STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165479	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Calvin Community	4210 Hickman Road Des Moines, IA 50310

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observation and staff interviews, the facility failed to maintain dignity for 1 of 17 residents reviewed (Resident#2). The facility reported a census of 52. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident#2 with a Brief Interview for Mental Status score of 1, which indicated severe cognitive impairment. Diagnoses on the MDS included anxiety, paranoid personality disorder, Alzheimer's Disease, and Parkinson's Disease. The MDS revealed Resident#2 utilized a manual wheelchair independently with staff supervision, but moderate to maximum staff assistance for upper/lower body dressing and bathing. During an observation on 1/23/25 at 8:25 AM, Resident#2 sat in a shower chair, in the hallway, outside of the shower room door. Resident#2 wore a short sleeved top and a blanket over his lower body. The blanket was pulled up to the upper thigh area leaving Resident#2's groin exposed for an unknown amount of time. At 8:33 AM, an unidentified employee checked on Resident#2 and pulled the blanket up to the waist area. In an interview on 1/23/25 at 10:15 AM, Staff B, Certified Nursing Assistant, explained staff will undress and transfer Resident#2 into a shower chair to prep for a shower. This included providing a blanket for the lower body not only for warmth but also for dignity as Resident#2 is not wearing pants or undergarments. Staff B reported Resident#2 preferred to wait outside the shower room until it's time. If waiting in another location, Resident#2 may self-propel out of the area, thus delaying the shower. In an interview on 1/23/25 at 10:30 AM, the Director of Nursing (DON) acknowledged Resident#2 typically waited outside the shower room on. The DON voiced an expectation that Resident#2 should be covered appropriately while in the hallway waiting for his shower.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on clinical record review and staff interview, the facility failed to accurately code the federally mandated Minimum Data Set (MDS) assessment for 1 of 17 residents reviewed in the sample (Resident#24). The facility reported a census of 52. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident#24 indicated the use of a diuretic and an anti-platelet. The MDS did not document the use of an anticoagulant. The Care Plan reviewed/revised on 1/21/25 for Resident#24 included a problem statement documented Resident#24 was prescribed anticoagulant therapy. Interventions included administering anticoagulants as ordered by the physician and to monitor/report labs as ordered by the physician. The Care Plan also included the diagnosis of chronic atrial-fibrillation, which is commonly treated with the use of anticoagulants. The Medication Administration Record for the months of November 2024 and December 2024 revealed Warfarin, a type of anticoagulant, was prescribed and administered to Resident#24 for the entirety of both months. In an interview on 1/23/25 at 2:25 PM, Staff A, Licensed Practical Nurse, acknowledged the MDS did not reflect the use of an anticoagulant even though it was actively prescribed.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on staff interviews, family interviews, observation and record review, the facility failed to update individual Care Plans for 3 of 19 reviewed (Residents #20, #22, and #38). The facility failed to revise Care Plans for R#20 for Hospice services and failed to update R#22, R#28 for wanderguard (device to alert/inhibit elopements). The facility reported a census of 52 residents. Findings include: 1. The Signature Change Minimum Data Set (MDS) dated [DATE] documented Resident #20 diagnoses included cancer and malignant neoplasm of prostate, secondary malignant neoplasm of bone. The Brief Interview for Mental Status (BIMS) was scored 12 out of 15 which indicated moderate cognitive impairment. The Care Plan last reviewed/revised 01/22/25 documented resident diagnosis cancer with metastasis. The Care Plan did not document that Resident #20 received hospice services. During an interview on 1/21/25 at 3:30 PM Resident #20 reported to received hospice services which included nursing staff and massage therapist visits. During an Interview on 1/23/25 at 2:25 PM with MDS coordinator, Nurse Staff A, reported the Significant Change MDS was completed on 11/22/24 due to resident choice for hospice. Staff A relayed the Care Plan should have been updated to include hospice services. The facility policy titled, Resident Assessments, revised 3/2022 documented the resident assessments are used to develop, review and revise the residents comprehensive care plan. 50500 2. The Quarterly MDS dated [DATE] documented Resident#22 with a BIMS score of 3 which indicted severe cognitive impairment. Diagnoses on the MDS included unspecified dementia. The MDS documented no wandering behaviors exhibited with no wander/elopement alarm in use. The Care Plan reviewed/revised on 1/7/25 included a problem statement indicating wandering behaviors with the placement of an elopement alarm. The Care Plan documented the wanderguard intervention start date as 10/29/24. During electronic record review, the Progress Note dated 11/28/24 documented Resident#22 exhibited active wandering behaviors with the placement of a wanderguard at this time. During an interview on 1/23/25 at 2:15 PM, Staff C, Unit Manager, explained Resident#22 had not shown exit-seeking behaviors prior to the incident on 11/28/24. Resident#22 had not worn a wanderguard alarm prior to the incident on 11/28/24. Staff C was not aware the Care Plan had the implementation date for the wanderguard as 10/29/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/25 at 2:25 PM, Staff A reported Care Plans updated as needed based on current information obtained during daily nurse meetings, such as placing or removing wanderguard alarms. Staff A reviewed Resident#22's Care Plan and acknowledged the wanderguard implementation date as 10/29/24. Staff A could not explain the discrepancy with the date on the Care Plan with the actual wanderguard placement date in November. The facility policy titled, Resident Assessments, revised 3/2022 documented resident assessments are used to develop, review, and revise resident comprehensive care plans. 3. The Quarterly MDS dated [DATE] documented Resident#38 with a BIMS score of 9, which indicated moderate cognitive impairment. The Care Plan reviewed/revised on 1/21/25 included a problem statement which indicated wandering behaviors with the placement of an elopement alarm. The Care Plan documented the wanderguard intervention start date as 10/10/24. During continuous observations from 1/22/25 thru 1/23/25, Resident#38 did not have wanderguard on her person. The whiteboard located on the third-floor nurses station listed out resident with active Wanderguards. Resident#38 was not on the list. The Progress Note dated 11/5/24 documented the wanderguard was initiated upon Resident#38's admission to the unit in October. Upon completion of the Elopement Evaluation, Resident#38 had shown no signs of elopement and the wanderguard was removed. The Progress Note dated 11/6/24 further documented the lack of elopement behaviors and removal of the wanderguard. During an interview on 1/23/25 at 2:25 PM, Staff A reported Care Plans updated as needed based on current information obtained during daily nurse meetings, such as placing or removing wanderguard alarms. Staff A acknowledged the presence of the wanderguard interventions on the current plan and noted that Resident#38 does not wear a wanderguard. Staff A relayed the Care Plan should have been updated in November when the wanderguard was removed. The facility policy titled, Resident Assessments, revised 3/2022 documented resident assessments are used to develop, review, and revise resident comprehensive care plans.