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	06/06/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review and staff interviews, the facility failed notify the long term care ombudsman for a resident transfer to an acute care hospital for 1 of 2 residents reviewed for hospitalization (Resident #36). Findings include: The Minimum Data Set (MDS) dated [DATE] of Resident #36 documented the resident transferred to an acute care hospital on 2/4/24. The Census Line portion of the Electronic Health Record (EHR) reflected a transfer out of facility date of 2/4/24 and a transfer into facility date of 2/8/24. The facility document Notice of Transfer Form to Long Term Care Ombudsman failed to include Resident #36 in the report for transfers which occurred during the month of February 2024. On 6/5/24 at 1:34 pm, the Business Office Manger (BOM) stated her procedure is to run an admission and discharge report on Point Click Care (PCC, the software program for the electronic health records). She stated when she ran the report, Resident #36's name was not on the report. The BOM additionally ran a sample report during the interview for the dates in question and again, Resident #36's name was not included in the report. She checked his census line in his EHR and stated the transfer out and transfer in were correct and she did not know why his name did was not generating on the report. On 6/5/24 at 1:56 pm, the Administrator stated she had called Information Technology (IT, software support). She stated IT will be looking at the reports and the settings to see if there is an error in the report running. In an email dated 6/6/24 at 12:16 pm, the Administrator stated the facility does not have a policy regarding Ombudsman notification but the procedure is to send the spreadsheet every month.

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 0684 Level of Harm - Minimal harm or potential for 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** 34817 Based on clinical record review, observations, staff interviews, and policy review, the facility failed to document skin assessments for one of two residents reviewed for skin conditions (Resident # 9). The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 9 had diagnosis of non-Alzheimer's dementia and diabetes. The MDS indicated the resident required partial to moderate assistance for bed mobility and dependent for transfers. The MDS documented the resident had a risk for pressure ulcer, and had a Stage 2 pressure ulcer that was present upon admission. The Care Plan initiated on 3/16/24 and revised on 4/8/24 revealed the resident had impaired skin integrity related to a Stage 2 pressure ulcer to the coccyx. The pressure ulcer was present upon admission. The care plan also indicated the resident had a self-care deficit and impaired mobility related to dementia. The Care Plan directed staff to perform a skin assessment weekly. The order summary report revealed a skin check with updated pictures and a Skin and Wound Total Body Skin Assessment completed every Friday on the evening shift started on 3/8/24. Review of the skin and wound assessments for Resident #9's Stage 3 pressure ulcer on the sacrum revealed a skin and wound assessment documented on 3/6/24, 3/25/24, 3/27/24, 4/4/24, 4/24/24, 5/3/24, 5/8/24, 5/24/24, and 6/2/24. Of these assessments, only three of the assessments had wound measurements documented: 3/6/24 (present on admission) =1.8 centimeters (cm) length (l) x 0.9 cm width (w) 3/27/24 5.5 cm x 2.0 cm 5/8/24 9.9 cm x 2.6 cm In addition, skin and wound assessments of a moisture associated skin disorder (MASD) on the rear left thigh were documented on 5/8/24, 5/24/24, 5/30/24, and 6/2/24. None of these assessments had wound measurements documented. Progress notes revealed the following: On 6/3/24 at 1:01 PM, culture obtained from the left gluteal fold wound. The wound had a palpable mass and the left buttock wound had redness. Resident continued on an antibiotic for this area. Review of the facility's electronic health record lacked other skin or wound assessments. Observations on 6/6/24 at 7:30 AM with Staff D, Licensed Practical Nurse (LPN), revealed an open wound on the left lower buttock and gluteal fold, and a nickel-sized wound and redness (MASD) to the coccyx area and buttock area, as well as an intact blister to his left heel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 6/4/24 at 2:12 PM, Staff E, Certified Medication Aide (CMA), reported the nurse completed the residents' skin assessments. Staff E reported she would let the nurse know if she found a skin related concern such as a bruise or open area. She would also fill out a stop and watch form about the concern. In an interview 6/4/24 at 2:15 PM, Staff F, Registered Nurse (RN), reported the nurse completed the residents' skin assessments at least weekly. Skin assessments are documented on the Medication Administration Record (MAR). If the resident had an open wound, a skin assessment documented in the EHR under the assessment tab. In an interview 6/4/24 at 2:42 PM, Staff G, RN, reported skin assessments documented at least weekly on each resident. They tried to perform a skin assessment whenever the resident had a shower but sometimes the CNA called the nurse during cares for the nurse to check the resident's skin. Staff G reported skin assessments documented in the EHR under the assessment tab, and also marked on the MAR. In an interview 6/4/24 at 3:00 PM, the Director of Nursing (DON) reported the nurses completed resident skin assessments and documented the assessment under the skin and wound assessment in the EHR. The nurses used an app on their phone to take pictures of the wound and it automatically provided wound measurements. The DON stated they had a Performance Improvement Plan (PIP) regarding wounds. In a follow-up interview 6/5/24 at 3:00 PM, the DON confirmed Resident #9's skin assessments don't include skin measurements on all of the skin assessments documented. She had done audits and educated staff about skin assessments and to use a sticker dot whenever they took a picture in order to get the wound measurements or staff needed to manually take wound measurement using a round transparent measurement device available at the facility. If staff used the dot placed by the wound, the app automatically calculated the measurements. The DON reported they hired a nurse to do skin assessments but she is no longer at the facility. In the interim, staff nurses were assigned to do the resident skin assessments weekly. A skin assessment policy revealed the facility's goal that each resident remained as free as possible of avoidable skin damage. To accomplish this, a skin assessment completed and documented weekly, and as needed, on each resident. A Quality Assurance Performance Improvement (QAPI) Action Plan dated 4/15/24 revealed the weekly skin assessments and wound assessments not completed in a timely manner by the nurses. A Root Cause Analysis identified the staff's knowledge deficit in the expectation of skin assessments and the usage of the EHR. Education on assessment charting completed on 4/19/24, and 5/23/24. An audit done 6/6/24 during the survey week, and individual nurses notified of any deficiencies.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observation, staff interview, and policy review, the facility failed to ensure staff provided incontinence care to minimize the risk of cross-contamination and minimize the risk of urinary tract infections for one of four residents observed for incontinence care (Residents #26), and failed to utilize infection control techniques and changed gloves when contaminated while providing incontinence cares. The facility reported a census of 51 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had diagnoses of Alzheimer's Disease and dementia. The MDS documented the resident had severely impaired cognition, and require substantial to maximum assistance for toileting hygiene, bed mobility, and transfers. The MDS also indicated the resident had incontinence. The care plan revised on 5/29/24 revealed Resident #26 had a self-care deficit and incontinence due to dementia. The care plan directed staff to check and change the resident and observe for signs of a UTI (urinary tract infection) (increased confusion, changes in behavior, frequency, urgency, concentrated, foul smelling urine). During observation on 6/4/24 at 3:27 PM, Staff A, certified nursing assistant (CNA), and Staff B, CNA, donned a pair of gloves. Staff B placed wet washcloths inside a plastic bag and placed the plastic bag by the bed. At 3:30 PM, Staff A and Staff B used a mechanical lift and transferred Resident #26 from a Broda chair to the bed. Staff A and Staff B removed the resident's pants and brief. Staff A took a wet folded washcloth, sprayed peri-wash foam onto the washcloth, then took the washcloth and cleansed across the resident's lower abdomen and groin, then down the front, folding the washcloth between each swipe. Staff A cleansed the labia, she pushed the soiled washcloth down and left the washcloth between resident's inner thighs. Staff A and Staff B rolled the resident onto her right side. At 3:38 PM, Staff B removed the soiled brief that was rolled under the resident. A moderate amount of stool observed on the resident's buttocks and leg creases. Staff B told Staff A she was going to need more washcloths. Staff A told Staff B to pull the washcloth out between the resident's legs and use it. Staff B reached between the perineum and thighs and pulled the soiled washcloth from under the resident, then folded the washcloth over and wiped the lower buttocks. Staff B placed the soiled washcloth into the trashcan next to the bed. Staff B then took another wet washcloth and cleansed the buttocks and gluteal creases, wiping in a downward fashion between the buttocks toward the perineum. Staff B folded the washcloth over and wiped a couple of times from back to front. Staff B reported she needed to get more washcloths. At this time, Staff A told Staff B she needed to change her gloves. Staff B removed her gloves, then obtained additional wet washcloths and returned to the bedside. Staff B proceeded to cleanse between the buttocks and the buttocks area from the upper buttocks toward the perineum (back to front). Staff A placed a clean brief under the resident. Staff B applied barrier ointment to the buttocks wiping in a downward and circular motion toward the perineum, and attached the brief tabs, then removed her gloves. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 6/4/24 at 3:00 PM, the Director of Nursing (DON) reported she expected staff cleansed from front to back whenever performed incontinence/ peri-care, and changed gloves whenever soiled or contaminated. An undated peri-care skills checklist revealed the following procedural steps: a. Assemble supplies (washcloth, peri-wash, and barrier cream) b. Wash hands and don gloves c. Removed soiled brief d. Remove gloves. Sanitize hands and don gloves e. Wipe across lower abdomen and down each groin while folded the washcloth after each wipe. f. Separate the labia and cleanse each side, folding the washcloth after each wipe, and always cleanse from front to back. g. Turn the resident onto the side. Wash buttocks and upper thigh and each hip, then wash the anal area front to back. Dry thoroughly. Replace pad and new brief. h. Remove gloves and wash hands. i. Apply moisture barrier j. Remove gloves and sanitize hands

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49990 Based on Centers for Medicare and Medicaid (CMS) Payroll Based Journal (PBJ) data, facility document review, and staff interviews, the facility failed to maintain a Register Nurse (RN) for at least 8 consecutive hours a day. The Facility reported a census of 51. Review of the CMS Payroll Based Journal data revealed the facility did not report an RN in the facility for a 48-hour period starting on 11/04/23 until the end of day on 11/05/23. Review of the staffing schedule provided by the Administrator on 06/05/24 at 08:19 AM confirmed the Payroll Based Journal data. There was not an RN in the facility for a 48-hour period starting on 11/04/23 and ending end of day 11/05/23. Review of the facility assessment last updated in 12/23 did not state the daily staffing requirements. In an interview on 06/06/24 at 11:37 AM, Staff C, Certified Nursing Aide (CNA), stated that the facility lets the staff know if there isn't an RN in the building. He stated the CNAs ask who the nurse in charge is when they come on shift. He stated he did not know of any time in the last six months where an RN was not in the facility for at least 8 consecutive hours a day, but believed it may have happened once at the end of 2023. In an interview on 06/06/24 at 09:50 AM The Director of Nursing (DON), acknowledged that an RN is required to be in the facility for 8 consecutive hours, seven days a week under current CMS rules. She stated herself and the Assistant Director of Nursing (ADON) have alternating on call schedules and her expectation is the nurse leader on call will be present in the facility in an event they are made aware an RN is not scheduled in a 24-hour period or in the event the only RN for the 24-hour period is not in the facility. She stated she did not recall the period of 11/04/23 to 11/05/23. In an email from the Administrator on 06/06/24 at 11:19 AM, she revealed the facility schedules at least one RN or Licensed Practical Nurse (LPN) per shift. If they lack an RN they will schedule two Medication Aides or one additional LPN. The facility schedules 13 Certified Nursing Aides (CNA) for the morning shift, 12 CNAs for the afternoon shift, and 7 CNAs for the overnight shift. The email stated they did not have a policy that stated an RN is required to be on the premise 8 consecutive hours a day, seven days a week. In an email from the Administrator on 06/05/24 at 12:08 PM the Administrator stated the facility did not have RN coverage on 11/04/23 or 11/05/23.