resident to inform him that comments like that were inappropriate. Resident stated I know I'm sorry. No other behaviors observed this shift. Will continue to monitor. Observation on 4/23/24 at 9:20 a.m., Resident #2 sitting in north lounge area in an armed chair with back against the east wall and Resident #4 in a wheelchair sitting next to Resident #2, for which Resident #4 was with in an arm's reach of Resident #2. No staff were in the area between 9:28 a.m.-9:30 a.m. Interview on 4/23/24 at 10:40 a.m., Staff D, CNA, recalled working on 3/16/24, and that Staff D witnessed Resident #2 ambulating independently with a walker, Staff D confirmed and verified that Staff D assisted Resident #2 to their room. Staff D stated that Resident #2 would make sexual comments to staff when cares where being performed. Resident#2 will do what Resident#2 wants to do. Staff D stated that staff were to keep an eye on Resident #2 when out of their room, but with the staffing status, that was not always being completed. Staff D reported that Resident#1 does not come out of her room as often as she did before the incident. Interview on 4/23/24 at 11:00 a.m., Staff E, CNA, recalled working on 3/16/24, and stated that Resident #1 had put on the call light, so Staff E went into Resident #1's room to answer the light. Resident #1 explained that Resident #2 had come into Resident #1 room and was sitting on the empty bed across from Resident #1 and that Resident #1 would like for Resident #2 to leave the room, and if Staff E would get the charge nurse. Staff E, remembered asking Resident #1 if there was something that Staff E could help with and Resident #1 said no. Staff E confirmed and verified that Resident #2 would make sexual comments during cares performed and Staff E would tell Resident #2 that those comments are not appropriate. Staff E reported that Resident#2 is well known for his sexual comments about wanting a kiss or wanting to relieve himself, and staff just ignore the comments or tell him that those comments are not appropriate. Staff E also confirmed and verified that Resident #2 needed to be supervised when out of their room but with our staffing numbers that was not always done. Interview on 4/23/24 at 12:50 p.m., Staff F, RN, recalled working on 3/16/24, and that Staff E came out of Resident #1 room and explained that the resident would like to speak with me. Resident #1 told Staff F that Resident #2 had touched Resident #1 in the private areas and that Resident #1 was scared of Resident #2 and did not know what to do. Staff F, confirmed and verified that Resident #2 is to be supervised when out of the room, but due to staffing issues that is not always done and Resident #2 can ambulate throughout the facility independently. Resident#2 can be by someone and you get up to do something, and then you look, and he is already up and walking away. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 4/23/24 at 2:00 p.m., the DON confirmed and verified that Resident #2 needed to be kept away from female residents and it is the expectation of the staff to make sure that Resident #2 is not in the proximity of any female resident. The DON reported that even before the incident with Resident#1 it was well known that Resident#2 had made sexual comments, and staff were to report it to the nurse, and intervene. The DON reported that when she was a charge nurse on the floor, and Resident#2 made these comments, she then told the upper management about. She reported that upper management responded with the comment that it was just Resident#2 and he had not acted on those comments. The DON also confirmed and verified that staff were aware before the incident that Resident #2 needed to be kept away from other female residents. The DON reported that when she questioned staff for the 100 and 300 hallways of their whereabouts when the incident happened, staff responded to be down the 300 hallway assisting a resident, another staff member was in the dining room, and the nurse was down the 200 hallway passing medications, and that no one knew that Resident#2 came out of his room until Resident#1 put on her call light. The DON reported that she had directed staff to keep Resident#2 away from other residents, but they failed to follow that directive. The DON confirmed and verified that the Resident#1 did not come out of her room for a week after the incident, and wanted the door shut due to being scared of Resident#2. The DON reported that she had visited with Resident#1 frequently since the incident, and the resident is just now allowing the door to her room to be opened. 2. The Annual MDS dated [DATE] documented that Resident#1 had diagnoses which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a BIMS score of 13, for which indicated no impairments with decision making or memory problems. The MDS documented that the resident had adequate hearing, was able to make self-understood, and had the ability to understand others. The MDS documented that the resident and needed partial to moderate assistance with personal hygiene. The Plan of Care with an initiated date 7/28/21, revealed a focus area that resident was at risk for cognitive deficit with impaired thought processes as evidenced by diagnosis of Bi-polar II, depression, anxiety, delusional disorder. Interventions include: *3/16/2024 - frequent checks every shift for 72 hours. Date Initiated: 03/21/2024 *prefers to have her door kept shut at all times. Date Initiated: 03/22/2024 The Progress notes documented on the dates and times as follows: *3/16/2024 at 6:07 p.m., Note Text: This resident CNA reported to nurse that resident is requesting nurse at bedside. This RN went to bedside and asked how can we help. female resident said, That man was in here and he touched me near my private area. She then said, He had trouble getting up by himself on that bed over there so I pushed my call light and the CNA girl came in and helped him up. RN found resident CNA next and asked her if she helped resident male resident up and CNA said, Yes, female resident called and said male resident needed help getting up. She then asked me to get a nurse. RN performed assessments and obtained vital signs. Resident denied pain, questions or concerns. INTERVENTION: 15 MIN CHECK STAT. RN stepped out of resident room and went to males' room next. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*3/25/2024 at 9:20 a.m., Note Text: Resident informed this writer that she would like to move to the other side of the room for multiple reasons. IDT in agreement with moving resident to the other side of the room. This writer notified maintenance; resident will be moved this morning. *3/27/2024 at 9:25 a.m., Late Entry: Note Text: SOCIAL SERVICES NOTE: This writer met with resident for her weekly visit. Resident stated that she is doing pretty good. *4/12/2024 at 2:16 p.m., COMMUNICATION - with Resident Late Entry: Note Text: SOCIAL SERVICES NOTE: This writer met with resident for her last weekly visit. Resident stated that she is doing well. Resident still prefers to have her door shut a majority of the time. Resident is enjoying her new recliner. Resident denied having any questions or concerns at this time. Social services to follow as needed. Interview on 4/23/24 at 9:45 a.m., Resident #1, confirmed and verified that Resident #2 came into the room and proceeded to touch Resident #1 private areas on 3/16/24. Resident #1 was scared and fearful of Resident #2. Resident #1 explained that after the incident with Resident #2, the door to her room was closed at all times. Resident #1 went on to say that Resident #2 would make comments to Resident #1 out in the dining room that Resident #1 felt was offensive and inappropriate comments about Resident #1 breast size. Resident #1 did not tell any staff about those comments, but did not go to the dining room to eat anymore. 3. The Quarterly MDS dated [DATE] documented Resident #4 had the diagnoses which included, hypertension, cerebrovascular accident, non-Alzheimer dementia, hemiplegia and depression. The MDS revealed the resident with short- and long- term memory problems and moderately impaired decision-making abilities. The MDS documented the resident, usually understood others, but missed parts of the intent of the message. The MDS documented the resident required substantial to maximal assistance with personal hygiene, and was dependent on staff for transfers and mobility. The Plan of Care with an initiated date 7/23/2019, revealed a focus area that resident is at risk for an ADL self-care performance deficit related to weakness, lack of coordination, difficulty walking, is at risk for alterations in mood/behavior as evidenced by diagnosis vascular dementia, depression, seizures and history CVA. She enjoys the attention of her male peers and will be observed holding hands and kissing her male peers. Interventions include: * TRANSFER: Assist x 2 with EZ-stand (mechanical lift to assist residents to stand and transfer). Ensure shoes always on when transferring. * Monitor resident when she is interacting with her male peers for sexual behaviors. Family is okay with resident holding hands, but no other inappropriate touching including kissing. * Notify Son, and nurse manager when if observed interacting inappropriately with another resident. This does not include hand holding. * Redirect and separate immediately and other resident when inappropriate sexual behavior is observed. This does not include hand holding. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*On 3/16/24 at approximately 3:45 p.m., RN spoke with Resident #2 in his room and asked if he went into Resident #1 room to which Resident #2 replied. Yes, I went in there to say hi to her. RN asked Resident #2 if he touched Resident #1 and responded No, I would not do that. The Nursing Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/1/2019 directed staff as follows; Policy Statement: All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in person degradation, including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. = Sexual abuse is non-consensual sexual contact of any type with a resident [however, see Iowa Code definition of sexual exploitation above which provides that consensual contact between a resident and staff can be sexual exploitation]. Sexual abuse includes, but is not limited to: *Unwanted intimate touching of any kind especially of breasts or perineal area; *All types of sexual assault or battery, such as rape, sodomy, and coerced nudity; *Forced observation of masturbation and/or pornography; and *Taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. *Sexual contact is generally nonconsensual if the resident either: *Appears to want the contact to occur, but lacks the cognitive ability to consent; or * Does not want the contact to occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Via of Des Moines		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 SW 19th Street Des Moines, IA 50315	

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 25858 Based on observation, clinical record review, and staff interviews, the facility failed to hold a medication as directed per the physicians orders for which caused a resident to reschedule an appointment for 1 or 3 residents reviewed. (Resident #1). The facility reported a census of 78 residents. Finding include: 1. The Annual Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 2/21/24, documented diagnosis for which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 13, for which indicated no impairments with decision making or memory problems. The MDS documented the resident had adequate hearing and is able to make self understood and had the ability to understand others. The MDS documented the resident required partial to moderate assistance with personal hygiene. An After Visit Summary Dated 2/15/24, documented next appointment on 4/4/24 at 9:30 a.m., and you will need to stop the following medications 48 hours prior to your appointment, Tramadol (pain medication), and noted to hold the Tramadol between 4/2/24-4/5/24. The Medication Administration Record (MAR), date 4/1/24-4/30/24 documented Tramadol oral tablet 50 milligrams, give 1 tablet by mouth three times a day for pain and to hold from 4/2/24-4/3/23, The MAR documented the medication held on 4/2/24 a.m. dose and given on: *4/2/24, noon and hour of sleep dose *4/3/24, a.m., noon and hour of sleep dose *4/4/24, a.m., noon and hour of sleep dose The Progress Notes dated 2/18/24 at 6:51 a.m., documented, noted after visit summary from 2/15/24 with noted follow up appointment on 4/4/24 for CT Myelogram. Order to hold Tramadol 48 hours before and 24 hours after. The Progress Notes dated 4/2/24 at 9:45 a.m., Residents Tramadol was to be held for upcoming CT scan. Resident was given medication at 8:50 a.m. Education for nurses and medication aides completed. Ordering physician notified and family physician notified. Sister notified and new appointment made for May 2nd at 8:30 a.m., arrival for imaging. SAME INSTRUCTIONS APPLY FOR IMAGING. NO TRAMADOL 48 HOURS PRIOR. Resident is to take medications with and is scheduled with neuro physician at 2:30 p.m. The Progress Notes dated 4/2/24 at 11:22 a.m., documented, Certified Medication Aide (CMA) came to this nurse and reported that they had by mistake given a medication that was on hold for an appointment on Thursday. Appointment changed. Family aware. Management aware. Interview on 4/25/24 at 12:31 p.m., the facility Director of Nursing confirmed and verified that the resident medication was given and stated that the expectation of the staff are to follow the physicians orders as written.

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NAME OF PROVIDER OR SUPPLIER Via of Des Moines		STREET ADDRESS, CITY, STATE, ZIP CODE 4911 SW 19th Street Des Moines, IA 50315	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25858 Based on clinical record review and staff and resident interview, the facility failed to provide two baths a week as directed for 2 out of 4 residents reviewed (#1 and #4). The facility reported a census of 78 residents. Findings include: 1. The Annual Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 2/21/24, documented diagnosis for which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 13, for which indicated no impairments with decision making or memory problems, had adequate hearing, and was able to make self understood, and had the ability to understand others. The MDS documented that the resident required partial to moderate assistance with personal hygiene and showers/bathing activity. Review of electronic documentation of task completion for Resident #1 revealed the facility failed to provide baths between April 8, 2024 and April 15th, 2024. In an interview on 4/23/23 at 9:50 a.m., Resident #1 stated that they did not receive their bath/showers between the dates above due to the shower aide was on vacation. Resident#1 reported she would like to have her bath/shower two times per week, and bath/showers are not being completed due to the facility not having enough staff. 2. The Quarterly MDS assessment dated [DATE], revealed Resident #4 had diagnosis that included hypertension, Cerebrovascular Accident, Non-Alzheimer's Dementia, hemiplegia and depression. The MDS documented the resident with short and long term memory impairments, and moderate impaired cognition. The MDS documented that the resident required substantial to maximal assistance with showers/bathing. Review of the electronic documentation of task completion for Resident #4 revealed the facility failed to provide baths between April 3,2024 and April 13th, 2024 On 4/22/24 at 3:15 p.m., Staff A, Certified Nursing Assistant (CNA) reported that the showers and baths are not getting complete two times a week due to not enough staff. On 4/25/24 at 12:31 p.m., the facility Director of Nursing stated that the shower/baths were not completed as required for Resident #1 and Resident #4, and that the expectation of the staff are to complete the baths twice a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165273	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Via of Des Moines	4911 SW 19th Street Des Moines, IA 50315

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 25858 Based on clinical record review, and staff interview the facility failed to have 1 of 3 residents seen at least once every 60 days by the physician. (Resident #1) The facility census was 78 residents. Finding include: 1. The Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 2/21/24, documented diagnosis for which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 13, for which indicated no impairments with decision making or memory problems, and had adequate hearing, and was able to make self understood The MDS documented the resident had the ability to understand others, and required partial to moderate assistance with personal hygiene. The Clinical Record for Resident #1 documented that the Physician visited the patient on these dates: *10/26/23 (Behavioral Health visit) *3/11/24 (Physician Assistant visit) The clinical record lacked documentation of the primary care physician seeing the resident between 10/26/23 and 3/11/24. Interview on 4/25/24 at 1:22 p.m., Regional Clinical Nurse Specialist, confirmed and verified that the expectation is that the residents are seen every other month by the physician. and that the clinical record lacked documentation of the resident being seen by the physician between October 2023 and February 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 25858 Based on resident and staff interviews, the facility staff failed to answer resident call lights in a timely manner (no longer than 15 minutes) for 1 of 3 residents reviewed . (Resident #1). The facility identified a census of 78 residents. Findings include: 1. The Annual Minimum Data Set (MDS) for Resident #1, with an assessment reference dated 2/21/24, documented diagnosis for which included hypertension, anxiety, depression and psychotic disorder. The MDS revealed the resident with a Brief Interview for Mental Status (BIMS) score of 13, for which indicated no impairments with decision making or memory problems. The MDS documented the resident had adequate hearing and was able to make self understood, and had the ability to understand others The MDS indicated the resident required partial to moderate assistance with personal hygiene and showers/bathing activity On 4/23/24 at 9:45 a.m., Resident #1 stated that it could take the staff over a half hour to answer the call light. During an interview on 4/22/24 at 3:15 p.m., Staff A, Certified Nursing Assistant (CNA) confirmed and verified that it could take over 15 minutes to answer a call light, and that the expectation is to answer the call light with in 15 minutes. During an interview on 4/22/24 at 4:10 p.m., Staff B, CNA, confirmed and verified that it takes over 15 minutes to answer the call lights. During an interview on 4/22/22 at 5:15 p.m. Staff C, CNA confirmed and verified that it does take over 15 minutes to answer the call lights. During an interview on 4/24/24 at 4:30 p.m., the Administrator confirmed and verified that the expectation of the staff are to answer call lights with in 15 minutes per the state and federal rules and regulations.