Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Springs of West Des Moines L L C	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to fully review and revise the comprehensive Care Plan for 1 of 3 residents (Resident #2) who were sampled for care plan review. The facility reported a census of 49 residents. Findings include:According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment. Resident #2 had diagnoses to include Non-Alzheimer's dementia and depression. The MDS documented the resident's current behavior status was worse compared to the prior assessment and the resident sometimes felt lonely or isolated from those around him. Review of the Electronic Health Record (EHR) revealed the following Progress Notes:a. Progress Note dated 5/31/25, titled Health Status Note: Resident upset this AM due to unable to leave, and not safe to leave in room alone. Staff attempted to engage in activities, distract with meals and assist to converse with peers. When on the phone with his family, resident stated that he would just kill himself since he could not leave, overheard by staff in common room with phone on speaker. Resident on 15 minute checks following phone conversation at 1000 to family. Spoke with resident, no plan or attempts, and denies even saying the above. Primary Care Physician (PCP) made aware and advised to keep 15-minute checks until at least Monday and follow up with psychiatry, if family allows, to evaluate for depression. b. Progress Note dated 12/5/25, titled Health Status Note: At HS (hour of sleep), it was brought to nurse attention that resident picked up a screwdriver and self-inflicted a small skin tear to his dorsal/the back of his left hand stating that he wants to un-alive (kill) himself. His family was notified immediately. He also refused to relinquish the screwdriver and threatened to harm anyone who try to take the screwdriver from his hand. He is currently sitting in the common area with the device in his hand while nurse and staff trying to deescalate the situation.The Care Plan for Resident #2 lacked a focus area, goal and interventions for staff regarding the resident's suicidal statements, ideations and self harm. The Kardex Care Plan from the household where Resident #2 resided, a hard copy document for staff use to know the care plan for each resident, did not contain any information related to the resident's suicidal ideations or self harm attempt, or interventions for staff. During an interview on 2/9/26 at 9:55 AM, the Director of Nursing (DON) stated the suicidal ideations and what to do should have been in Resident #2's Care Plan and she expected the Care Plan be updated after each suicidal statement and self harm incident. The DON acknowledged the Care Plan was not updated. During an interview on 2/9/26 at 11:50 AM, the Administrator stated an expectation the Care Plan be updated and acknowledged the Care Plan was not updated in May of 2025 or in December of 2025 after Resident #2 made comments of suicidal thoughts and self harmed. Review of the facility policy Care Plan and Care Conference Policy, revised 3/1/21, documented the Comprehensive Care Plan will be reviewed and revised on a quarterly basis, with a significant change in condition and as needed.

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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, family interview and staff interviews, the facility failed to appropriately supervise and maintain an environment free of potential hazards for 1 of 1 residents reviewed (Resident #2) after a resident made suicidal statements and self harmed. The facility reported a census of 49 residents. Finding include:According to the Minimum Data Set (MDS) dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment. Resident #2 had diagnoses to include Non-Alzheimer's dementia and depression. The MDS documented the resident's current behavior status was worse compared to the prior assessment and the resident sometimes felt lonely or isolated from those around him. The Care Plan, revised on 6/18/25, documented Resident #2 used antidepressant medication related to a depression diagnosis and instructed staff under interventions to administer antidepressant medications as ordered by the physician and document/report an needed adverse reactions to antidepressant therapy, including social isolation and suicidal thoughts. Review of the Electronic Health Record (EHR) revealed the following Progress Notes:a. Progress Note dated 12/5/25 at 10:50 PM, titled Health Status Note: At HS (hour of sleep), it was brought to nurse attention that resident picked up a screwdriver and self-inflicted a small skin tear to his dorsal/the back of his left hand stating that he wants to un-alive (kill) himself. His family was notified immediately. He also refused to relinquish the screwdriver and threatened to harm anyone who try to take the screwdriver from his hand. He is currently sitting in the common area with the device in his hand while nurse and staff trying to deescalate the situation.b. Progress Note dated 12/6/25 at 10:01 AM, titled Health Status Note: Assisted Manager on Duty (MOD), Social Services Director (SSD) to search resident's room for any potential weapons to harm self or others from resident's room and removed call light to replace with bell to call for help. Removed items were placed in a basket and taken to the nurses station. 15 min check sheet initiated to monitor, direct care staff aware and verbalized understanding.c. Progress Note dated 12/6/25 at 12:00 PM, titled Social Services: Met with resident this morning to assess psychosocial needs and risk of self-harm. Resident was in the common area upon my arrival. He appeared in good spirits throughout my visit, with friendly mannerisms to include smiling and a pleasant tone of voice. He was alert to self only, was disoriented to time and place and spoke about how he's busy at work on his airplanes. He was asked if he had any safety concerns and he stated his line of work has several safety concerns because if he doesn't do his job correctly then others are placed at risk. Asked resident about events last night and gestured towards resident's laceration on the back of his hand. Resident stated, Oh, I was just playing around. I asked if he was attempting to hurt himself last night and he stated that a lot of people can be hurt if he doesn't do his job correctly. Validated the important work he does ensuring airplanes are operating correctly, agreeing this is a very important task. After speaking about airplanes for a little while I later oriented resident to facility and asked if he had any safety concerns regarding his living environment. He looked around the room before answering that no, he has no safety concerns. He stated he feels he's in a nice place. Resident was asked if he was having any current thoughts of hurting himself or anyone else and he denied this.During an interview on 2/4/26 at 1:45 PM, a family member stated a recollection of the night of 12/5/25, she received a call from the facility, from Staff A, Licensed Practical Nurse (LPN), at around 8:45 PM. Staff A advised her Resident #2 had a screwdriver and was upset and trying to harm himself, he hurt his hand with the screwdriver. She couldn't remember for sure, but he might have said he wanted to kill himself. She arrived at the facility approximately 30 minutes later. When she arrived, Resident #2 still had the (continued on next page)

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