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	04/23/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, pharmacy record review and policy review, the facility failed to follow professional standards regarding following physician's orders by failing to remove previously applied fentanyl patches after 72 hours of use and before applying new patches, putting residents at risk of an overdose for 1 of 3 residents (Resident #1) reviewed for medication administration. The facility reported a census of 69 residents. Findings include:Review of Minimum Data Set (MDS) dated [DATE] revealed, Resident #1's Brief Interview for Mental Status (BIMS) of 14, indicating cognitively intact. Resident #1's diagnoses include coronary artery disease, respiratory failure with hypoxia, history of polio resulting in chronic pain, muscle wasting and atrophy, anxiety, depression, and PTSD with dependence of two for assistance with a mechanical lift for ambulation and use of wheelchair for mobility. Resident #1's MDS included antipsychotics, antidepressants, diuretic, opioid and anticonvulsant high risk medications. Review of Care Plan dated 10/8/2025 documented Resident #1's use of opioid pain medication therapy with interventions to administer pain medications as ordered by physician, monitoring and documenting side effects and effectiveness. Review of Resident #1's Physician Order Summary indicated an order for Fentanyl patch 72 hour, 75 mcg, apply one patch to skin one time every 3 days (72 hours) for pain and removal per schedule. Review of Pharmacy provided Emergency Kit-Transactions By Patient report revealed on 3/23/26 at 9:01 PM one Fentanyl 25 mcg patch and at 10:05 PM two Fentanyl 25 mcg patches, to equal total 75 mcg, were removed from the Emergency medication kit for Resident #1. Review of Resident #1's March 2026 Medication Administration Record (MAR) revealed on 3/23/26 previously applied Fentanyl patch was removed and 75 mcg patch administered. With indication noted to see nursing progress notes related to Fentanyl patch administration. Review of Resident #1's Nursing Progress note dated 3/23/26 at 9:04 PM noted three 25 mcg patches received from pharmacy and applied to Resident #1's shoulders. A Pharmacy provided Packing Slip Proof of Delivery document dated 3/24/26 revealed two 75 mcg Fentanyl patches delivered and received at the facility for Resident #1. Review of Resident #1's March 2026 MAR documented on 3/26/26 previously applied Fentanyl patches were removed and 75 mcg Fentanyl patch was applied to Resident #1. Review of Controlled Drug Record log labelled 75 mcg fentanyl patch, quantity of two patches delivered on 3/24/26 with start date of 3/26/25 documented on 3/26/26 at 8:00 PM, one of two patches was administered to Resident #1, with one patch remaining. A Nursing Progress note dated 3/29/26 at 9:15 PM documented Resident #1 with altered mental status, not at baseline with response to her name. Resident #1's representative contacted, representative reported noticing the change with Resident #1 when visiting earlier in the day. Order received from provider, Resident #1 transferred to the local Emergency Department to be evaluated. Review of Emergency Department Provider note dated 3/29/26 revealed, Resident #1's chief complaint was altered mental status, nursing home staff had not seen her since she was checked on at shift change (2:00 PM) and she was not acting herself and not making sense. Two fentanyl patches were found on both of her shoulders dated three days ago and unsure of dosages. Emergency Medical Services (EMS) gave Narcan (medication used to treat patients exposed to high-potency opioid) dose en route to hospital, which helped a little. An additional dose of Narcan was given in ED with little (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improvement. Resident #1 admission to the Intensive Care Unit (ICU) for further workup and management. Further review of Resident #1 hospital admission documents indicated, Resident #1 was discharged , returning to the facility on 4/1/26.A Pharmacy provided Packing Slip Proof of Delivery document dated 4/10/26 revealed five 75 mcg Fentanyl patches delivered and received at the facility for Resident #1. Review of April 2026 MAR documented previously applied Fentanyl patches were removed and 75 mcg Fentanyl patch was applied to Resident #1 on 4/10/2026, 4/13/2026, 4/16/2026, and 4/19/2026. Review of Controlled Drug Record log labelled 75 mcg fentanyl patch, quantity of five patches delivered on 4/10/26 with start date of 4/10/25 documented on 4/10/26 at 11:00 PM, 4/13/26 at 9:00 PM, 4/16/26 at 8:00 PM and 4/19/26 at 9:00 PM patches were administered to Resident #1, with one of five patches remaining. A Nursing Progress note dated 4/20/26 at 7:05 PM revealed, Resident #1 noted to be unresponsive to verbal stimulation, Resident #1 sent to the local Emergency Department. Review of Hospital Progress note dated 4/22/26 at 10:05 AM stated, Resident #1 presented with altered mental status potentially in the setting of unintentional opioid overdose, as two fentanyl patches were removed en route to hospital. Naloxone (Narcan) was administered on 4/20/26.During an interview on 4/23/26 at 12:20 PM Director of Nursing (DON) reviewed and acknowledged the extra patches documented to be on Resident when transporting to the hospital via EMS. DON stated after 72 hours the patches don't have much effect, that's why they're removed and changed every 72 hours, it is sloppy nursing and an opportunity to re-educate the nurses on removing and applying patches. Review of facility provided Administering Topical Medications Policy, stated the following for trans-dermal patches:a. Clean and dry a selected area that is approved for application of the patch. Rotate sites with each new application, if possible. b. Remove old patch. c. Remove wrapper from the patch. Do not touch the adhesive surface. d. Apply to the skin, pressing firmly for approximately ten seconds.e. Remove gloves. Wash and dry hands thoroughly.