

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165514	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Ramsey Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1611 27th Street 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)		
<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>46873</p> <p>Based on clinical record review, facility document review, and staff interview, the facility failed to treat a resident with respect and dignity when providing cares one of three residents reviewed for dignity (Resident # 9). The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>A Quarterly Minimum Data Set (MDS) Assessment documented Resident#9 had the diagnoses including non- traumatic brain dysfunction, dementia, high blood pressure, and stroke. The Brief Interview for Mental Status (BIMS) documented the resident scored a 3 out of 15, which indicated severe cognitive loss for daily decision making skills. The MDS revealed the resident required maximum assist of two staff members for transfers from surface to surface, and total dependence for cares including toileting, and showers. The MDS indicated that the resident used a manual wheelchair for moving about the facility with total dependence of staff.</p> <p>A facility Self Report dated 8/5/24 revealed Staff A, Certified Nurse Aide (CNA) reported an allegation that Staff B, Certified Medication Aide (CMA), while assisting a resident who became verbally aggressive and combative with cares, attempted to place a glove in the resident's mouth. The self report additionally documented Resident #9 stated he wished he wasn't in the facility and Staff B responded to the resident in an unkind and demeaning manner.</p> <p>On 8/6/24 at 12:53 pm, Staff A, CNA stated she was in the room of Resident #7, which he shares with his spouse, on the evening of 8/4/24 with Staff B, CMA. She stated both residents have behaviors. She explained she and Staff B were getting both residents ready to go to dinner and Resident #7 was speaking about not wanting to live in the nursing facility. She reported Staff B replied to Resident #7 that his children don't care about him and that is why he lived there. She stated Staff B needed to change the resident's soiled clothing and after she was through, Staff B removed her soiled gloves and balled the gloves up into her hand and put them towards the mouth of Resident #7 while telling him to Shut up. She stated Resident #7 closed his lips. She stated she could not say if Staff B was trying to put the gloves in the resident's mouth but they were near his mouth. Staff A stated the rest of the shift was busy and the incident slipped her mind and she did not report this until the following day. She stated she reported it to Staff C, Licensed Practical Nurse (LPN) the morning of 8/5/24.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 165514
		If continuation sheet Page 1 of 8

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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>On 8/6/24 at 3:52 pm, Staff C, LPN stated Staff A reported her concerns regarding Staff B and Resident #7 to her, stating Staff B was being aggressive and mean to the resident. She stated she immediately called the manager on duty for the facility and reported this to her.</p> <p>The facility provided an educational memo to all staff on 8/6/24. The memo included direction to staff as follows;</p> <p>a. Emotional Abuse defined as verbal or non-verbal behavior that causes psychological harm.</p> <p>b. Reports should be made even if you are unsure about the validity of the suspicion, it is better to report and let authorities investigate.</p> <p>All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.</p> <p>The facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, revision date July 2019, documented the following:</p> <p>Key Definitions:</p> <p>Personal degradation of a dependent adult. Personal degradation means a willful act or statement by a caretaker intended to shame, degrade, humiliate, or otherwise harm the personal dignity of a dependent adult, or where the caretaker knew or reasonably should have known the act or statement would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person. Personal degradation includes the taking, transmission, or display of an electronic image of a dependent adult by a caretaker, where the caretaker ' s actions constitute a willful act or statement intended to shame, degrade, humiliate, or otherwise harm the personal dignity of the dependent adult, or where the caretaker knew or reasonably should have known the act would cause shame, degradation, humiliation, or harm to the personal dignity of a reasonable person</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>46873</p> <p>Based on clinical record review, pharmacy &amp; hospital record review, and staff interview, the facility failed to notify the physician when medication was unavailable and was not administered for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 61.</p> <p>Findings include:</p> <p>The Medical Diagnosis section of Resident #3 Electronic Health Record (EHR) reflected a diagnosis of Permanent Atrial Fibrillation (a condition where an irregular heartbeat can't be reset and no further treatments are attempted to restore a normal sinus rhythm).</p> <p>The Admission Orders to the facility from the hospital, dated 3/20/24 reflected the resident had orders for:</p> <p>-Warfarin (a blood thinning medicine, used to treat and prevent blood clots, which can be caused by Atrial Fibrillation), 2.5 mg tablet, take 2 tablets each Monday.</p> <p>-Warfarin, 2.5 mg tablet, take 1 tablet each Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday.</p> <p>The Coumadin Flow Sheet for Resident#3 documented as follows;</p> <p>The INR (international normalized ratio, a blood test to time how long it takes blood to clot) Result Report dated 3/21/24 documented an INR of 1.8. The physician responded to change the Warfarin orders to:</p> <p>- Warfarin, 2.5 mg tablet, take 2 tablets each Monday and Friday.</p> <p>- Warfarin, 2.5 mg tablet, take 1 tablet each Tuesday, Wednesday, Thursday, Saturday and Sunday.</p> <p>The Medication Administration Record (MAR) of Resident #3, for March of 2024 reflected that the resident did not begin receiving Warfarin until the 21st of March rather than the 20th as ordered. Additionally, on March 23rd and 24th, the Warfarin was documented as not given and linked to a progress note.</p> <p>The Progress Notes failed to reveal any documentation of the physician being notified on any of the dates of the resident not receiving her ordered Coumadin. The Progress Notes for March 23 and 24th reflected the medication to be on order from the pharmacy.</p> <p>On 8/7/24 at 1:36 pm, the Director of Nursing (DON) stated Warfarin is not a medication that is stocked in the Emergency Kit of medications at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at 3:56 pm, the DON stated his expectation is for the physician to be notified when a medication is not administered as ordered. He stated the facility has no policy regarding physician notification.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>46873</p> <p>Based on clinical record review, facility document review, and staff interview, the facility failed to report suspected dependent adult abuse within the required two hour time frame for one resident (Resident # 9). The facility reported a census of 61 residents.</p> <p>Findings include:</p> <p>A Quarterly Minimum Data Set (MDS) Assessment documented Resident#9 had the diagnoses including non- traumatic brain dysfunction, dementia, high blood pressure, and stroke. The Brief Interview for Mental Status (BIMS) documented the resident scored a 3 out of 15, which indicated severe cognitive loss for daily decision making skills. The MDS revealed the resident required maximum assist of two staff members for transfers from surface to surface, and total dependence for cares including toileting, and showers. The MDS indicated that the resident used a manual wheelchair for moving about the facility with total dependence of staff.</p> <p>A facility Self Report dated 8/5/24 revealed Staff A, Certified Nurse Aide (CNA) reported an allegation that Staff B, Certified Medication Aide (CMA), while assisting a resident who became verbally aggressive and combative with cares, attempted to place a glove in the resident's mouth. The self report additionally documented Resident #9 stated he wished he wasn't in the facility and Staff B responded to the resident in an unkind and demeaning manner.</p> <p>The Self Report noted the approximate date and time of the occurrence was 8/3/24 at 5:00 pm.</p> <p>The Amendment Details of the report documented the report was initially filed on Sunday, 8/4/24 but was filed in error regarding the Assisted Living portion of the facility. That was closed out and refiled on Monday 8/5/24 correctly for the nursing facility.</p> <p>On 8/6/24 at 11:25 am the Administrator stated the incident happened on Saturday 8/3/24. The report was initially filed with the State Agency on Sunday 8/4/24 and amended on Monday 8/5/24. She stated Staff B, CMA was suspended immediately upon notification of the incident. She stated Staff B had been employed at the facility since mid June, 2024 and had no disciplinary action prior to this incident. The Administrator stated Staff A, CNA had been employed since 7/16/24 but had been a CNA since November of 2023. She stated education was given to Staff A of the need to report abuse concerns immediately.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/6/24 at 12:53 pm, Staff A, CNA stated she was in the room of Resident #7, which he shares with his spouse, on the evening of 8/4/24 with Staff B, CMA. She stated both residents have behaviors. She explained she and Staff B were getting both residents ready to go to dinner and Resident #7 was speaking about not wanting to live in the nursing facility. She reported Staff B replied to Resident #7 that his children don't care about him and that is why he lived there. She stated Staff B needed to change the resident's soiled clothing and after she was through, Staff B removed her soiled gloves and balled the gloves up into her hand and put them towards the mouth of Resident #7 while telling him to Shut up. She stated Resident #7 closed his lips. She stated she could not say if Staff B was trying to put the gloves in the resident's mouth but they were near his mouth. Staff A stated the rest of the shift was busy and the incident slipped her mind and she did not report this until the following day. She stated she reported it to Staff C, Licensed Practical Nurse (LPN) the morning of 8/5/24.</p> <p>On 8/6/24 at 3:52 pm, Staff C, LPN stated Staff A reported her concerns regarding Staff B and Resident #7 to her, stating Staff B was being aggressive and mean to the resident. She stated she immediately called the manager on duty for the facility and reported this to her.</p> <p>The facility provided an educational memo to all staff on 8/6/24 with the definition of abuse and neglect and the need for immediate reporting of any such instances. The memo directed staff as follows;</p> <p>All allegations of Resident abuse, neglect, exploitation, mistreatment, injuries of unknown origin and misappropriation should be reported immediately to the charge nurse. The charge nurse is responsible for immediately reporting the allegations of abuse to the Administrator, or designated representative.</p> <p>The facility policy Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, revision date July 2019, documented the following:</p> <p>Reporting -</p> <p>All allegations of Resident abuse shall be reported to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation is made.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46873</p> <p>Based on clinical record review, pharmacy &amp; hospital record review, staff interview, and facility policy review, the facility failed to transcribe and administer medication as ordered by the physician for 1 of 3 residents reviewed (Resident #3). The facility reported a census of 61.</p> <p>Findings include:</p> <p>The Medical Diagnosis section of Resident #3 Electronic Health Record (EHR) reflected a diagnosis of Permanent Atrial Fibrillation (a condition where an irregular heartbeat can't be reset and no further treatments are attempted to restore a normal sinus rhythm).</p> <p>The Pharmacy Warfarin Consult, dated 3/19/24 documented the INR (international normalized ratio, a blood test to time how long it takes blood to clot) Goal to be 2-3.</p> <p>The Admission Orders to the facility from the hospital, dated 3/20/24 reflected the resident had orders for:</p> <ul style="list-style-type: none"> <li>-Warfarin (a blood thinning medicine, used to treat and prevent blood clots, which can be caused by Atrial Fibrillation), 2.5 mg tablet, take 2 tablets each Monday.</li> <li>-Warfarin, 2.5 mg tablet, take 1 tablet each Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday.</li> </ul> <p>The INR Result Report dated 3/21/24 documented an INR of 1.8. The physician responded to change the Warfarin orders to:</p> <ul style="list-style-type: none"> <li>- Warfarin, 2.5 mg tablet, take 2 tablets each Monday and Friday.</li> <li>- Warfarin, 2.5 mg tablet, take 1 tablet each Tuesday, Wednesday, Thursday, Saturday and Sunday.</li> </ul> <p>The Medication Administration Record (MAR) of Resident #3, for March of 2024 reflected that the orders from the hospital were originally transcribed correctly, but never administered. The order was changed on 3/21/24 to reflect:</p> <ul style="list-style-type: none"> <li>- Warfarin, 2.5 mg tablet, take 2 tablets each Monday and Friday.</li> <li>- Warfarin, 1 mg tablet, take 1 tablet each Tuesday, Wednesday, Thursday, Saturday and Sunday. This dose was a decrease of 1.5 mg each day from what the physician ordered.</li> </ul> <p>The Coumadin Flow Sheet reflected an INR test result of 1.6 on the following test on 3/28/24, a decrease from 3/21/24 testing.</p> <p>On 8/7/24 at 3:56 pm, the Director of Nursing (DON) stated the order was transcribed incorrectly into the EHR and there was no order for a 1 mg dose of Warfarin.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication and Treatment Orders Policy, dated 2001, documented a Policy Statement of Orders for medications and treatments will be consistent with principles of safe and effective order writing.</p>		