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	10/23/2025

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 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** Based on observation, record review, staff interview, and policy review, the facility failed to provide repositioning and incontinence care for 1 of 3 residents (#6). The facility reported a census of 69 residents.Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #6 revealed a Brief Interview for Mental Status (BIMS) score of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of renal (kidney) disease, Alzheimer's Disease, non-Alzheimer's dementia, disorder of kidney and ureter, and need for assistance with personal care. The MDS documented that the resident required supervision with eating, maximal assistance with oral and personal hygiene, bathing, upper body dressing, and rolling left and right in bed, and was dependent with all other Activities of Daily Living (ADLs) and mobility. The MDS also indicated he was always incontinent of bowel and bladder.The Care Plan dated 12/15/22 and revised 8/28/24 documented the following; the resident had bladder incontinence and used disposable briefs. 2-4 times per shift and prn and directed staff to clean peri-area with each incontinence episode. It also indicated the resident had bowel incontinence and directed staff to check the resident per schedule and assist with toileting as needed, provide a bedpan/bedside commode, and provide pericare after each incontinent episode. A revision dated 10/01/25 indicated the resident was dependent with toilet use and required 2-person assistance and a mechanical lift for all transfers. Check resident per schedule and assist with toileting as needed.During a continuous observation on 10/23/25 that began at 8:46 AM, Staff I, Certified Medication Aide (CMA) brought Resident #6 in his wheelchair to the TV lobby area after breakfast. The resident stayed in the location where he was placed and in the same position in his wheelchair until 11:00 AM at which time Staff J, Certified Nursing Aide (CNA) transported him back to the dining room to eat lunch. Between 11:12 AM and 11:27 AM, Staffs A, B, H, J, and K, CNAs, and Staffs L, M, and N, Licensed Practical Nurse (LPN) stated they had not assisted Resident #6 for repositioning or toileting after breakfast.The Electronic Health Record (EHR) indicated the resident received bladder elimination and personal hygiene assistance on 10/23/25 at 8:52 AM and toileting transfer and toileting hygiene at 8:53 AM.At 11:30 AM, Staff O, CNA, stated she provided Resident #6's incontinence care and repositioning at 9:40 AM. She also stated Staff J and Staff K assisted her. She further stated she documents resident hygiene care after she completes it and the times documented were from before breakfast.At 2:46 PM, the Director of Nursing (DON) stated staff should've taken the resident to his room after his breakfast and performed incontinence care and repositioning.A policy titled Repositioning revised May 2013 indicated residents who are in a chair should be on an every one hour (q1 hour) repositioning schedule.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review, staff interview, and policy review, the facility failed to ensure mechanical lifts were used correctly during transfers for 3 of 5 residents (#1, #4, #5). The facility failed to lock wheelchairs during resident transfers for 2 of 5 residents (#2, #4), and failed to ensure foot pedals were attached while transporting a resident in a wheelchair for 1 of 5 residents (#3). The facility reported a census of 69 residents.Findings include:. 1. The Minimum Data Set (MDS) for Resident #1 dated 9/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of end-stage renal disease, Alzheimer's Disease, non-Alzheimer's dementia, lack of coordination, and abnormalities of gait and mobility. It indicated she was independent with eating, required setup assistance with oral hygiene, maximal assistance with toileting hygiene, bathing, upper body dressing, and all mobility except lying to sitting on the side of the bed, and was dependent with lower body dressing, footwear, personal hygiene, and lying to sitting on the side of the bed. It also indicated she was frequently incontinent of bowel and bladder, and she used a walker and wheelchair for mobility.The Care Plan dated 4/02/24 indicated the resident had bowel and bladder incontinence and directed staff to check the resident per schedule, assist with toileting as needed, and to provide peri care after each incontinent episode. A revision dated 9/17/24 indicated the resident required 1-person assistance with a walker for transfers.On 10/22/25 at 12:13 PM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA took Resident #1 to the shower room to check and change her. The staff locked the sit-to-stand mechanical lift to raise the resident from the wheelchair, however did not lock the mechanical lift when the resident was raised from the toilet. On 1/22/25 at 12:44 PM, Staff B stated the mechanical lift's wheels are unlocked to lift a resident and she only locks the wheelchair if the resident is transferring to or from it. She added sometimes the mechanical lift's wheels are locked and sometimes they aren't.At 1:13 PM, Staff A stated the sit-to-stand mechanical lift's wheels should be locked when transferring a resident. She stated the wheels should not have been unlocked and suggested Staff B might have forgotten to lock them.The manufacturer's document titled Operation Manual revised 10/06/16 directed staff to unlock the sit-to-stand wheels after the resident was raised.2. The MDS for Resident #2 dated 8/18/25 revealed a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of coronary artery disease, diabetes mellitus, Alzheimer's Disease, non-Alzheimer's dementia, macular degeneration, and periprosthetic fracture (fracture around a prosthetic knee). It indicated she required supervision with eating, moderate assistance with oral hygiene, maximal assistance with upper body dressing, personal hygiene, and rolling left-to-right in bed, and was dependent with all other Activities of Daily Living (ADLs) and mobility. It also indicated she was always incontinent of bowel and bladder and used a wheelchair for mobility.The Care Plan dated 8/05/25 indicated the resident had bowel and bladder incontinence and directed staff to check the resident per schedule, assist with toileting as needed, and to provide peri care after each incontinent episode A revision dated 9/05/25 directed staff to complete all transfers with transfer disc and assist of 2 and gait belt.On 10/22/25 at 12:44 PM, Staff B, CNA and Staff C, CNA took Resident #2 into the shower room to check and change her. Staff C placed a gait belt around the resident and Staff B and Staff C assisted Resident #2 to a standing position from her wheelchair. The rear wheelchair tires were noted to be unlocked during the transfer and Staff C pushed it away to pivot Resident #2 to sit on the toilet.At 1:00 PM, Staff C stated sit-to-stand wheels and wheelchairs should be locked during resident transfers. She stated she thought she locked the wheelchair but added there is no reason to leave a wheelchair unlocked during a resident transfer. She also added it made moving the wheelchair easier as Resident #2 had a hard time holding the toilet assist bar.At 1:08 PM, the Unit Manager (UM) stated the resident's left wheelchair lock needed to be tightened because it was loose and allowed the wheel to turn when in the locked position.3. The MDS for Resident #3 dated 7/15/25 revealed a BIMS score of 04 out of 15 which indicated severely impaired cognition. It included diagnoses of non-Alzheimer's dementia, cerebrovascular accident (stroke), renal (kidney) disease, abnormalities of gait and mobility, and cognitive communication deficit. It indicated she was independent with eating and required maximal assistance with all other ADLs. She was independent with rolling left-to-right, required supervision with sit-to-lying and bathing, moderate assistance with lying-to-sitting, and maximal assistance with all other mobility. It also indicated she was frequently incontinent of bowel and bladder and used a wheelchair for mobility.The Care Plan dated 1/15/25 indicated the resident's wheelchair leg of pedal should be padded.On 10/22/25 at 1:43 PM, Staff D, Hospice CNA transported Resident #3 down the unit hall to her room in a

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interview, and policy review the facility failed to disinfect a mechanical lift after use between 2 of 2 residents, failed to perform hand hygiene during perineal care for 1 of 3 residents reviewed (#4), and failed to remove Personal Protective Equipment (PPE) before leaving a resident's room who was on Enhanced Barrier Precautions (EBP). The facility reported a census of 69 residents. Findings include:1. On 10/22/25 at 2:56 PM, Staff A, Certified Nurse Aide (CNA) and Staff E, CNA used a mechanical lift in a resident's room to transfer him from his wheelchair to his bed. After they completed the transfer, Staff E pushed the mechanical lift into the hallway and returned to the resident's room. The mechanical lift was not sanitized.At 3:16 PM, Staff F, Certified Medication Aide (CMA), took the mechanical lift into Resident #4's room to transfer him from his bed to his wheelchair and did not sanitize it. Staff F positioned the lift near Resident #4's bed and Staff F and Staff G stated Resident #4's perineal care needed to be completed before they transferred him to his wheelchair. Staff F and Staff G, CNA, performed hand hygiene and both donned gloves. Staff F handed Staff G a trashcan and Staff G grabbed it with her left, gloved hand and placed it on the floor beside the foot of the resident's bed. As Staff F left the room to get more gloves, Staff G used the same left, gloved hand to remove some perineal wipes from the packaging and performed Resident #4's perineal care that included retracting his foreskin and wiping the head of his penis. She did not perform hand hygiene or change gloves.The Minimum Data Set (MDS) for Resident #4 dated 8/14/25 did not include a Brief Interview for Mental Status (BIMS) score because the resident was rarely or never understood. It included diagnoses of Alzheimer's Disease, non-Alzheimer's dementia, the need for assistance with personal care, lack of coordination, and cognitive communication deficit. It indicated he was independent with eating, required moderate assistance with oral hygiene, maximal assistance with toileting hygiene, personal hygiene, lower body dressing, and all forms of mobility, and was dependent with bathing, upper body dressing, and footwear. It also indicated he was always incontinent of bowel and bladder.The Care Plan dated 1/31/25 indicated the resident had bowel and bladder incontinence and directed staff to check the resident per schedule, assist with toileting as needed, and to provide peri care after each incontinent episode. A revision dated 8/19/25 indicated he required assistance with transfers.At 3:35 PM, Staff F and Staff G completed Resident #4's perineal care and used the mechanical lift to transfer him from his bed to his wheelchair without sanitizing the lift.At 3:40 PM, Staff F stated shared resident equipment is sanitized before and after each use but added he assumed the previous users sanitized it when they were finished using it.At 4:13 PM, Staff G stated she should've performed hand hygiene between moving the trashcan and performing Resident #4's perineal care.A policy titled Handwashing/Hand Hygiene revised [DATE] directed staff that hand hygiene is indicated immediately before touching a resident; before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching a resident's environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal.A policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised [DATE] directed staff that Durable Medical Equipment (DME - medical equipment that can withstand repeated use) must be cleaned and disinfected before reuse by another resident.On 10/23/25 at 2:46 PM, the Director of Nursing (DON) stated staff should've removed the gloves, performed hand hygiene, and donned new gloves before performing perineal care and staff should sanitize shared equipment before and after each use.2. On 10/23/25 at 7:34 AM, Staff H, CNA, donned PPE and entered a semi-private resident room with both residents on EBP. At 7:36 AM, Staff H exited the room with the PPE gown on and walked to another unit to get a mechanical lift. At 7:40 AM, Staff H stated both residents were on EBP due to each one had an invasive device. He stated he didn't know he wasn't supposed to exit the room wearing PPE if he hadn't touched anything but added he should've known better.A policy titled Personal Protective Equipment - Using Gowns revised [DATE] directed staff that gowns must be discarded in the appropriate container located in the room.On 10/23/25 at 2:46 PM, the DON stated staff should've removed the PPE before exiting the residents' room.