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	06/30/2026

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

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and guidance from the 2025 Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, the facility failed to complete a significant change in status assessment (SCSA) that should have been completed within 14 days after it was determined the resident's status from baseline had occurred for 2 of 12 residents reviewed (Resident #3 & #1). The facility failed to complete a SCSA when Resident #3 experienced a decline in activities of daily living physical function after the return from hospital care for fractured hip repairs on 3/10/26 and on 5/6/26. The facility also failed to complete a timely significant change for Resident #1 when enrolled into Hospice care. The facility reported a census of 46 residents.Findings include: 1.The Quarterly Minimum Data Set (MDS) dated for 1/8/26 for Resident #3 revealed the diagnoses of dementia, muscle weakness and abnormalities of gait and mobility. The MDS did not identify a pain medication regimen nor that Resident #3 identified the experience of pain. The MDS identified one fall with an injury, not a major injury. No prior orthopedic surgery identified. Resident #3 required moderate assistance from staff for dressing and ambulation. Resident #3 was incontinent of bowel and bladder and dependent on staff for toileting and personal hygiene. The Brief Interview for Mental Status (BIMS) score was a 4 which revealed severe cognitive impairment and no adverse behaviors were identified. The Annual Assessment MDS dated [DATE] for Resident #3 revealed the diagnoses of dementia, anxiety, osteoporosis and fractured hip. The MDS identified two or more falls without injury. The MDS identified that Resident #3 underwent a surgical intervention for hip, required skilled care and surgical wound care. The MDS identified pain and the use of opioid pain medication. The MDS identified Resident #3 was dependent on staff for dressing, toileting, personal care, transfers and ambulation did not occur. The MDS dated [DATE] coded as an entry to the facility for Resident #3. The MDS dated [DATE] coded as a Medicare Part A 5-day scheduled assessment for Resident #3 revealed diagnoses of dementia, anxiety, age-related osteoporosis without current pathological fracture, repeated falls, hip fracture and muscle weakness. The MDS identified that Resident #3 underwent a surgical intervention for hip, required skilled care and surgical wound care. The MDS identified pain and the use of opioid pain medication. The MDS identified Resident #3 was dependent on staff for dressing, toileting, personal care, transfers and ambulation did not occur. The MDS identified a fall in the last month, a fall in the last 2-6 months and a fracture related to a fall in the 6 months prior to this assessment. The MDS failed to identify fall with major injury. During an interview on 6/24/26 at 3:21 pm, Staff D, Licensed Practical Nurse (LPN) MDS Coordinator identified significant changes with residents as increase in falls, behaviors, a decline in function with (continued on next page)

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dementia and falls that resulted in hospitalization for a fracture with a return to the facility for skilled care. Staff D stated the hip fractures that Resident #3 experienced would warrant a significant change. Staff D stated the facility had completed a Medicare 5-day MDS assessment for Resident #3 on 5/12/26, but thought afterwards that should have been a significant change. She stated she had missed a Quarterly Review on Resident #3, the facility's QAPI team had identified and put a performance improvement plan (PIP) in place regarding the missed MDS assessment. Staff D stated she had discussed the missed MDS's with the Director of Nursing (DON) and the Administrator a couple of months ago. 2. The MDS of Resident #1 dated 4/3/26 documented the resident was receiving hospice services. Page 59 of the MDS documented the assessment completion date of 4/17/26. The Census Line of Resident #1 identified he enrolled in hospice care on 3/31/26. The Health Status Note dated 3/31/26 documented the resident was admitted to hospice. Page 38 of the MDS RAI manual directs the MDS completion date must be no later than the 14th calendar day after determination that a significant change in resident's status occurred (determination date + 14 calendar days). Pages 45-46 of the MDS RAI manual documents: A significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. An SCSA (Significant Change in Status Assessmet) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). On 6/30/26 at 11:10 am, the Director of Nursing stated the facility does not have an MDS policy. She stated they follow the CMS and RAI guidelines for when an MDS is due or indicated.

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F 0689 Level of Harm - 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 observation, clinical record review, resident, family and staff interview and policy review, the facility failed to provide appropriate supervision for 1 of 3 residents reviewed for falls (Resident #3). The facility failed to provide a complete assessment and investigation to determine the root cause and failed to monitor and modify interventions in order to prevent further accidents for Resident #3. The facility also failed to utilize assistive devices per care plans to prevent bruising injuries for 2 of 2 residents (Resident #4 & #6). During the survey process, staff were observed to transfer residents by gripping forearms and hands. After alerting the facility, to prevent further injury, the staff were observed to place the gait belt then continue to grip the residents by the arms and not by the gait belt during transfers. The facility reported a census of 46 residents.Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #3 revealed the diagnoses of dementia, muscle weakness and abnormalities of gait and mobility. The MDS did not identify a pain medication regimen nor that Resident #3 identified the experience of pain. The MDS identified one fall with an injury, not a major injury. No prior orthopedic surgery identified. Resident #3 required moderate assistance from staff for dressing and ambulation. Resident #3 was incontinent of bowel and bladder and dependent on staff for toileting and personal hygiene. The Brief Interview for Mental Status (BIMS) score was a 4 which revealed severe cognitive impairment and no adverse behaviors were identified. The MDS dated [DATE] for Resident #3 revealed the diagnoses of dementia, anxiety, osteoporosis and fractured hip. The MDS identified two or more falls without injury. The MDS identified that Resident #3 underwent a surgical intervention for hip, required skilled care and surgical wound care. The MDS identified pain and the use of opioid pain medication. The MDS identified Resident #3 was dependent on staff for dressing, toileting, personal care, transfers and ambulation did not occur. The Care Plan with revision date of 5/4/26 directed staff to allow Resident #3 to express her frustration when she feels stuck here at (facility name). Encourage Resident #3 to discuss her feelings and concerns with long term care. Report, document and address episodes of anxiety, fear, and distress. Resident #3 loved to paint, attempt color therapy & any sorts of crafts. Activities of daily living plan of care directed staff to provide 1 person assist for transfers, ambulation with a front wheeled walker for short distances and a wheelchair for longer distances. Toilet Resident #3 frequently when awake as she was occasionally incontinent of urine, needed assistance with toilet hygiene. Document and report as needed any changes, potential for improvement, a self-care deficit or if declines in function. Resident #3 was identified as an elopement risk and directed staff to distract Resident #3 from wandering by offering pleasant diversions, structured activity, food, conversation, television, a book. Resident #3 enjoyed walking, conversation, reading. The care plan directed staff to identify a pattern of wandering, intervene and redirect as appropriate. Provide structured activities. The care plan identified Resident #3 as had dementia with behaviors therefore anticipate her needs, provide medication, allow time to express self and offer choices. Intervene before escalation. The care plan lacked any update or revision to the fall risk problem after the fractured hip was found on 3/4/26. During an interview on 6/23/26 at 10:13 am, Resident #3's husband stated his wife experienced two falls that resulted in a fractured hip that required surgical intervention within two months. The husband stated he was at the facility every day and after he would leave, the 2nd shift staff would (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	call requesting him to talk to his wife. The husband stated he wondered why staff can't handle it when she gets upset and if Resident #3 was in her room by herself, the door had to be open so the staff could stick their head in the door to check on her. The husband stated in March 2026, he was notified Resident #3 had pain in her hip and right knee that increased over 3-4 days and an x-ray revealed she had a fractured right hip. The husband stated the staff was unaware of how it happened but stated she had osteoporosis. The husband stated two months later, he was notified she was bleeding from the back of her head from a fall and the emergency room physician reported that Resident #3 told him she had pain in her left hip. The husband stated the nursing staff told him the head injury was why they sent her to the hospital as she was on a blood thinner. The husband stated Resident #3 had a fractured left hip and a urinary tract infection (UTI). The husband stated he complained about the supervision and felt if she was properly supervised, it could have prevented the fall. The husband stated he was told two staff was present all the time but did not feel that was true since they go on breaks and only one was monitoring the residents. The husband questioned the report of her crawling out of the recliner in the common area, walked and hit her head on a door jam. The husband stated Resident #3 had not walked since she fractured the first hip and with both hospitalizations it was found that she had UTI's. During an observation on 6/23/26 at 10:13 am, Resident #3's room had an entryway and the bed was to the right. If you stick your head in the door, you cannot visualize Resident #3 in her bed or chair, if she was in her room, a person must enter the room and look around the wall of the bathroom. The common area had recliners with room to propel a wheel chair around both sides. Resident #3's room door was approximately 10 feet from the closest recliner. A sign on the door read, keep the door closed when resident in not in the room. Resident #3 was in a wheelchair with husband at bedside. emergency room notes dated 3/5/26 at 8:31 am revealed Resident #3 presented with a confirmed right hip fracture. There is no known history of trauma. Resident #3 had significant dementia; her husband was at bedside. Resident #3 complained of right groin and right knee pain. Apparently, the facility initially obtained an x-ray of the knee which showed arthritic changes and later noted that she had right hip pain which confirmed the fracture. She otherwise has no complaints at this time. She is not anticoagulated.Medical Decision Making This is a nontoxic-appearing [AGE] year-old female with a right hip fracture. I did discuss the patient's care with the orthopedic team. They plan for surgical repair tomorrow. I have independently visualized the patient's imaging and reviewed her lab testing. She and husband are agreeable to the plan. Hospital notes dated 3/6/26 at 4:45 pm for Resident #3 revealed: Reason for admission: Fracture of unspecified part of neck of right femur, initial encounter for closed fracture. Subjective: Patient was transferred here from (local hospital named) for surgical repair of right hip fracture prior to being seen by hospitalist there. Resident #3 was awake but not willing to answer questions. Daughter was at bedside and help provide some information. Resident #3 was not endorsing any acute symptoms currently.Urine: Turbid (cloudy) yellow with [NAME] Blood Cells (WBC's) 500 (normal 0-5). Urinary Tract Infection (UTI) Ceftriaxone 1 gram intravenous (IV) daily.Physical Therapy evaluation and treatment. Previous level of function: Skilled Care Facility assist with mobility per husband using Hoyer lift for all transfers few months and prior to that was using a walker. Results: decreased strength, endurance, balance, mobility, cognition and pain. The Progress Notes for Resident #3 revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/26/26 at 5:09 pm, Staff C, Advanced Registered Nurse Practitioner (ARNP) documented visit for complaint of swelling right knee with pain. Resident #3 was resting in her chair, calm and at baseline. Staff reported Resident #3 and her husband reported left lower limb and upper limb pain. Resident #3's husband would like to keep her comfortable with some pain medication but not to keep her too sedated, concerned about the fact she was sleeping too much. We will consider a very small amount to ensure she is not in pain. Resident #3 was not very verbal so it was very hard to know what she was feeling.Resident #3 complained about the same symptoms on the February 9. The x-ray at that time, result negative. I do not think it is necessary to repeat an x-ray at this time. Staff reported: no recent falls, no change in appetite, no sleep disturbance, no change in behavior. On 3/2/26 at 10:09 am, Staff C, Advanced Registered Nurse Practitioner (ARNP) documented visit due to nursing and CNA were concerned about her severe pain. Resident #3 said it was on her hip, Resident #3 was shaking, displaying a lot of discomfort. Resident #3 had been put on a very small amount of tramadol on 2/27/26 and nursing staff said that observing the patient it is not enough. Resident #3 not always able to express what she felt as she has severe dementia. The husband agreed with the treatment course of increasing the tramadol. At the moment of the visit, Resident #3 was with physical therapist and occupational therapist. Staff C advised to work the upper body and assess and see how her hips. Staff C recommended an x-ray to exclude a possible fracture. On 3/3/26 at 8:52 am Resident #3 was sleepy with poor appetite. Possible Hospice recommendation. On 3/4/26 10:58 am, Husband notified of x-ray result and Staff C, ARNP expressed concerns as husband decided to send Resident #3 to hospital for an evaluation on 3/5/26. On 3/5/26 8:16 am Resident #3 was sent to the hospital emergency room with a right hip fracture. On 3/10/26, Resident #3 returned from the hospital utilized the mechanical lift for transfers and Oxycodone for pain management. On 3/12/26, Staff C, ARNP documented Resident #3 and husband were satisfied with the right hip repair. Staff C instructed the staff to be careful when they help Resident #3 to stand up from her wheelchair and when they change her in her bed as she was very frail due to her severe osteoarthritis. Staff reports: no recent falls, no change in appetite, no sleep disturbance, no change in behavior. On 5/2/26 at 9:36 pm, Staff G documented Resident #3 going toward her room and landed on the floor, apparently hit her head on her room door before staff tried to prevent fall. Resident assessed and complained of Right hip pain. A 0.3-centimeter, minor cut was noted to the back of Resident #3's head. The vital signs obtained was temperature 97.6, blood pressure 126/82, pulse 73, respirations18, SP02 (oxygen level in blood) 96%. The call provider was notified and advised Resident #3 should be sent to hospital for further evaluation. Resident #3's husband was notified. Fall Investigation dated 5/2/26 for Resident #3 revealed: 1. BIMS level 3. 2. Diagnosis Fractured neck of right femur, clot in deep veins right lower leg, lack of coordination, muscle weakness, restlessness and agitation. 3. Saturday May 2nd, 2026 approximately 7:15 pm Resident #3 was sitting in a recliner in the Birchwood Neighborhood living room following dinner with other residents. Staff Staff F, CNA was in the dining area coloring with another resident when she witnessed Resident #3 stand from the recliner and move towards her bedroom door. Prior to Staff F being able to get to Resident #3 she tripped and fell. Hitting her head on bedroom door causing a laceration. Resident #3 was assessed and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	complained of pain to right hip. Provider on call and family was notified and due to Resident #3 being on Eliquis (blood thinner) and hitting her head orders were given to have her sent to hospital. [NAME] was sent via ambulance. Prior to fall, Resident #3 was restless looking for husband with interventions such as toileting and offering food ineffective.4. On 5/4/26, the Director of Nursing (DON) followed up with Resident #3's husband. Resident #3 had a fracture to the left hip and was currently in surgery.5. Interventions: The family and physician were notified. Resident #3 was sent to emergency room via ambulance.6. Root Cause: Restless resident attempting to look for husband. A document titled Fall Investigation for CNA's dated 5/2/26 for Resident #3. Fall Description: Staff was watching everyone, went to assist another resident at the table coloring. When staff turned Resident #3 was walking to her room and before staff could get to her, she was on the floor. Before the fall: Resident #3 was in the recliner.Last seen: Sitting talking about her husband.Factors you think could have contributed to the fall?: Resident #3 wanted to see her husband, wanted to get her things earlier to go find him. The floor was dry. Last toileted 2 hours. Resident #3 was incontinent.Interventions in place at time of fall? Yes. Resident was safe. What do you think could have been done to prevent the fall from happening? Staff F documented: When Resident #3 would get upset about her husband, it was hard to redirect her, I walked her, offer food, toileted her with no effect. Signed: Staff F, CNA dated 5/2/26. On 5/4/26, Resident #3 was hospitalized for a fractured left hip. Hospital report dated 5/4/26 for Resident #3 revealed: Reason for admission: Left hip fracture and surgical repair. Resident #3 with a history of right hip surgical repair, dementia, mood disorder presented to the emergency room after unwitnessed ground-level fall. Resident #3 was diagnosed with Left displaced femur neck fracture.Urine Turbid 500 WBC's and 0.03 blood Staphylococcus culture. UTI: Ceftriaxone 2 gm IV daily for 3 days. Laceration of scalp.Occupational Therapy documented as an unwitnessed fall. Provider Progress Note: Follow-up Hospital discharge date d 5/7/26, Resident #3 was recently returned from hospitalization last month, status post-surgical intervention for right femoral head fracture. Unfortunately, Resident #3 had a fall during the weekend, fractured her left hip and had an open area to the back of her head. Resident #3 had been in the hospital and returned for post-operative care. Resident #3 was doing okay, administered oxycodone every 6 for pain. (provider wrote) I am concerned about these falls, Resident #3 broke her hip 6 weeks ago, the right side, and now she has broken the left side. Nursing staff was between 2 more creative ways in keeping the patient more supervised, maybe a chair alarm. Staff reported: no recent falls, no change in appetite, no sleep disturbance, no change in behavior. Documented by Staff C, ARNP. During an interview on 6/25/26 at 9:40 am, Staff F, Certified Nursing Assistant (CNA) stated she was made aware during a report from the other CNA's that Resident #3 fell and broke her hip in March 2026. Staff F stated she provided care for Resident #3 after that injury. Staff F stated she was not the same person and had increased anxiety during the evenings after her husband left. Staff F stated Resident #3's husband was at the facility every day. Staff F stated she informed the nursing that everything on Resident #3's care plan, give food, color, talk to her, did not work, saying she was a sundowner. Staff F stated every night Resident #3 had behaviors and overnight she would try to get up. Staff F stated she would assist Resident #3 into the recliner, held her hand and that worked. Staff F stated she arrived to work on 5/2/26 approximately 10:38 am and worked until 10 pm. Staff F stated when she arrived, Resident #3's husband had left for the day and she was very agitated, yelling she wanted him. Resident #3 refused to walk after the first fall so she would be propelled in a wheelchair. Staff F stated she assisted Resident #3 into the wheelchair and pushed her through the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	halls until it was supper time. Staff F stated Resident #3 calmed down until after supper when she wanted to go to her room. Staff F stated Resident #3's bedroom door was open and she could see her room. Staff F stated Staff H, CNA partner was going on break, so they assisted Resident #3 into the recliner in the common area. Staff F stated Resident #3 wanted to have her feet down and a blanket. Staff F stated Staff H went on break. Staff F stated she was helping another resident who was pacing around and was able to get him to sit at the table to color. Staff F stated it was calm for about 10-15 minutes then Resident #3 stood up, took a step, and before she could get up from the table, Resident #3 was on the floor. Staff F stated Resident #3 was in pain as she hit her head and said her hip hurt. Staff F stated she called on the walkie for assistance and Staff G, LPN responded, assessed Resident #3 and said to stand her up because she was ok. Staff F stated Resident #3 was not ok, her hip hurt, and informed Staff G to call 911. Staff F stated Staff G did not want to send Resident #3 out of the facility. Staff F stated Resident #3's husband would not like this so she called Staff E, LPN to assess Resident #3. Staff F stated Staff E responded and said she heard the earlier call for help, she checked Resident #3 and said she would call the husband. Staff F stated her partner returned from break and Resident #3 was sent to the hospital. Staff F stated she would report to the nurses that Resident #3 was anxious and yelling every night. Staff F stated Resident #3 tried to get up herself and when she was in a wheel chair, she would go to the door to try to leave. Staff F stated staff in the day shift was two CNA's, a float person and others to help. Staff F stated staffing during the 2-10 shift only and when a break was needed, she would walkie for supervision and would receive a slow response or didn't come. Staff F stated she was by herself when the other person went on breaks and at night time there was only one staff per unit. During an interview on 6/25/26 at 10:39 am, Staff H, CNA stated she worked on 5/2/26 with Staff F, CNA. Staff H stated Resident #3 was assisted to the recliner with her feet up. Staff H stated there was a male resident up and wandering and 4-5 other residents sitting in recliners. Staff H stated she went to break at approximately 6:30 pm. Staff H stated when she returned, Staff F stated that Resident #3 fell. Staff H stated she observed Resident #3 in a wheelchair and obviously in pain. Staff H stated she did not see Staff G, LPN perform an assessment but witnessed Staff G call Staff E, LPN on the walkie to come to assist. Staff H stated Staff E arrived, assessed the cut on Resident #3's head and the nurses called 911. Staff H stated she was not working the day Resident #3 broke her first hip but remembered no one was able to say how it happened. Staff H stated Resident #3 usually had the behaviors in the evening, asking for her husband and trying to get up out of the recliner to look for him. Staff H stated she would assist Resident #3 into a wheelchair and walk her, tried food, colored, none of the interventions worked. Staff H stated conversation helped Resident #3 for a little bit then she snaped back to the bad behaviors. Staff H stated she would tell the nurse, usually they come in observe and do things to calm her down. Staff H stated the nursing staff was aware of Resident #3's behaviors. During an interview on 6/25/26 at 10:54 am, Staff G, Licensed Practical Nurse (LPN) stated the 2-10 shift must be two staff at all time on each unit. Staff G stated the CNAs communicate on the walkie for supervision assist then they go on break and she will go supervise. Staff G stated she did not receive a call on the walkie in the evening of 5/2/26 until Resident #3 was on the floor. Staff G stated Resident #3 would get more confused in the evening and wanted her husband. Staff G stated she would have to call him often to calm his wife. Staff G stated if staff was not sitting right next to Resident #3, she will get up. Staff G stated when she arrived to the unit, Resident #3 was on the floor near her bedroom door. Staff G stated Staff F, CNA reported she was wiping down the dining table after supper and the other CNA was on break. Staff G stated she had told Staff F that she must be supervising residents. Staff G stated Staff F reported by the time she seen that Resident #3 was out of the recliner, she had fallen to the floor. Staff G stated Resident #3 could voice herself, but at that time she was quiet, not complaining of pain. Staff G stated Resident #3 could only walk a little if a staff was with her and used her walker, but she could not walk by herself. Staff G stated after her assessment, she assisted Staff F to lift Resident #3 to a wheelchair and then put her to bed. Staff G stated when Staff H, CNA (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	returned to the unit, Resident #3 was in bed. Staff G stated Staff E, LPN entered the unit and received a report that Staff C, ARNP directed to send Resident #3 to the ER for the head injury and was on a blood thinner. Staff G stated she notified the husband. Staff G stated she was not aware Resident #3 had a fractured hip and was not aware of a urine infection. Staff G stated she remembered on the first of March 2026, Resident #3 had decreased mobility and the nurses couldn't figure out what happened to her. Staff G stated it was an unknown injury and the other nurses were concerned for 2-3 days. Staff G stated, we knew something was not right and requested an x-ray. Staff G stated the nurses were unaware Resident #3 had the fractured hip. During an interview on 6/29/26 at 1:39 pm, Staff E, LPN stated she had worked on 5/2/26 on the 2-10 shift. Staff E stated she was aware that Resident #3 was agitated as she had observed Staff F, CNA propelling Resident #3 by wheelchair in the halls to calm her. Staff E stated after dinner she heard a call on the walkie for a nurse then was requested by Staff G, LPN to go there. Staff E stated she found Resident #3 in a wheelchair in the common area with a laceration to her head. Staff E stated Staff G explained Resident #3 got up and fell. Staff E stated she assisted with the assessment of the laceration on the back of Resident #3's head and remembered it was deep. Staff E stated that Staff G had notified Staff C, Advanced Registered Nurse Practitioner (ARNP) who gave an order to send Resident #3 to the emergency room (ER) for further evaluation as she was on Eliquis (a blood thinner). Staff E stated the husband asked if it could be treated at the facility and explained it was a deep laceration and needed further treatment. Staff E stated the prior doctor would have the nursing staff complete neurological assessments for 72 hours and the new provider said if the resident was not symptomatic, but this was a head injury on a blood thinner. Staff E stated that Resident #3 was sent to the ER due to the head injury. Staff E stated Resident #3 was responding and her vitals were good so she returned to her own unit. Staff E stated all of the residents were in the common area and Staff F, CNA was the only staff in that unit as her partner was on a break. Staff E stated Staff F said she got up to put something in the trash and Resident #3 fell. Staff E stated breaks were based on the environment. Staff E stated in the evenings, the facility was not staffed with a float person and the nurse had to be the person responding to calls for supervision. Staff E stated Resident #3 had behaviors in the evenings and needed to be monitored closely. Staff E stated that same unit had another resident with wander behaviors and she voiced the need to have the extra person due to high behaviors in the evenings. Staff E stated the nurse had to respond to help supervise and that made the nurse late for passing medication. Staff E stated the Director of Nursing (DON) was new and replied you can handle it, but we can't. During an interview on 6/25/26 at 12:25 pm, the DON stated the facility was staffed to have two people on each unit ideally. The DON stated the staff are to call on the walkie to ask for supervision assistance when one of the two go on their break. The DON stated the expectation for nursing was to do complete assessments and when interventions are not effective to notify management. The DON stated a full investigation should have been completed for Resident #3 following the identification of the fractures. The DON stated she was aware that Resident #3 had a urinary infection identified on admit to the hospital from the fall in May 2026 and was planning to have her urine re-checked. During an interview on 6/25/26 at 1:08 pm, the Administrator stated the reason they staffed the units with two staff was in response to a supervision incident in the past but it was not made into a policy. The Administrator stated Resident #3's injury identified on 3/5/26 should have been reported and investigated. The Administrator stated he was not aware that Resident #3 had urinary tract infections when she was admitted to the hospital for the hip fractures on 3/5/26 and 5/2/26 and that could have contributed to the situations. The Administrator stated the investigation for the fall on 5/2/26 could have been more complete and more discussion to the need for more in-depth analysis with the Quality Assurance (QA) team to determine the true root cause. The Administrator stated the DON had (continued on next page)

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	06/30/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	been in her position for a short period of time and they were learning. Document titled Fall assessment dated [DATE] revealed: 1. To identify residents who are at risk for falls. 2. To implement interventions to prevent or reduce the incidence of further falls. Fall Risk Assessment: a. Residents will be assessed for fall risk on admission to the facility along with quarterly assessments and/or significant change in status. b. Residents identified as high risk for falls will have fall interventions implemented. c. Interventions for reducing the residents' risk for falls will be resident-specific and based on assessment findings. Protocol: a. When a resident was observed or discovered to have fallen, the staff present, if not the charge nurse, will immediately radio the Charge Nurse to the neighborhood. b. The charge nurse will assess the resident for injury and provide emergency first aid if needed. c. If there is suspected major injury, the charge nurse will notify the physician and the POA immediately. d. If the physician and the POA choose for emergency treatment, the charge nurse will facilitate transfer to the chosen acute care setting. e. If the resident has a known head injury, resident was observed hitting their head, or the fall was unwitnessed, neurological checks will be implemented as follows: Full vital signs, orientation, level of consciousness, pupil size and reaction, response to verbal commands, pain, and movement of extremities. Neurological Assessment are as follows: i. Initial ii. Every 15 minutes x2 iii. Every 1 hour x2 iv. Every 2 hours x2 v. Every 4 hours x2 vi. Every shift x6 d. If at any time the nurse assesses a change in neuro status the physician will be contacted. 2. The comprehensive MDS for Resident #4, dated 4/22/2026, documented the following relevant diagnoses: aftercare following joint replacement surgery, ataxic gait (unsteady walking), muscle (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	weakness (generalized), cognitive communication defect, chronic obstructive pulmonary disease (COPD), Alzheimer's disease with late onset, dementia, bilateral primary osteoarthritis of knee (arthritis in both knees), difficulty in walking. It documented her need for assistance with transfers and walking as partial/moderate assistance and supervision/touch assist with ambulation. The Care Plan, last revised 04/16/2026, documented the resident suffers from a self-care deficit due to her right hip replacement and requires 1-2 staff for transfers. The Nursing Progress Notes from 04/03/2026 through 06/30/2026 document the resident's primary mode of transportation is her wheel chair and uses the assistance of two staff members for transfers. A direct observation on 06/23/2026 at 12:10 PM revealed Resident #4 being transferred by two staff members, identified as Staff K, CNA, and Staff L, CNA. During the observation Staff K placed a gait belt on Resident #4, then both Staff K and Staff L gripped the resident's forearms and pulled her out of her recliner and transferred her to a seated position in her wheelchair. During the transfer Resident #4 was observed to repeat Ow, ow, ow as staff members gripped her forearms, which ceased as soon as the transfer was complete. The resident was observed to rub her forearm after the transfer, though no injury was visible. 3. The comprehensive MDS for Resident #6, dated 05/26/2026, documented the following relevant diagnoses: unspecified dementia, chronic fatigue, ataxic gait, generalized muscle weakness. It documented her need for assistance with transfers and ambulation as being supervision or touching assistance. The June Medication Administration Record (MAR) documented the resident was on the following medications: aspirin 81mg (anticoagulant).The Nursing Progress Notes from 06/13/2026 note bruising to both arms/hands with an unknown origin. The Care Plan for Resident #6, last revised on 06/12/2026, documented the resident's need for an assist of one staff member when transferring and ambulating. A direct observation on 06/23/2026 at 10:13 PM revealed Staff M, CNA, assist Resident #6 to a seated position by using her forearm to ease her into her chair. Minutes later the resident requested to get out of her chair and Staff M placed the gait belt on the resident, then pulled her up by her forearm. Resident #6 is noted to have hand-shaped bruising present on her forearm where the staff member grabbed her to assist her to standing. A direct observation on 06/30/2026 at 08:45 AM showed Staff K transferring Resident #6 using her forearm to pull her up from a seated position. At 08:49 AM Staff K used the resident's forearm to lower her to a seated position from standing. In an interview on 06/30/2026 at 09:14 AM Staff N, CNA, stated the process for transferring a resident is to place a gait belt on the resident, then use the gait belt to pull them to a standing position or lower them to a sitting position. She stated she has been told not to pull the resident up by the forearm because it could injure them. She stated Resident #4 and #6 are not known to refuse use of the gait belt. In an interview on 06/30/2026 at 09:59 AM Staff O, CNA, stated she is supposed to put the gait belt on a resident then use it to help them transfer. She stated she never grips a resident by the forearms for transfers because she doesn't want to bruise or hurt the resident. She stated she is only allowed to hold on to the gait belt during transfers. In an interview on 06/30/2026 at 09:19 AM Staff Q, Certified Medication Aide (CMA), stated if a resident needs assistance to stand you first place the gait belt on the resident, then use the gait belt to assist the resident to their desired position. She stated she was instructed to avoid pulling on a resident's arms or forearms for transfers but she did not know why. She added she assumed it was because it could cause issues with skin integrity or break bones. In an interview on 06/30/2026 at 10:09 AM Staff P, Licensed Practical Nurse (LPN), stated that transfers with one or two assist for residents who don't use a mechanical lift require a gait belt. They are instructed to use the gait belt to assist the resident to a seated or standing position and not to grab other parts of the resident's body, as it is a high risk