

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 09/18/2025
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interview, the facility failed to maintain complete and accurate documentation of an ENT (Ear, Nose and Throat) referral for 1 of 3 residents' records reviewed (Resident #1). The facility reported a census of 82 residents. Findings Include: Review of Resident #1 Minimum Data Set (MDS) dated [DATE], documented Brief Interview for Mental Status score (BIMS) of 4, indicating severe cognitive impairment. Documented diagnoses included Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, Bipolar Disorder, Obsessive Compulsive Disorder and behaviors including hallucinations and delusions. Review of an Emergency Department After Visit Summary dated 8/27/25 revealed Resident #1 was seen for a fall that resulted in a nasal fracture. Discharge instructions stated Resident #1 to be re-evaluated in the next week by ENT for nasal fracture. Review of Resident #1's Electronic Health Records failed to provide documentation of communication or referral to ENT. In an interview on 9/17/25 at 12:10 PM, Director of Nursing (DON), stated she was not able to recall the exact date, but thought the first week of September was the first call she had made to the ENT clinic about Resident #1's referral for nasal fracture. The DON informed ENT staff, Resident #1 was seen in the ER and a nasal fracture was noted and Resident #1 was to have a follow up with ENT. DON informed ENT staff that it is difficult for Resident #1 to be seen outside of the facility due to diagnoses and behaviors, requested the Doctor review Resident #1's x-rays. DON stated she called the ENT clinic again on 9/10/25 due to not hearing back and was notified Resident #1 only needed to be seen if there were issues related to the fracture. If repair is wanted or needed, Resident #1 would need to consult with plastic surgery. DON acknowledged at time of interview no documentation for ENT referral had been entered into Resident #1's EHR. Review of Resident #1's EHR, a Late Entry Progress Note was created by the DON on 9/17/25 at 12:13PM, with an effective date of 9/10/25 at 11:30 AM stated, received communication back from the ENT office. No follow up needed at this time, follow up if breathing issues develop. Resident's daughters were notified via email. In agreement with plan at this time. In an interview of 9/18/25 at 4:10 PM with the Facility Administrator and DON, DON acknowledged the failure to document the communication the ENT Clinic and Resident #1's family in Resident #1's chart and verbalized need for improvement with documenting these communications.</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
---	-------	-----------