STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165548	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER: Arbor Springs of West Des Moines L L C		STREET ADDRESS, CITY, STATE, ZIP CODE: 7951 E P True Parkway West Des Moines, IA 50266	

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** 44512 Based on observations, clinical record review, staff interviews, facility staff correspondence and policy review, the facility failed to provide a thorough assessment and timely intervention for 1 of 4 residents reviewed. (Resident #1). On [DATE] Resident #1 was lowered to the floor. Staff E, Certified Nurse Assistant (CNA) notified Staff A, Licensed Practical Nurse (LPN) who failed to complete a thorough assessment. The Assistant Director of Nursing (ADON) was notified at 9:15 AM on [DATE] that Resident #1 was in pain, the ADON failed to do an assessment until 3:15 PM and the Director of Nursing (DON) obtained an order for pain medication yet failed to ensure that it was administered. An x-ray on [DATE] revealed a displaced hip fracture that required surgical intervention. The facility reported a census of 53 residents. Findings are as follows: The Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed a diagnosis of a compression fracture of the thoracic spine at level T11 and T12 vertebrae due to repeated falls and a history of transient ischemic attacks (small blood clots) with cerebral (brain) bleed. Resident #1 required moderate assistance with care, toileting and dressing, and moderate assistance with sit/stand and ambulation. Resident #1 was frequently incontinent of bowel and bladder. Resident #1 had a Brief Interview for Mental Status (BIMS) score of 2 which suggested severe cognitive impairment. The MDS documented the resident had vocal complaints of pain observed for 1 to 2 days. The Care Plan dated [DATE] for Resident #1 informed staff that she was a wander risk and a fall risk with walking and during toileting. The Care Plan identified that Resident #1 was evaluated by physical therapy and occupational therapy. The Care Plan directed staff to anticipate and meet needs, assistance of 1 staff for toileting, report and document physical, nonverbal indicators of discomfort or distress, follow up as needed and to report a decline in cognitive status, mood, or decline in activities of daily living (ADL). Resident #1 used disposable briefs, check and change frequently when awake. The Physician Orders for Resident #1 revealed the following pain medication orders: 1. Acetaminophen 325 milligram (mg) 2 tablets three times a day, ordered [DATE]. 2. Acetaminophen 325 mg, 2 tablets as needed (PRN), ordered [DATE] for pain/fever. 3. Diclofenac Sodium 75 mg, 1 tablet every 12 hours PRN, ordered [DATE] for pain. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165548	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Arbor Springs of West Des Moines L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 7951 E P True Parkway West Des Moines, IA 50266	

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Medication Administration Record (MAR) dated February 2025 for Resident #1 revealed: 1. Acetaminophen 325 milligram (mg) 2 tablets three times a day administered on: a. [DATE] at 8AM, 2PM, and 10PM. b. [DATE] at 8AM, 2PM, and 10PM. c. [DATE] at 8AM, 2PM, and 10PM. 2. Acetaminophen 325mg PRN administered on [DATE] at 3:07 AM. 3. Diclofenac Sodium 75 mg administered on [DATE] at 3:01 AM. 4. Oxycodone 5mg give 1 tablet every 6 hours for pain, initiated on [DATE] and discontinued on [DATE], that was not administered. The MAR for February 2025 revealed no PRN pain medications were administered on [DATE] or [DATE]. The Progress Notes for Resident #1 revealed: -On [DATE] at 3:10 PM, Resident #1 was admitted for physical and occupational therapy (PT/OT) following a T12 fracture. She was alert, confused, was to wear the back brace at all times and was to be assisted by 1 staff with walker for ambulation. Resident did have complaints of pain, PRN Tylenol given. - On [DATE] at 1:36 PM, is on skilled level of care due to PT/OT related to fracture. Has no complaints or concerns. Is wearing back brace and states no pain. - On [DATE] at 9:23 PM Residents pain controlled with PRN pain meds. Resident eating supper at the neighborhood table this evening with no complaints. Brace in place. - On [DATE] at 10:55 AM, Staff B, Medical Doctor, examined Resident #1, conducted a medication review to include the discontinuation of Oxycodone due to hyper vivid dreams. The son was present. - On [DATE] at 1:40 PM Resident has pain and relief with PRN meds and repositioning. Back brace in place. - On [DATE] at 10:36 AM, Staff C, Registered Nurse (RN) documented a skilled assessment that included no impairment of Range of Motion (ROM) of lower extremity, and was able to reposition self. Verbal complaints of pain rated at 1. Non-medication interventions provided relief. - On [DATE] at 3:17 PM, the DON documented that resident was in bed this shift, refused to get up, bear weight, or allow for cares. The resident called out and expressed pain with turns, legs were equal in length and ROM within normal limits (WNL). The resident called out in pain when attempted to sit resident up, and was unable to localize the pain. The DON notified Staff B, MD and will monitor through the evening then reevaluate in the morning. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

- On [DATE] at 3:45 PM, a late entry by the DON, Staff B, MD ordered Oxycodone every 6 hours prn pain, the point click care (PCC) was updated and the son notified.

- On [DATE] at 2:23 PM, Staff D, LPN documented the resident was noted with increased pain to the left hip and no weight bearing. Notified the physician and received an order for an x-ray.

- On [DATE] at 4:43 PM, the DON documented the x-ray result revealed a fracture of the left hip, discussed with the physician and was ok for a transfer to the Emergency Department or remain at the facility with hospice care as per family choice. The son was notified.

- On [DATE] at 7:17 PM, the DON documented received call from 2nd son and after an update was given, chose to have resident transferred to a tertiary hospital.

- On [DATE] at 12:47 PM, Resident #1's son called and stated the surgery took a little longer, more issues then they saw and resident will return to the facility.

The Progress Notes lacked any documentation of any incidents or assessments related to any incidents that occurred on [DATE].

During an observation on [DATE] at 12:29 PM, Resident #1 was located in her room, in a bed that was low in the lower position, wearing a back brace and a foam wedge between her legs. Resident #1 was alert, confused and requested to have water. An untouched lunch tray was on her night stand.

During an interview on [DATE] at 1:41 PM, Staff M, CNA revealed that she worked on [DATE] 6AM-2PM with the resident. She stated when she got report the aide did not say anything about Resident #1. Staff M stated she had to call the nurse because even when you touched the resident she screamed in pain. She stated she stayed in bed that day and refused food. She stated the nurse assessed her and gave her pain meds but she does not remember the nurses name. She stated when the pain meds wore off she started screaming again. She stated the resident usually walked around but that day she did not get up.

During an interview on [DATE] at 10:12 AM, Staff H, Physical Therapy Assistant (PTA) stated Resident #1 was very alert, energetic, engaging and followed directions. Staff H stated the last encounter on [DATE], Resident #1 ambulated by hand hold assistance, due to unsteadiness and used a wheeled walker.

During an interview on [DATE] at 10:34 AM, Staff I, Director of Rehabilitation stated during an encounter on [DATE] had found Resident #1 wandering around and required redirection to sit as she had complained of back pain. Staff I stated the next encounter on [DATE], Resident #1 was unable to sit on the side of the bed. Staff I stated Staff J, Speech Therapist (ST), attempted to assist but Resident #1 was yelling out in pain and rubbing both hips. Staff I stated Resident was soaked in urine and notified the CNA's and advised that they change her in the bed. Staff I stated they notified the ADON of Resident #1's change of condition and complaint of pain.

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

During an interview on [DATE] at 10:52 AM, Staff J, ST stated she had a session in the gym on [DATE] with Resident #1, worked on sit to stand and reaching back to the chair. Staff J stated Resident #1 was independent 100 percent by the end of the session. Staff J stated on the morning of [DATE], she had assisted Staff I with Resident #1 who was very agitated, very distressed and cried when they attempted to sit her up onto the side of the bed. Staff J stated she consulted with the ADON to express her concerns and suspected pain. Staff J stated Resident #1 had medication changes and would be monitored. Staff J stated in the afternoon, attempts were made to work with Resident #1 but was unable to continue due to the extreme level of pain.

During an interview on [DATE] at 11:57 AM, Staff F, CNA revealed that she had worked on [DATE] 6AM-10 PM and provided care for Resident #1. Staff F stated Resident #1 was running around and tried to put herself on the floor from a standing position and was going to fall. Staff F stated Staff G, CNA assisted her and they placed Resident #1 on the floor. Staff F stated she notified Staff A, LPN who failed to provide an assessment for Resident #1. Staff F stated at 9:15 PM, Staff G assisted to get Resident #1 off the floor, to the bathroom and to bed. Staff F stated Resident #1 always complained about pain. Staff F stated when she had returned to work on [DATE] at 2 PM, Resident #1 was in bed, therapy had recommended her to stay in bed, the DON conducted an assessment and ordered an x-ray. Staff F stated that Resident #1 was yelling out in pain and she was very wet with urine and did not want the day shift staff to touch her. Staff F stated Resident #1 had to be changed regardless and cried when she was turned during care.

During an interview on [DATE] at 12:18 PM, Staff A, LPN stated she was the nurse on [DATE] evening shift and had been notified by Staff F, CNA that Resident #1 was sitting on the floor but did not follow through with an assessment or complete an incident report as she thought this was behavior that she had been doing on other shifts. Staff A stated she did not check the Care Plan to see if Resident #1 was allowed to be on the floor. Staff A stated she did not administer pain medication to Resident #1.

During an interview on [DATE] at 12:48 PM, Staff K, LPN stated she had worked the over night shift on [DATE] to [DATE] and was not notified Resident #1 was on the floor during the previous shift and was not informed that Resident #1 had pain during the night shift. Staff K stated Resident #1 wandered but did not ever sit on the floor. Staff K stated the staffing on the night shift consisted of one CNA in each of the 4 neighborhoods and one nurse. Staff K stated the CNA would inform her if a resident experienced pain.

During a follow up interview on [DATE] at 2:46 PM, Staff A, LPN stated if a resident received routine Tylenol and had increased pain, the expectation was to assess the pain and notify the physician. Staff A stated she remembered asking Resident #1 if she wanted to stay on the floor, she said yeah, but did not ask why she was on the floor. Staff A stated the CNA's did not inform her the resident was having pain when they got her off the floor. Staff A stated, I think there was a miscommunication.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:12 PM, the ADON stated if a resident was assisted to the floor it was to be considered as a fall and the expectation was that the staff would inform the nurse who would complete an assessment, including an assessment signs and symptoms of pain. The ADON stated she was unaware that Resident #1 was on the floor on [DATE] until she read an email from Staff L, Activities on [DATE] at 12:25 PM. Resident #1 was on the floor in the main living area on [DATE] at 3 PM, was unsure if the resident was care planned to be on the floor. Staff F, CNA was in a recliner with her feet up facing Resident #1 and Staff L did not inform the nurse at that time. The ADON stated she was informed by the Director of Therapy and Staff J, ST on the morning of [DATE] that Resident #1 was in pain when they attempted to get her out of bed. The ADON stated she went to Resident #1's room [ROOM NUMBER] hours later to assess her and found her to be in pain and was unable to lift her legs due to pain. The ADON stated the DON arrived and conducted an assessment. The ADON stated she asked the DON if they should get an x-ray and the DON told her no since she was unable to locate an origin of the pain. The ADON stated she was called away for a phone call and the next day, [DATE] after 8 AM, Staff D, LPN reported that Resident #1 continued to have pain and was unable to get out of bed. The ADON stated she had told Staff D to call the doctor and get an order for an x-ray. An email dated sent on [DATE] at 12:25 PM from Staff L sent to Department Heads documented the following: Hello, sorry that I am just getting this email sent now and looking back I should have alerted the nurse on this side rather than assuming the resident in question is care planned to be allowed to sit on the floor. I am concerned that something occurred yesterday afternoon during the 3PM hour. Several residents were in the common areas but the newest resident, Resident #1, was sitting on her behind on the floor in the middle of the sitting area just in front of the TV. I didn't see her walker or a chair near her. Staff F was sitting in a recliner with her feet up facing Resident #1. While I was in there, about half an hour, another aide (I don't remember who) joined the group in the main sitting area. Resident #1 did scoot around a bit on her bottom. I regret that I didn't inform the floor nurse yesterday. During an interview on [DATE] at 4:14 PM, Staff G, CNA stated she had worked on [DATE] at 2 PM till 6 AM. Staff G stated Resident #1 was running and was going to fall, then tried to get down to the floor. Staff G stated Staff F, CNA notified the nurse who did not do anything. Staff G stated she had assisted to get Resident #1 off the floor and she was screaming, but she always screamed. Staff G stated she had checked on Resident #1 during the night, Resident #1 did not get out of bed that night and was screaming a lot. (continued on next page)

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(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	During an interview on [DATE] at 4:45 PM, the DON stated she had received an e-mail from Staff L, Activities on [DATE] that Resident #1 was sitting on the floor and didn't know if she was care planned to be on the floor. The DON stated she had called Staff F, CNA whom stated Resident #1 was getting up without a walker, was fearful she would fall, and resident requested to be on the floor. The DON stated Staff A, LPN reported she did not know that Resident #1 was on the floor. The DON stated that Resident #1 complained of pain since admit and her son stated it was attention seeking behavior. The DON stated she assessed her at 3:15 PM, found Resident #1 to be in pain but was unable to replicate the pain. The DON stated she had called the physician who asked if she fell and was told no but she was on the floor. The DON stated the physician had ordered Oxycodone for pain and deferred if they transfer to the hospital to the family. The DON stated she did not give the Oxycodone but did call the son who wanted to confer with his brother. The DON stated the next day, on [DATE], Staff D, LPN had received an order for an x-ray and the 2nd shift nurse informed her that Resident #1 had a fractured hip. The DON stated the family was then informed and requested transfer to the hospital. During an interview on [DATE] at 1:47 PM, Staff B, Medical Doctor stated when he was informed on [DATE] that Resident #1 was on the floor the evening before, that she should be evaluated in the emergency department since it was too late for a mobile x-ray but felt the family delayed in decision. Staff B stated he ordered Oxycodone to be given and it was his expectation that it be given for pain. Staff B stated Resident #1 had osteoporosis and could have had a spontaneous fracture. Staff B stated on [DATE] the x-ray revealed a hip fracture and family agreed to a surgical intervention. Staff B stated that Resident #1 made it through surgery but she didn't bounce back and the result was death on [DATE] at 10:10 AM. A facility policy revised [DATE] and titled Fall Assessment revealed: Procedure: 1. Residents will be assessed for fall risk on admission and residents identified as a high risk for falls will have fall interventions implemented. 2. When a resident falls the Charge Nurse will complete the Fall Scene Investigation and create a Progress Note describing the event. Protocol: 1. When a resident is observed or discovered to have fallen, the staff present will immediately radio the charge nurse. 2. The charge nurse will assess the resident for injury. 3. If there is suspected major injury, the charge nurse will notify the physician and the power of attorney (POA) immediately. 4. Vital signs are taken every 8 hours for 72 hours with follow-up documentation charted on status of resident or as ordered by the physician.