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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, guidance from the Centers for Disease Control (CDC) and facility policy review the facility failed to implement enhanced barrier precautions for one of one resident reviwed (Resident #4), and failed to perform appropriate hand hygiene during personal cares for three of three residents observed for toileting hygiene (Res #3, Res #4 and Res #61). The facility additionally failed to properly sanitize a full body mechanical lift between the usage of the lift between two residents. The facility reported a census of 62 residents. Findings include: 1. The admission Minimum Data Set (MDS) of Resident #4 dated 6/14/25 recorded the resident to require substantial/maximal assistance for toileting hygiene. The Care Plan of Resident #4 documented the resident had an indwelling urinary catheter, dated 6/10/25. Observation of transfer, toileting, and catheter care began on 8/27/25 at 10:13 am with Staff E and Staff I, Certified Nurse Aides (CNA) present. Resident #4 was sitting in her wheelchair. Staff E, CNA, placed gloves on her hands and removed the resident's cushioned boots (for skin protection). She removed the foot support from the wheelchair and then stepped out of the room momentarily and returned still wearing gloves. Staff I, CNA entered the room with a stand up mechanical lift and donned gloves. Staff E placed the sling for the mechanical lift behind Res #4 and gave the resident simple one step instructions as to how they would transfer her. Both staff continued to wear the same gloves as they positioned Res #4 into the lift, assisted her to a standing position, guided her to the toilet, lowered her pants and brief, and lowered her safely onto the toilet. Staff E obtained a graduated cylinder and placed it on the sink next to the toilet. She then disconnected the safety sling from the standing mechanical lift and placed the graduated cylinder directly on the floor. She opened the drain from the resident catheter urine bag and emptied the urine into the graduated cylinder. Staff I stated she was going to obtain an alcohol swab to cleanse the drain tip. She left the room and returned quickly with an alcohol swab which she handed to Staff E, not wearing gloves at that time. Staff I placed new gloves on her hands, with no hand hygiene witnessed. Staff E remained in the same gloves she had on since the beginning of the observation. She cleansed the tip of the drain, placed the drain in place and replaced the urine bag into a dignity bag. She picked the graduated cylinder up off the floor and stated she would hold it until the resident was off the toilet. Staff I then opened a cart with supplies in it, and obtained wet wipes from the cart. Staff E then placed the graduated cylinder, still with urine in it, back on the floor. She removed her gloves, disposed of them, and placed new gloves on her hands, with no hand hygiene observed. Staff I, still wearing gloves, obtained the standing mechanical lift and brought it back to the room. Both staff assisted the resident securely back into the sling to stand. Staff E ran the remote control of the mechanical lift with her gloved hand and Staff I held the catheter bag in place as the (continued on next page)

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

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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident was raised to a standing position. Staff E then cleansed the buttocks of resident #4, still wearing the same gloves used to raise the standing left. Staff E then removed her gloves and placed new gloves on with no hand hygiene witnessed. Both staff members assisted the resident to replace her clothing and then guided her back to her wheelchair and placed her urinary bag clipped under her wheelchair. Staff E then returned to the restroom, picked up the graduated cylinder off the floor and emptied the urine into the toilet. She then obtained paper towels and dried the graduated cylinder without rinsing it and placed it back on the floor. Both staff at the end of the observation removed their gloves and used hand sanitizer. On 8/27/25 at 10:25 am, Staff E, CNA was asked about a fully stocked isolation cart outside of Resident #4's room. She stated it contained isolation gowns but neither Resident #4 nor her roommate were in isolation. When asked if she had received education regarding Enhanced Barrier precautions and stated she was not aware what that meant. She stated she could ask a nurse what that was. She added the isolation cart had been outside of that room for quite a while but nobody used it. On 8/27/25 at 11:00 am, the Director of Nursing stated staff has been educated about enhanced barrier precautions and they discuss it in morning huddle. 2. The Annual MDS of Resident #61, dated 8/10/25 documented him to be fully dependent for toileting hygiene and bed mobility. The MDS coded the resident to be always incontinent of bowel and bladder. The Care Plan of Resident #61 documented a problem area of Activities of Daily Living (ADL) self care performance and directed staff to check and change the resident for incontinence every two hours. Observation began on 8/28/25 at 3:00 am. The resident was in bed, with his call light on the bedside table several feet away from him out of reach. At 3:22 am, Staff R, Certified Nurse Aide (CNA) entered the room, stated she was just checking on the resident and quickly exited the room again. At 4:30 am, Staff R entered the room again, and stated she needed to perform incontinence cares for the resident. She entered the bathroom, obtained supplies and placed gloves on her hands with no hand hygiene observed. She went to the bedside and opened the incontinence brief of Resident #61 which appeared to be heavily saturated with urine. Staff R stated her normal routine on the night shift is to perform incontinence cares for the resident every two hours. She cleaned his penis and groin with wet wipes, cleaning front to back. She then turned the resident to his left side, tucked his soiled brief and two disposable under pads underneath him. The resident was incontinent of bowel. Staff R then cleansed his buttocks, removed the soiled supplies and placed the items in a trash can on the floor next to her. She then obtained a clean brief and a clean disposable under pad. She then removed and disposed of her gloves and obtained barrier cream from a night table across the room. She placed new gloves on her hands with no hand hygiene witnessed and placed barrier cream on the resident's groin. She then fastened the incontinence brief and placed a support pillow between the resident's knees. She removed her gloves, adjusted his sheets and blankets and put away the wipes and barrier cream and lowered the bed. Staff S, Licensed Practical Nurse (LPN) then entered the room to assist Staff R to reposition the resident. Staff R then stated when they repositioned him, he had urinated again so they were going to change him again. Staff R then changed her gloves and obtained new supplies. She opened the resident's brief, and again cleansed his penis and groin. She tucked the brief underneath him as she turned him to his side. Staff S, LPN then cleansed his buttocks and removed the soiled brief and (continued on next page)

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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disposed of it. Staff S then removed her gloves, entered the bathroom to wash her hands and placed new gloves on her hands. Staff S then went to the doorway where a linen cart was parked and obtained a clean hospital gown. She then placed a new disposable under pad and a new brief underneath the resident and applied a prescription powder on his buttocks. Both staff removed the wet hospital gown from the resident and Staff R then put the soiled gown on the floor next to the trash can. Staff S placed the clean gown on the resident. Staff R removed the trash bag from the trash can, picked the gown up off the floor, and exited the room still wearing her gloves. Upon returning to the room at 4:56 am, Staff R placed a new liner in the trash can and put away extra supplies. She placed the support pillow again between the resident's legs and positioned the resident in a comfortable position. She then removed the call light from the bedside table and clipped it to his sheets. She stated the call light is normally always in reach. She replaced the fall mat on the floor next to the bed and left the bed in a low position. An article from the CDC dated 6/28/24 titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes documented the following: Point 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of Multidrug-Resistant Organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Point 3. Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The facility policy Handwashing/Hand Hygiene, revision date October 2023, documented the following: Indications for Hand Hygiene: 1. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task c. after contact with blood body fluids, or contaminated surfaces; d. after touching a resident e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal. (continued on next page)

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	08/28/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The admission Minimum Data Set (MDS) dated [DATE] indicated that Resident #3 needed substantial/maximal assist for toileting hygiene, upper and lower body dressing and was dependent with sit to stand and chair to bed transfers. The Care Plan initiated 6/17/25 indicated that Resident #3 had a self-care performance deficit with dressing and personal hygiene requiring assist of one. During an observation on 08/27/2025 at 10:27 AM Staff I, CNA and Staff J, CNA performed morning cares including transfer for Resident #3. Resident #3 was incontinent of bladder so peri cares were provided. Staff I, CNA and Staff J, CNA then transferred Resident #3 via pivot disk. Both Staff I, CNA and Staff J, CNA failed to perform hand hygiene between glove changes during peri care when going from dirty area to clean area. In an interview on 08/27/2025 at 1:23 PM The DON stated that hand hygiene should be performed in many instances. Stated hand hygiene should be performed with glove changes when providing peri-care. 4. On 8/25/25 at 1:04 PM, Staff C, Certified Nurse Aide (CNA) and Staff D, CNA exited Resident #11's room with a mechanical lift and transported it into Resident #33's room without sanitizing it. At 1:14 PM, Staff C and Staff D stated there was not a reason why the mechanical lift wasn't sanitized between use. A policy titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 7/2014 indicated reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). On 8/28/25 at 8:25 AM, the Director of Nursing (DON) stated staff should have sanitized the mechanical lift before using it on the next resident.

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	08/28/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record review, staff interview, and policy review, the facility failed to notify the physician of blood sugars <60 for 1 of 1 residents reviewed for insulin use (Resident #22). The facility reported a census of 62. Findings include: The Quarterly Minimum Data Set (MDS) Assessment completed on 5/24/25, revealed Resident #22 with a Brief Interview for Mental Status score of 2, indicated severe cognitive impairment. Diagnoses on the MDS include diabetes, stroke, seizure disorder, and non-Alzheimer's dementia. Medications listed include an anticonvulsant and hypoglycemic (to lower blood sugar). The Medication Administration Report (MAR) on Resident #22 for August 2025 listed the use of a long acting insulin, Lantus 32 units, administered one time a day in the morning, and the use of a short acting insulin, Humalog, administered at meals three times a day in amounts based on blood sugar readings. Blood sugars are checked three times a day to correlate with meal service.The MAR for August and July 2025 documented the following low blood sugars for Resident #22: 59mg/dL on 7/3/25 at 5:00 p.m.55mg/dL on 7/6/25 at 5:00 p.m.60mg/dL on 7/19/25 at 5:00 p.m.56mg/dL on 8/2/25 at 5:00 p.m. 60mg/dL on 8/3/25 at 5:00 p.m.No documented interventions to correct the low blood sugars identified in the electronic or paper health record. This includes repeat blood sugar checks to ensure levels improved prior to the next scheduled check. No documented communication to the physician or their designee notifying of the low blood sugars identified in the electronic or paper health record. During an interview on 8/27/25 at 3:25 PM, Staff U, Registered Nurse, explained Resident #22 was unable to report their blood sugar is low and typically does not show physical signs of low blood sugars. These are usually noted during scheduled checks. During an interview on 8/28/25 at 930 AM, Staff T, Unit Manager, explained their preference is for staff to recheck blood sugars for levels <65. These should then be documented in the electronic health record. Staff T acknowledged the lack of documented staff interventions regarding Resident #22's low blood sugars. Staff T noted there are no parameters written in current orders on when to notify the physician for low blood sugars. After reviewing Resident 22's blood sugars, Staff T believed the physician should be notified. During an interview on 8/28/25 at 12:00 PM, Staff T confirmed Resident #22's inability to tell staff if they feel funny and may be experiencing low a blood sugar. Staff T clarified further the physician should be notified if a blood sugar is <60mg/dL, as per facility protocol. The facility document Geriatric Protocols for [NAME] Village, signed by the Medical Director on 1/9/25, outlined the following:Report blood sugars <60 or >400 to the appropriate providerFingerstick blood sugar can be done as needed for signs/symptoms of hypo/hyperglycemia (low or high blood sugars)Nurses: When a protocol is used:a. Document in the Progress Notes what protocol initiated and whyb. Put the order into the resident's eMAR; Select verbal as the communication method when entering the orderc. Print, note, and double note the orderd. Include necessary information for physician notification on the order if needed; Use nursing judgement to determine if a fax or follow-up of the concern is needed

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	08/28/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review, staff interview, and policy review, the facility failed to identify target behaviors for psychotropic medications (medications that affect a person's mental state, emotions, and behavior) for 2 of 5 resident (#28, #50). The facility reported a census of 62. Findings include: 1. 1. The Quarterly Minimum Data Set (MDS) assessment for Resident #28 dated 8/10/25 revealed a Brief Interview for Mental Status (BIMS) score was not established because the resident was rarely or never understood. The MDS documented diagnoses of cerebral infarction (tissue damage caused by lack of blood flow to the brain), non-Alzheimer's dementia, anxiety, depression, sarcopenia (age-related loss of muscle mass, strength, and function), and quadriplegia. It indicated the resident required setup assistance with eating, maximum assistance with oral and personal hygiene, upper body dressing, and rolling left-to-right in bed, and was dependent with all other Activities of Daily Living (ADLs) and other mobility. It further revealed the resident took antianxiety and antidepressant medications in the 7-day look-back period. The Care Plan with a target date of 11/24/25 documented antianxiety and antidepressant medication use but did not include resident specific target behaviors for staff to monitor for or nonpharmacological interventions for staff to attempt. The Progress Notes dated 5/13/25 and 8/19/25 indicated the resident did not have behaviors or mood symptoms but failed to identify the resident's target behaviors.2. 2. The Annual Minimum Data Set (MDS) assessment for Resident #50 dated 5/31/25 revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated severely impaired cognition. The MDS documented diagnoses of heart failure, non-Alzheimer's dementia, and chronic obstructive pulmonary disease (COPD). The MDS indicated the resident required setup assistance with eating, maximum assistance with oral hygiene and upper body dressing, and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility. It further revealed the resident took antianxiety and antipsychotic medications in the 7-day look-back period.The Care Plan did not include resident specific target behaviors for staff to monitor for antipsychotic medication use or nonpharmacological interventions for staff to attempt. The Progress Notes dated 1/07/25 at 8:05 a.m. documented the resident scratched and swatted at staff but did not indicate for which diagnosis this behavior was associated.Nurses Note on 4/14/25 at 9:00 a.m. documented as follows; This nurse attempted to give resident her medication and resident pulled away. This nurse reminded resident that it was important to take her medication and she threw the cup of water she washolding in this nurses face and chest. It was at that moment no further attempts were made, but did not indicate for which diagnosis this behavior was associated.A Social Service Note dated 6/11/25 at 12:49 documented as follows the resident does have behaviors at times, she may refuse cares and get verbal.A Pharmacist's Recommendation to Prescriber dated 4/14/25 recommended a Gradual Dose Reduction (GDR) for Resident #50's antipsychotic medication. The physician declined the GDR recommendation due to psychotic disorder with delusions due to known physiological condition but did not include resident specific target behaviors.On 8/26/25 at 1:28 PM, Staff B, Licensed Practical Nurse (LPN) stated residents' behaviors should be listed on their Treatment Administration Record (TAR) or Medication Administration Record (MAR). He stated neither resident had orders for their behaviors. He further stated since neither resident had an order on their TAR or MAR, staff should enter a progress note regarding behaviors. He confirmed he was not able to locate the resident specific target behaviors on either resident's Care Plan.On 8/26/25 at 1:45 PM, Staff D, Certified Nurse Aide (CNA) stated Resident #50's behaviors included scratching, biting, and kicking and she documents observed behaviors in the Electronic Health Record (EHR). She also stated she has never been provided a list of resident specific behaviors for Resident #28 or #50. She indicated the resident specific target behaviors were not identified in documentation but stated all residents who receive psychotropic medications have the same behavior symptoms list in their EHR.On 8/26/25 at 2:30 PM, Staff F, Certified Medication Aide (CMA) stated she had not been told (continued on next page)

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	08/28/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which resident specific target behaviors were on the behavior symptoms list.On 8/27/25 at 7:53 AM, Staff G, LPN, stated she was new and didn't know the residents very well. She stated Resident #50 sometimes refused her meds was what she had been told. She was not able to locate the residents' specific target behaviors.At 9:36 AM, Staff H, Assistant Director of Nursing (ADON) stated she didn't know the residents well because she'd only been there for 3 weeks.Both residents' EHR included MARs which revealed both residents received their psychotropic medications but lacked resident specific target behaviors. It also revealed Resident #50's EHR did not include a behavior symptoms list.Neither residents' Physician Orders included resident specific target behaviors for psychotropic medication use.On 8/28/25 at 8:27 AM, the Director of Nursing (DON) stated staff should have clarified the target behaviors with prescribing providers.A policy titled Psychotropic Medication Use revised 2022 indicated consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes.

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	08/28/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual, and facility policy review, the facility failed to fully develop a comprehensive care plan for 3 of 17 residents reviewed (Resident #4, #28, & #50). The faciltiy reported a census of 62 residents. Findings include: 1. The admission Minimum Data Set (MDS) of Resident #4 dated 6/14/25 recorded the resident experienced mood symptoms of feeling down, depressed, or hopeless; having trouble concentrating on things, and moving or speaking slowly or being fidgety or restless during the previous 2-week look back period. The MDS recorded diagnoses that included Alzheimer's Disease, Anxiety and Depression. The MDS documented the resident received antipsychotic, antianxiety, and antidepressant medications during the prior 7 days of the lookback period. Section V of the MDS, The Care Area Assessment Summary (CAA) documented communication, behavioral symptoms, and pressure ulcer/skin integrity would be included on the resident Care Plan. The MDS question V0200B2 was signed 6/16/25. The RAI Manual stated the RN coordinator is required to sign and date the CAA Summary after all triggered CAA's have been reviewed to certify the completion of the comprehensive assessment. Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. Facilities should use the date at V0200B2 to determine the date at V0200C2 by which the care plan must be completed (V0200B2 + 7 days). The Order Summary of Resident #4 documented Lorazepam, an antianxiety medication, had started on 8/22/25. The Order Summary additionally documented the use of Seroquel, an antipsychotic medication in use since 6/11/25. Review of Resident #4's care plan conducted on 8/26/25 revealed the Focus Areas of Potential for Skin Breakdown and Pressure Ulcers were both added to the Care Plan on 8/11/25. The Care Plan failed to reveal communication or behavioral symptoms to be addressed on the Care Plan. The Care Plan additionally failed to reveal documentation of the use of anti anxiety or antipsychotic medications. The care plan listed Psychotropic medications, with no target behavior symptoms noted to be addressed. The Care Plan additionally noted the use of an antidepressant, also failing to address the target behaviors being addressed for the use of the medication. On 8/28/25 at 10:46 am, the MDS Coordinator stated the Care Plan should be developed within 14 days of completing the MDS. She stated she had not been made aware Resident #4 had been started on an antianxiety medication, but said the normal process is for the floor nurses to inform her of medication changes to update the Care Plan. On 8/28/2025 at 12:21 pm, the Administrator stated triggered CAAs should be listed on the care plan. 2. The Quarterly MDS assessment for Resident #28 dated 8/10/25 revealed a Brief Interview for Mental Status (BIMS) score was not established because the resident was rarely or never understood. It included diagnoses of cerebral infarction (tissue damage caused by lack of blood flow to the brain), non-Alzheimer's dementia, anxiety, depression, sarcopenia (age-related loss of muscle mass, strength, and function), and quadriplegia. It indicated the resident required setup assistance with eating, maximum assistance with oral and personal hygiene, upper body dressing, and rolling (continued on next page)

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	08/28/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	left-to-right in bed, and was dependent with all other Activities of Daily Living (ADLs) and other mobility. It further revealed the resident took antianxiety and antidepressant medications in the 7-day look-back period. The Care Plan included antianxiety and antidepressant medication use but did not include resident specific target behaviors for staff to monitor or nonpharmacological interventions for staff to attempt. The Progress Notes dated 5/13/25 and 8/19/25 indicated the resident did not have behaviors or mood symptoms but failed to identify the resident's target behaviors. 3. The MDS assessment for Resident #50 dated 5/31/25 revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of heart failure, non-Alzheimer's dementia, and chronic obstructive pulmonary disease (COPD). It indicated the resident required setup assistance with eating, maximum assistance with oral hygiene and upper body dressing, and was dependent with all other Activities of Daily Living (ADLs) and all forms of mobility. It further revealed the resident took antianxiety and antipsychotic medications in the 7-day look-back period. The Care Plan did not include resident specific target behaviors for staff to monitor for antipsychotic medication use or nonpharmacological interventions for staff to attempt. The Progress Notes dated 1/07/25 indicated the resident scratched and swatted at staff but did not indicate for which diagnosis this behavior was associated. A Progress Note dated 6/11/25 indicated the resident refused cares and became verbal but did not indicate for which diagnosis this behavior was associated. On 8/26/25 at 1:28 PM, Staff B, Licensed Practical Nurse (LPN) stated residents' behaviors should be listed on their Treatment Administration Record (TAR) or Medication Administration Record (MAR). He stated neither resident had orders for their behaviors. He further stated since neither resident had an order on their TAR or MAR, staff should enter a progress note regarding behaviors. He confirmed he was not able to locate the resident specific target behaviors on either resident's Care Plan. On 8/28/25 at 8:34 AM, the Director of Nursing (DON) stated staff should have included the residents' target behaviors in their respective Care Plans. The facility policy Care Planning - Interdisciplinary Team, revision date March 2022, directed the following: - Resident Care Plans are developed according to the timeframes and criteria established by 483.21. - Comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team.

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	08/28/2025

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 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. Based on electronic health record review, staff interview, and policy review, the facility failed to update the Care Plan for 1 of 17 residents reviewed (Resident #9) for the discontinued use of a diuretic. The facility reported a census of 62. Findings include: The Quarterly Minimum Data Set (MDS) Assessment completed on 6/8/25 revealed Resident #9 with a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. Diagnoses on the MDS include Alzheimer's dementia, hypertension, and seizure disorder/epilepsy. The MDS noted the use of an anticonvulsant and no other high-risk drug. The Care Plan, with a target date of 9/14/25, listed the use of diuretic therapy for edema. This was initiated on 9/20/24. The Progress Noted dated 9/19/24 at 9:43 a.m. documented the use of Lasix, a diuretic, for three days due to edema (swelling) and tenderness to Resident #9's lower legs. The medication order history noted an order for Lasix from 9/19/24 to 9/22/24. The Order Summary Report, obtained on 8/28/25, did not list a current order for a diuretic. During an interview on 8/28/25 at 9:30 AM, Staff T, Unit Manager, explained they initiate and update resident Care Plans for the chronic confusion or dementia illness (CCDI) unit. This is completed upon admission, quarterly, and as needed with input from floor nurses. Staff T noted Resident #9 is not currently on a diuretic and acknowledged this was not removed from the Care Plan in a timely manner. The facility policy Care Planning-Interdisciplinary Team, revision date March 2022, stated the following:Resident Care Plans are developed according to the timeframe and criteria established by S483.21Comprehensive, person-center Care Plans are based on resident assessments and developed by an interdisciplinary team

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	08/28/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and policy review, the facility failed to ensure safe and accurate delivery of oxygen therapy for one of three residents reviewed for respiratory care (Resident #71). The facility reported a census of 62 residents.Findings include:The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #71 had diagnoses of anemia, congestive heart failure, chronic respiratory failure with hypoxia and obstructive sleep apnea. The MDS documented that the resident had oxygen therapy. The MDS documented a Brief Interview for Mental Status score of 14 out of 15 for the resident, which is a score for cognitive status skills intact.The Care Plan documented a problem with initiated date 8/19/25 as follows; Resident #71 had altered respiratory status and difficulty breathing requiring oxygen. The Care Plan lacked documentation on oxygen flow rate or delivery method. It also indicated that Resident #71 could use Continuous Positive Airway Pressure (CPAP) on preset settings at night and as needed during the day if she requested it.The Physician's Orders indicated Resident #71 had oxygen that could be titrated to maintain oxygen saturations above 90% on nasal cannula (nc) initiated on 8/22/25. The Physician's Orders lacked an order for CPAP use. The orders were updated on 8/26/25 to indicate oxygen at 1 liter nc that may be titrated to keep oxygen saturation greater than 90%.The Progress Notes indicated that resident #71 was wearing CPAP during the night shift 5 times (8/20/25 at 2:26 a.m., and 8/24/25 at 12:58 a.m.) without indicating the oxygen flow rate to the CPAP machine. The Progress Notes (8/23/25 at 4:31 a.m., 8/20/25 at 2:26 a.m., and 8/24/25 at 12:58 a.m.) lacked documentation of Resident #71 wearing oxygen while sleeping during the day or that Resident #71 puts the CPAP on by herself. The Progress Notes also lacked assessment of respiratory status or pulse oximetry when wearing oxygen with the CPAP.The Vital Signs tab revealed that oxygen saturations were never less than 90% on room air. It further revealed that the oxygen saturation was only taken 4 times while the CPAP was on Resident #71 and once when oxygen was on at an unknown flow rate via nc.In an observation on 08/26/2025 at 1:26 PM Resident #71 was resting in bed with eyes closed wearing CPAP mask with 1 liter oxygen running to the CPAP machine.During an interview on 08/26/2025 at 1:30 PM Staff K, LPN stated that Resident #71 used the CPAP when she is sleeping and she puts it on by herself. It is usually at night but sometimes she puts it on during the day if she is sleeping.During an interview on 08/26/2025 at 1:38 PM Staff K, LPN stated that Resident #71 arrived with oxygen and thought it was at 2 liters but wasn't sure. He also stated that they check her pulse oximetry 2x daily. Staff K, LPN then stated that Resident #71's oxygen had not been adjusted as she was stable so it must have been 1 liter and not 2 liters. Staff K, LPN could not answer where the documentation indicating Resident #71 wears oxygen with her CPAP when she sleeps and not when short of breath.During an interview on 08/26/2025 at 2:30 PM The DON stated that if a resident had a CPAP, they must maintain it for themselves. He would not expect and order for CPAP as the staff does not assist. When asked if they would accept a CPAP with oxygen to it he stated he would have to assess it to see if they could meet the needs. The DON reported oxygen would need an order. When informed of Resident #71 having oxygen to her CPAP he was unaware. The DON stated he would not expect any documentation of oxygen in the chart if Resident #71 was putting on the oxygen herself. He added that she does what she wants to do.The Care Plan lacked documentation that the resident was assessed for self-administration of oxygen or CPAP, or was able to do so.In an interview on 08/27/2025 8:27 AM Resident #71 stated that she had oxygen at 1 liter to her CPAP every time it is on and she puts it on whenever she sleeps. She denied putting on oxygen because she is short of breath or because of low saturations. Resident #71 added that she checks her own pulse oximetry and had a finger machine in a chain around her neck. She takes care of the CPAP herself but stated that no one told her she had to she just does it herself. Stated she turns the machine off and on but does not adjust the machine. Stated not sure who set up the oxygen.In an interview on 08/27/2025 at 1:23 (continued on next page)

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	08/28/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM The DON stated that a CPAP should actually have an order. Stated that the Assistant DON did get an order yesterday after this surveyor asked about it. Stated Resident #71 was not short of breath as her saturations have all been above 90% and at 94% on room air when she admitted . He then stated that if resident is putting oxygen on with the CPAP despite not being short of breath, she is choosing to do so. The DON added that nursing should be documenting somewhere that she is using the oxygen. When questioned if the oxygen order should actually be at 1 liter when using the CPAP, he stated, I don't disagree. The DON denied having a policy on CPAP or oxygen use.

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	08/28/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, family interviews and staff interviews, the facility staff failed to provide sufficient staff to safely feed residents who required feeding assistance during three of three meals observed. The facility staff also failed to complete incontinence care for 1 of 2 residents reviewed for incontinence care (#2) in a timely manner. The facility reported a census of 62 residents.Findings include:1.On 8/25/25 at 1:30 pm, a family member of Resident #61 stated she comes to feed her family member daily every day for lunch and again for supper. She stated she feels if she is not there to feed him, he would not get feeding assistance. She added that when she arrives, there are other residents at the next table who require feeding assistance and often no staff is present, or if they are present, they are often on their phones rather than assisting the residents.On 8/26/25 at 5:25 pm, observation began for the evening meal. Resident #61 was at one table, with his family member assisting him to eat. Residents #8, #17, #23 & #64 were sitting at Table #2, all had meals in front of them. Staff L, Certified Nurse Aide (CNA) was sitting at table 2, assisting Resident #8 to eat her meal. The other three residents had food in front of them but nobody to assist them. Six minutes into the observation, Staff L stood and walked around the table and assisted Resident #17 to take some of his meal. At 5:32 pm, Staff M, CNA arrived to assist but only stayed for a moment and left again. She returned at 5:38 pm and sat to feed Resident #17. Staff L rotated to assist the other three residents. Staff N, CNA was observed entering and exiting the dining room periodically during the observation but never assisted any of the residents who required feeding assistance. On 8/26/25 at 5:55 pm, Staff L, CNA was asked if it was a common occurrence for her to be the only staff member to assist four different residents. She stated it varies. She added it is on the schedule for each hallway which staff member is supposed to assist in the dining room, and she had not been scheduled for the dining room. She had been scheduled to pass room trays but when room trays arrived, another staff member was all ready passing them, so she came to the dining room to assist. When the meal was over, it was observed that resident #64 had eaten 10-15% of her meal. During chart review the following day, Resident #64's meal record was recorded at having eaten 75-100% of her evening meal on 8/26/25. The documentation was recorded to have been done at 5:00 pm, prior to meal service. This was documented by Staff O, CNA, who was not observed to be in the dining room during the meal service. During clinical review of all staff members of the facility who were current in CPR training, which includes training for if a resident is choking, no staff members present in the dining room were noted to have the current training. On 8/27/25, at 9:23 am, the Director of Nursing reported if there was an emergency in the dining room, his expectation would be for the staff member to run and get a nurse to assist. He stated typically there are at least two CNAs scheduled to assist in the dining room. He said whichever staff member assists to feed a resident, it is their responsibility to chart how much the resident eats. On 8/27/25 at 10:02 am, Staff O, CNA stated the other staff member who was working on the hall with her that day gave her the information as to how much the residents ate. She stated she had completed all of the other charting except meal intake, and the other staff member told her how much they ate and she documented it. Lunch observation on 8/27/25 began at 11:35 am. Residents #8, #17, #23 & #64 were sitting at Table #2, all had meals in front of them with no staff present at the table with them. Resident #8, who had a diet order of puree diet with honey thickened liquids reached for her food with her fingers and began eating independently. Resident #8 was noted to be coughing lightly. After several minutes, Staff E arrived and sat to assist to feed Resident #17. Staff E then assisted Resident #8 to clean her hands and assist her to eat her meal. Breakfast observation began on 8/28/25 at 8:37 am. Resident #8 was observed with food in front of her, feeding herself, with no staff present at the table. Various facility staff were observed at the opposite end of the dining room. Resident #8 was again observed to be lightly coughing during when feeding herself. The Care Plan of Resident #8 directed staff she needed supervision and cueing for her meals, (continued on next page)

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	08/28/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention dated 10/11/24. On 8/28/25 at 8:39 am, Resident #17 was heard stating loudly I would like to eat my breakfast as his food sat in front of him but no staff were present to assist him. At 8:42 am, Staff P, CNA arrived and began assisting both Resident #8 and Resident #17.Staff Q, CNA was at the next table assisting Resident #61. Staff Q was additionally walking throughout the dining room offering set up assistance to multiple other staff members and periodically returning to assist Resident #61. At 8:44 am, the MDS Coordinator arrived and sat to assist Resident #8. Resident #8 was noted to continue coughing lightly with intake. At 8:50 am, Resident #8's cough intensified, and the MDS Coordinator removed her from the dining room. At 9:04 am, Resident #8 was observed in the common area near the nursing station, with the MDS Coordinator assessing her, listening to her lung sounds and obtaining a pulse oximetry. She stated she had notified the hospice nurse of the morning episode and they would be arriving shortly. She stated she thought Resident #8 had probably aspirated some during breakfast. On 8/28/25 at 8:55 am, Staff P, CNA stated when the food was served to the eating assist residents, she was present at the table with them. She explained she got up and left the table to go to the other end of the dining room to assist others with set up assistance. She stated that Resident #8 is to be supervised when eating but it's ok to be in the general area and not directly at the table. On 8/28/25 at 12:20 pm, the Administrator stated she expects staff to be present in for feeding assist residents at the time their plates are served and should be assisting them throughout their meal. On 8/28/25 at 12:22 pm, the DON verified the two staff members discussed the prior day had no training on file for choking or performing the Heimlich maneuver. He again stated if there were an emergency with a resident, staff would need to get a nurse to assist. 2. On 8/25/25 at 11:47 AM, Resident #2 informed Staff C, Certified Nurse Aide (CNA) that he had a bowel movement and had not been changed. Staff C asked Resident #2 if it was ok to change him at that time. Resident #2 stated he would notify her to change him when he finished eating.At 11:48 AM, Resident #2 activated his call light and Staff C entered his room, turned off the call light, and exited his room within two (2) minutes.At 12:27 PM, Resident #2 stated he had not been cleaned of his bowel movement yet.At 12:54 PM, Staff C and Staff D, CNA entered another resident's room to assist her to the restroom per her husband's request.At 12:58 PM, Resident #2 stated he still had not been cleaned from his bowel movement.At 1:04 PM, Staff C and Staff D exited a resident's room with a mechanical lift and transported it to another resident's room.At 1:05 PM, Resident #2 activated his call light.At 1:12 PM, Staff C and Staff D entered Resident #2's room to clean him.The Minimum Data Set (MDS) assessment for Resident #2 dated 7/18/25 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus, cerebral infarction (tissue damage caused by lack of blood flow to the brain), non-traumatic intracerebral hemorrhage (brain bleed), and constipation. It indicated he required setup assistance for eating, moderate assistance with upper body dressing, maximum assistance with oral and personal hygiene, and bathing, and was dependent with toileting, lower body dressing, and footwear.The Care Plan dated 1/09/25 directed staff to check the resident per schedule and assist with toileting as needed and to provide pericare after each incontinent episode. It also revealed he required two-person assistance for turning, repositioning, and toilet use.At 1:28 PM, the Director of Nursing confirmed the resident's call light was activated at 11:58 AM and again at 1:05 PM.On 8/27/25 at 11:11 AM, Staff E, CNA stated she did not recall Staff C asking her for assistance. She was on the hall the first half of the lunch shift.At 2:46 PM, Staff C stated she did not recall if she asked anyone for assistance with Resident #2 prior to Staff D helping her.On 8/28/25 at 8:32 AM, the Director of Nursing (DON) stated staff should have consulted for assistance when asked by the resident.A policy titled Activities of Daily Living (ADL), Supporting revised March 2018 indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:a. Hygiene (bathing, dressing, grooming, and oral care);b. Mobility (transfer and ambulation, including walking);c. Elimination (toileting);d. Dining (meals and snacks); ande. Communication (speech, language, and any functional communication systems)

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	08/28/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview and manufacturer's instructions, the facility failed to prime an insulin flexpen prior to administering the insulin dose to ensure the proper amount of insulin administered for one of one residents observed who received insulin during medication pass (Resident #72). The facility reported a census of 62 residents.Findings include:The electronic health record (EHR) Medical Diagnosis list revealed Resident #72 had a diagnosis of Type 2 Diabetes Mellitus with diabetic peripheral angiopathy without gangrene. The Order Summary for Resident #72 dated 8/27/25 included a physician's order for insulin Aspart 10 units subcutaneously (SQ) two times daily for diabetes started on 8/25/25. It also included a physician's order for additional insulin Aspart on a sliding scale based on Resident #72's blood sugar results three times daily for diabetes started on 8/25/25.The Medication Administration Record (MAR) dated 8/1/25 - 8/31/25 revealed an order for insulin 10 units and an additional sliding scale dose based on Resident #72's blood sugar results SQ. The MAR revealed Staff B, Licensed Practical Nurse (LPN), documented Aspart insulin 10 units SQ with an additional 2 units for blood sugar of 234 milligrams per deciliter administered on 8/26/25/25.In an observation on 08/26/2025 at 11:22 AM Staff B, LPN reported that Resident #72's blood sugar was 234. Staff B, LPN attached a needle on the end of the Aspart insulin FlexPen and dialed the pen to 12. Staff B, LPN failed to prime the insulin pen prior to administering the dose.During an interview on 08/26/2025 at 11:30 AM Staff B, LPN stated he does not prime the insulin pens as someone told him with the current needles he did not have to. Staff B, LPN showed this surveyor the bottom of a new needle and stated the needle goes down further. Did not know who had told him this.During an interview on 08/27/2025 at 1:23 PM the Director of Nursing (DON) stated that insulin pens should be primed with 2 units and pushed to inject to get rid of any air that might alter the dose. Then dial to desired dose and give to the resident. The DON denied that the needles they use do not need to be primed. He also added that they have no policy for insulin pens and they follow the manufacturers guidelines.The manufacturer's guidelines for the Aspart insulin FlexPen indicate the proper use starting on page 81 and ending on page 84. The following are the listed steps for proper usage:a. Pull off the pen cap.b. Remove the paper tab from a new disposable needle. Screw the needle straight and tightly onto your FlexPen.c. Pull off the big outer needle cap and keep it for later.d. Pull off the inner needle cap and dispose of it. Never try to put the inner needle cap back on the needle. You may stick yourself with the needle.e. Turn the dose selector to select 2 units.f. Hold your FlexPen with the needle pointing upwards and tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge.g. Keeping the needle upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If a drop of insulin still does not appear, the pen is defective, and you must use a new one.h. Turn the dose selector to select the number of units you need to inject. The dose can be corrected either up or down by turning the dose selector in either direction until the correct dose lines up with the pointer. When turning the dose selector, be careful not to push the pushbutton as insulin will come out. You cannot select a dose larger than the number of units left in the cartridge.i. Inject the dose by pressing the push-button all the way in until 0 lines up with the pointer. Be careful only to push the push-button when injecting. Turning the dose selector will not inject insulin.j. Keep the push-button fully depressed and let the needle remain under the skin for at least 6 seconds. This will make sure you get the full dose. Withdraw the needle from the skin, then release the pressure on the push-button. Always make sure that the dose selector returns to 0 after the injection. If the dose selector stops before it returns to 0, the full dose has not been delivered, which may result in too high blood sugar level.k. Lead the needle into the big outer needle cap without touching it. When the needle is covered, carefully push the big outer needle cap completely on and then unscrew the needle. Dispose of it carefully and put the pen (continued on next page)

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	08/28/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cap back on. The link for the manufacturer's guideline can be found at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.ema.[NAME].eu/en/documents/product-inf