STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165514	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramsey Village	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review, the facility failed to appropriately provide assessments and interventions for necessary care and services for 1 of 4 residents reviewed (Resident #1). Clinical record review revealed the Assistant Director of Nursing notified the nursing staff of a wound on Resident #1's left foot after admission. The nurse failed to conduct an assessment and failed to notify the provider to acquire an intervention for 48 days after admission. The facility reported a census of 61 residents. Findings include: A Minimum Data Set (MDS) dated [DATE], documented that Resident #1 admitted to on 9/23/25 from Home/Community (e.g., assisted living). This MDS documented that Resident #1's diagnoses included diabetes, Alzheimer's disease, functional quadriplegia (the complete inability to move due to severe disability or frailty caused by another medical condition without damage to the spinal cord), bipolar disorder, and polyneuropathy (nerve damage that affects the hands and feet). A Brief Interview for Mental Status (BIMS) for Resident #1 revealed a score of 12 out of 15, which indicated moderately impaired cognitive functioning. Resident #1 required substantial/maximal assistance (Helper does more than half of the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort.) for shower/bathing, upper body dressing and lower body dressing. Resident #1 was dependent (Helper does all of the effort, resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) on putting on/taking off footwear. Resident #1 required substantial/maximal assistance for rolling left to right in bed, sitting to lying in bed, Lying to sitting in bed, sitting to stand, chair/bed transfer and toilet transfer. This resident was dependent on staff for wheelchair assistance. This MDS documented that Resident #1 had no diabetic foot ulcers identified nor did she have an infection of the foot and was not on a turning repositioning program. It documented that Resident #1 had no other open lesions on the foot. Care Plan dated 9/23/24 directed staff as follows: Check all of the body for breaks in skin and treat promptly as ordered by the doctor. Don't use over the counter remedies for corns and calluses, refer to a podiatrist to treat. Educate the resident and family that diabetes is a chronic disease and that compliance is essential to prevent complications of the disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review complications and prevention with the resident and family. Elicit verbal understanding from the resident and family. The nails should always be cut straight across, never cut corners and file rough edges with emery board. The Medication and Treatment Administration Record (MAR/TAR) for September and October 2024 failed to identify an intervention for Resident #1's wound to the left foot. The progress notes for Resident #1 revealed: 1. On 9/23/24 at 12:56 admitted resident #1, an assessment completed by Staff D, MDS Coordinator, no skin issues were identified and no swelling in the feet. 2. A late entry on 9/23/24 at 12:57 PM, a wound on the left foot, resident #1 placed on enhanced barrier precautions and staff was notified. Documented by Staff E Assistant Director of Nursing (ADON). 3. On 9/27/24 Staff F, Medical Director (MD) conducted a in house visit for Resident #1 and ordered a Chest x-ray (CXR) due to resident wheezing. 4. On 10/26/24 at 2:11 PM Resident #1 fell to the floor. 5. On 10/29/24 Resident #1 was seen by Staff F and aware of the fall. 6. On 11/10/24 a Certified Nursing Assistant (CNA) reported to a nurse that there was blood on EZ stand platform (stand up lift) after a transfer of Resident #1 and blood on a sock. The CNA noted a wound bottom of Resident #1's left (lt)foot. The wound bed was black and foul smelling and measured 3 centimeters (cm) x 3 cm with a blood blister above this that was intact that measured 1.5 cm x 1 cm. The foot was cleansed, a protective foam boot was applied. The top of the lt foot was red, warm, and Resident #1 had a temperature of 97.1 and denied pain. The nurse notified Staff F, Physician and received a new order for (antibiotics) Cephalexin 500 milligrams (mg) given three times a day (TID) for 7 days. The daughter was notified. 7. On 11/12/24 Staff F examined the diabetic wound, continued betadine treatment two times a day (BID) and ordered a consult by the wound nurse. An X-ray was ordered to rule out osteomyelitis (Infection of the bone) and Levofloxacin 250 mg for 7 days, in addition to the Cephalexin antibiotic. 8. On 11/11/24 the wound nurse documentation of a diabetic wound that measured 3.5 x 3 cm, an in house acquired wound, unknown how long the wound was present, the odor had increased. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/24/25 at 9:32 AM, Staff E, ADON stated she had worked in this facility for 1.5 years, and had taken over the wound nurse position recently. Staff E explained in the past, if a wound was identified, the nurse would notify the physician, receive an order for treatment, then notify the family. Staff E stated when Resident #1 was admitted in September 2024, Staff D, MDS Coordinator would have completed the admit assessments. Staff E stated she had identified the wound to Resident #1's left foot and notified the staff nurse. Staff E stated the expectation was that the nurse would have notified the physician, received an order for treatment and notified the family. Staff E stated it was the nurses responsibility at that time. Staff E stated she did not see the wound again until it was identified by a CNA in November 2024. Staff E stated that was when she had taken over the admit assessments, for early identification of wounds. Staff E stated the facility had a large number of agency nurses last fall, communication was difficult and she didn't want to see anyone get hurt due to that negligence. Staff E stated she was the current wound specialist and if staff finds a wound, she would assess it, all of the body parts, then scan the results to Staff G, Doctor of Nursing Practice (DNP) who will provide an assessment, order a treatment and monitor the wound until it is healed. Staff E stated nurses conduct weekly wound checks. Staff E stated Resident #1 was placed on skin assessments on Wednesday's during showers and was compliant with care. During an interview on 4/24/25 at 10:09 AM, Staff G, DNP stated she became the wound nurse in November 2024. Staff G stated she had examined Resident #1 on 11/21/24. Staff G explained that when Staff E, ADON becomes aware of a wound, she would scan a note to Staff G's office and will put the resident on the wound sheet and if the resident had a consent on file then Staff G would come to the facility and examine the resident. Staff G stated Staff E had been her contact person since 11/2024. Staff G stated her assessment of Resident #1's left foot wound revealed 95% slough (a yellow, white devitalized tissue that accumulates in a wound bed) with moderate serosanguinous drainage and did not note an odor. Staff G stated she had ordered betadine moistened gauze, secured with tape two times a day (BID) and apply foam boots (Prevolone). Staff G explained the picture of Resident #1's left foot that she had initially reviewed could not have developed overnight. Staff G was not aware of when Resident #1 acquired the wound or she would have documented, staff did not advise her when it was first identified. Staff G stated Resident #1 was transferred with a mechanical lift at that time. Staff G stated she was not aware if the facility staff conducted daily diabetic foot checks. Staff G stated Resident #1's wound was healed, fully resolved, by 2/13/25. Staff G stated she feels the facility staff are making good progress. A policy titled Procedure for Identifying a New Skin Area dated 11/9/20 revealed: 1. Assess the area and notify the physician by fax, phone or in person if the provider is in the facility. 2. Implement treatment if ordered. 3. Notify family, power of attorney (POA) or responsible party. 4. Complete an incident report in Point Click Care (PCC) computer. 5. Notify the DON if the skin area requires treatment at a higher level of care (hospital or ER). A policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 2001 revealed: (continued on next page)

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