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	05/29/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on employee file review, staff interview, and policy review, the facility failed to ensure completion of dependent adult abuse training within six months of hire for 1 of 5 employee files reviewed. The facility reported a census of 53 residents. Findings include: Employee record review of Staff P, Certified Medication Aide, showed a hire date of 9/7/23. The file lacked documentation of Staff P completing dependent adult abuse training within six months of their hire date or annually. During an interview on 5/29/25 at 2:00 PM, the Director of Nursing (DON) confirmed the lack of dependent adult abuse training documentation for Staff P. The policy Abuse Prevention, Identification, Investigation, and Reporting Policy, revised 4/1/17, outlined the following: 1. Employees are required to complete two hours of training related to identification and reporting of dependent adult abuse within six months of initial employment 2. All nurses' aides will receive initial and annual resident abuse prevention training.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. Building B. Wing	05/29/2025

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 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** Based on record review, observation, resident and staff interview, and policy review the facility failed to document follow up skin assessments for 1 of 3 residents reviewed for skin concerns (Resident #2). The facility reported a census of 53 residents. Findings include: The admission Minimum Data Set assessment (MDS) dated [DATE] revealed Resident #2 admitted to the facility on [DATE] and had diagnoses of a left femur fracture and Alzheimer's Disease. The MDS indicated the resident had a risk for pressure ulcers but had no skin issues. The MDS recorded the resident had a Brief Interview for Mental Status score of 11, indicating moderately impaired cognition. The Care Plan initiated on 5/6/25 revealed the resident had a stasis ulcer on the right outer ankle related to peripheral vascular disease. The Care Plan also documented the resident took aspirin post-surgically. The Care Plan directed staff to utilize a pressure reduction mattress and document adverse reactions of antiplatelet therapy such as bruising. An admission Skin Observation Tool dated 4/29/25 revealed Resident #2 had a skin tear on the left elbow, a surgical incision to the left thigh, and a stasis ulcer to the right ankle. The Skin Observation Tool lacked measurements of the wounds. The Skin & Wound Evaluations revealed the following: a. A right ankle arterial stasis ulcer 4/30/25 1.8 centimeter (cm) x 1.4 cm 5/24/25 1.8 cm x 1.6 cm The Skin and Wound Evaluations dated 4/30/25 and 5/24/25 lacked further information such as drainage, odor, and appearance of the wound. The resident's record lacked further documentation of skin assessments of the right ankle between 5/1/25 to 5/23/25. b. A skin tear to the left lateral calf and a bruise to the right upper (inner) arm on 5/28/25 but no wound measurements or documentation related to the wound appearance. The Treatment Administration Record dated 5/1/25 to 5/31/25 revealed orders for the following: a. Complete Skin and Wound Total Body Skin Assessment and update pictures every Thursday on the evening shift had a start date 5/1/25. b. Apply honey ointment and Mepilex dressing to the right ankle every 3 days, had a start date 5/6/25. The Progress Notes revealed the following: (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	05/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 4/29/25 at 1:49 PM, the resident admitted to the facility and had a stasis ulcer to the right ankle. b. On 5/8/25 at 2:18 PM, ulcer on right ankle. c. On 5/27/25 at 3:00 PM, skin warm and dry. Stasis ulcer on right outer ankle. The Progress Notes lacked documentation of skin concerns or bruises to the resident's arms. Observation on 05/28/25 at 12:00 PM, Resident #2 had a large dark purple bruise to her left forearm. The right posterior arm had three small scabs. Resident #2 reported she told the staff to go slow and easy with her when they were changing and moving her because she had parts of her body that really hurt. In an interview 05/28/25 at 02:09 PM, the Director of Nursing (DON) reported skin assessments completed by the nurses. Weekly skin assessments were documented on the Medication Administration Record (MAR). The nurse documented the skin assessment on a Skin and Wound Assessment whenever a skin issue is found. The DON reported she had worked as the DON for only 3 weeks, and during this time, she had identified skin assessments were not getting done. In an interview 05/28/25 at 04:00 PM, the DON reported Resident #2's family member voiced concern about bruises to the resident's arms on Thursday 5/22/25. The DON stated she spoke with Staff K, Licensed Practical Nurse (LPN), and requested him to do a skin assessment. The DON reported she did not find any skin assessment documentation on Resident #2. She spoke with Staff K and told him he needed to document in the electronic health record (EHR). The DON reported she thought the bruises had occurred when staff transferred her. The resident also took medication that increased the chance of bruising. In an interview 05/29/25 at 08:12 AM, Staff N, Certified Nursing Assistant (CNA), reported she would report to the nurse if a resident had a change in condition or a skin concern such as bruises. Staff N reported she had not noticed any bruises on Resident #2 recently. She normally checked and changed the resident as needed during the night. Staff N reported when Resident #2 said they were hurting her. Staff N stated she stopped what she was doing, let the resident know what she was doing and asked her to turn so they could change her. Staff N stated she let the nurse know the resident thought staff were hurting her. The nurse directed the staff to have two staff whenever they performed cares with Resident #2. This intervention started approximately two weeks ago. In an interview 05/29/25 at 08:40 AM, Staff M, LPN, reported a Stop and Watch done whenever a resident had a change in condition. She did an assessment, notified the physician, placed the resident on a 24-hour watch (hot chart), and monitored the skin issue weekly until the area had resolved. Staff M reported the nurse assessed any skin concerns, took pictures and measured the area. Staff M confirmed skin assessments documented under the assessment tab in the EHR. The skin assessments were completed by the day shift nurse. Staff M stated she followed the facility's skin protocol and entered a Progress Note, but did not fill out an incident report whenever a skin concern was found. Staff M stated she did not remember Resident #2 having any skin issues, and indicated nothing flagged or popped up on the computer about something that needed attention. The resident used a mechanical stand lift. Staff M reported she did not notice anything when she assisted Resident #2 out of bed the last time she worked with the resident. (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	05/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 05/29/25 at 08:58 AM, Staff L, CNA, stated she reported to the nurse if a resident had a change in condition or skin concern such as a bruise or a wound. The nurse checked the resident's skin normally when the resident was in the shower. Staff L stated she had not noticed any bruises on Resident #2, except for a bruise on her hip when she first admitted to the facility. In an interview 05/29/25 at 12:53 PM, Staff K, LPN, reported he mainly worked the evening shift. Staff K stated he reported a change in the resident's condition to the DON and also documented an assessment or Progress Note about a change in the resident's health status. Staff K reported if he noticed a bruise on the resident, he tried to determine how the resident got the bruise. Staff K confirmed he observed Resident #2's skin the prior week. He was unable to open the phone app and therefore did not obtain skin measurements or document the skin assessment at that time. Resident #2 got irritated waiting and said she was getting cold. At that time, Resident #2 had bruises on her arms and legs. He documented a Total Body Assessment in the computer. Resident #2 didn't tell him how she got the bruises. Staff K stated he reported the resident's bruises and the inability to take pictures of the areas to the overnight shift. In an interview 05/29/25 at 09:41 AM, the DON reported she expected skin assessments completed weekly and whenever a new skin concern identified. She also expected the nurse to document a skin assessment under the Assessments tab in the EHR and fill out an incident report. In an interview 05/29/25 at 10:38 AM, Staff J, Registered Nurse (RN), reported skin assessments documented in the EHR on the MAR weekly, and on the Skin and Wound Assessment whenever a resident had a wound or skin condition. In an interview 05/29/25 at 12:21 PM, the DON reported Staff K documented the skin assessment on Resident #2 under the Total Body Skin Assessment. Staff K told the DON Resident #2 bruises were not measured because the camera wasn't working. A Self-Identification and Correction Form dated 5/27/25 revealed the facility's nurse consultant and interim DON self-identified skin concerns not being updated weekly on 5/19/25. Head to toe assessments completed on all residents. The Facility's policy titled A Use of Stop and Watch Communication Form dated 7/19/18 revealed a Stop and Watch form filled out whenever a change in the resident's condition identified including any new skin issues. The charge nurse completed a thorough assessment and put an intervention in place to address the Stop and Watch form. The DON/ ADON (Assistant Director of Nursing) reviewed the Stop and Watch form for accurate assessment and intervention.

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	05/29/2025

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 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. Based on direct observation, staff interview, and clinical record review, the facility failed to protect residents from potential accidents and hazards for 1 of 16 residents reviewed (Resident #46). The facility reported a census of 53 residents. Findings include: The quarterly Minimum Data Set (MDS) for Resident #46, dated 04/29/2025, documented the following relevant diagnoses: Alzheimer's disease and muscle weakness. It did not document the resident using a wheelchair. The Care Plan for Resident #46, last revised on 05/23/2025, documented the resident uses a wheelchair as his primary means of locomotion. It documented the resident is dependent on staff for locomotion with his wheelchair. A direct observation on 05/27/2025 at 11:03 AM revealed Staff E, Certified Nurse Aide (CNA), pushing Resident #46 in a wheelchair with his feet dragging on the floor in socks. The resident was pushed like this from the unit living room to the dining room. The resident was observed to kick his feet erratically, alternating from dragging under his wheel chair to kicking out in front of and to the side of his wheel chair. A direct observation on 05/27/2025 at 11:57 AM revealed a second improper transfer by Staff E, CNA. During the transfer, Staff E placed one of Resident #46's feet into a wheelchair foot pedal, but did not place the second foot in the pedal before pushing him from his place at the dining room table to another table. During the observation, Resident #46's foot was again visualized to be dragging under the wheel chair. A direct observation on 05/27/2025 at 12:15 PM showed Staff E, CNA, again moving Resident #46 in his wheel chair. This time with one foot still on the foot pedal and the other dragging under the wheel chair. During the observation, the resident's foot was nearly run over by the wheel chair wheels as it dragged. In an interview on 05/29/2025 at 09:03 AM with Staff I, CNA, she stated the proper procedure for pushing a resident in a wheel chair is to first ensure their feet are elevated on foot pedals. She stated she had mentioned the improper transfers to Staff E late in the day on 05/27/2025. She stated residents can fall and hurt themselves if their feet are not up during wheel chair locomotion. In an interview on 05/29/2025 at 09:12 AM with Staff H, Certified medication aide (CMA), she stated all residents undergoing wheel chair locomotion are supposed to have their feet up and in the foot pedals at all times. She stated they cannot push a resident without foot pedals. She stated she has seen residents injured in this way in the past. In an interview on 05/29/2025 at 10:03 AM with Staff G, CNA, she stated a resident has to have their feet up on pedals when being pushed or pulled in a wheel chair. She stated that if their feet drag on the ground it could cause abrasions, and residents have fallen in the past. (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	05/29/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/29/2025 at 11:04 AM with the Director of Nursing (DON), she stated the proper technique for assisting a resident with wheel chair locomotion requires a resident's feet to be up on the foot pedals of the chair. She stated her expectation is that staff monitor residents to ensure their feet are on the foot pedals and not dragging. During the survey, a facility policy regarding wheel chair locomotion was requested but not provided.

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	05/29/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had diagnosis of hypertension (high blood pressure). The Order Summary Report dated 5/28/25 revealed Metoprolol Succinate Extended Release (ER) 25 milligrams (mg) by mouth (PO) daily for hypertension. During observation on 05/28/25 at 07:59 AM, Staff O, CMA, prepared the following medications for Resident #1: Acetaminophen 650 mg PO Aspirin 81 mg PO Fluconazole 100 mg PO Furosemide 20 mg PO Metoprolol ER 25 mg PO Vitamin C 1000 mg PO Staff O crushed the pills, mixed the contents in applesauce, and administered the crushed medications to Resident #1. In an interview 05/28/25 03:18 PM, the Pharmacist reported an ER tablet or capsule should not be crushed. The Pharmacist reported the resident could receive too much of the medication at one time if an ER medication got crushed. Based on clinical record review, observations, staff interview, pharmacy interview, manufacturer recommendations, and policy review the facility failed to ensure a medication error rate of less than 5%. During observations of medication administration, the facility had 2 errors out of 30 opportunities for error resulting in an error rate of 6.67 % (Residents #1 and #21). The facility identified a census of 53 residents. Findings include: 1. The Order Review History Report dated 5/1/25-5/28/25 indicates Resident #21 has an order for Potassium Chloride Extended Release (ER) oral tablet 20 Milliequivalents (MEQ) one time a day with a start date of 10/26/24. It further indicates that medications may be crushed unless contraindicated by pharmacy with a start date of 2/15/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165548	A. Building B. Wing	05/29/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 05/28/25 07:36 AM Staff F, Certified Medication Aide (CMA) prepared and crushed Resident #21's Potassium Chloride 20 MEQ ER with the rest of her medications. Staff F mixed the crushed medications with grape jelly and was preparing to give them to Resident #21. At that time, the surveyor intervened and instructed Staff F not to give the medications as the Potassium Chloride can not be crushed. At 07:40 AM Staff F discarded the medications, and attempted to dissolve the Potassium Chloride in water but it would not dissolve. During an interview on 05/28/25 07:40 AM Staff F, CMA stated that Potassium Chloride cannot be crushed. Staff F stated the rest of the medications would be given separately and Staff A would be notified that Resident #21 needs an alternate form of Potassium Chloride. During an interview on 05/28/25 09:30 Staff A, Licensed Practical Nurse (LPN) stated she contacted the doctor about an alternate form of Potassium Chloride. During a phone interview with the pharmacy on 5/28/25 at 3:18 PM the pharmacist reported crushing extended release medication depended upon the medication. Metoprolol ER capsule can be opened, sprinkled and given with pudding but the capsule or tablet are not able to be crushed. Can open capsules but don't crush the contents inside. Resident could receive too much of the medication at one time if ER/ Delayed Release (DR) medication is crushed. Also, there could be a delay in receiving medication if delayed release medication is crushed. Potassium chloride ER tablet should not be crushed. Potassium could be dissolved in water but some potassium is micro dispersible and will not dissolve. Facility's Administration of Medications policy dated 3/1/21 documents that if the medications are ordered to be crushed due to difficulty swallowing, use the pill crusher. Crush the pill and then mix with water, pudding, applesauce or other depending on resident's preference. In addition, the facility policy lacked information regarding what medications could be crushed such as extended release.

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	05/29/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on direct observation, clinical record review, staff interview, and policy review, the facility failed to provide residents with prescribed therapeutic diets for 1 of 3 residents reviewed (Resident #30). The facility reported a census of 53 residents. Findings include: The significant change Minimum Data Set (MDS) for Resident #30, dated 02/14/2025, documented the following relevant diagnoses: gastroesophageal reflux disease (GERD), non-Alzheimer's dementia, seizure disorder, muscle weakness, and cognitive communication deficit. It documented the resident was rarely or never understood, and had severely impaired cognition skills. It further documented the resident was on a mechanically modified diet and required supervision and touch assistance while eating. The Care Plan for Resident #30, with a last revised date of 05/19/2025, noted the resident had a history of significant weight loss. It instructed staff to provide a therapeutic diet as ordered. It noted the resident's diet as being mechanically altered (mechanically soft diet), with soft or ground meat. A direct observation on 05/27/2025 at 12:26 PM, Staff C, dietary assistant, was observed bringing Resident #30 his lunch. He placed it in front of the resident, and Staff I, Certified Nurse Aide (CNA), began feeding Resident #30. While feeding the resident, it was observed Staff I looked confused before she began to feed the resident a bite of the soup. When approached, it was noted there were large chunks of what appeared to be beef and vegetables in the stew. Staff I was asked to take a piece of the meat out of the soup bowl and attempt to cut and mash it, to see if it was appropriate for a mechanically altered diet that requires soft and ground meats. Staff I attempted to cut the meat, and it did not cut easily. She attempted to crush the chunk of meat with the back of a spoon, and the meat resisted compression and slid out from under the spoon intact. A call was placed to the dietary manager. In an interview on 05/27/2025 at 12:33 PM the dietary manager confirmed the bowl of soup Resident #30 had been served was not approved for his diet. She confirmed it was regular diet, and provided the resident with the mechanically altered diet alternative. In an interview on 05/29/2025 at 09:03 AM with Staff I, CNA, she stated it is the kitchen's responsibility to plate the food, they include the appropriate diet and the CNAs pick up and serve the food to the residents. She stated the diet card for Resident #30 reflected he was to receive a mechanically altered diet, and that she was going to serve the soup to the resident. When asked why she looked confused she stated it was because she knows soup can be served to residents on mechanically altered diets, but the meat chunks looked far bigger than mechanically altered soups usually had. She confirmed the meat she cut for the resident was tough, not at all soft enough. In an interview on 05/29/2025 at 09:12 AM with Staff H, Certified Medication Aide (CMA), she stated the kitchen is responsible for plating the food and the CNAs are responsible for serving it to residents. She stated if a CNA notices the wrong diet has been served they are to report the issue to the kitchen and not serve the resident the incorrect meal. (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	05/29/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/29/2025 at 11:04 AM with the Director of Nursing (DON), she stated CNAs are responsible for serving food to residents, dietary staff are responsible for plating food and matching it to the dietary card. Her expectation is that if a therapeutic diet is prescribed to a resident they received the correct therapeutic diet. In an interview on 05/29/2025 at 11:19 AM with the Registered Dietician, she stated Resident #30 had been on a mechanically altered diet for a significant period of time. She stated the resident does not have a diagnosis of dysphagia, but had been moved to a mechanically soft diet by hospice to promote intake and prevent weight loss. In an interview on 05/29/2025 at 11:32 with the Dietary Manager, she stated Resident #30 had been under the care of a different hospice provider at one point in time, and that the previous hospice provider had ordered a mechanically soft diet with pleasure feedings of normal textured foods. The resident had since switched hospice providers and the current order only recommended mechanically altered diet with ground meats. She stated she believed this is where the confusion had occurred. Review of a facility provided document titled Addendum to Simplified Diet Manual: Texture Altered Diets, with an effective date of 06/01/2024, stated the following: The Facility will offer the following diets for consistency alteration. The mechanical soft diet is designed to permit easy chewing. The general diet is modified in consistency and texture by cooking, grinding, chopping, mincing, or mashing. The diet includes foods soft in texture such as cooked fruit and vegetables, moist ground meats and soft bread and cereal products.

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	05/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and policy review, the facility failed to follow Enhanced Barrier Precautions (EBP) practices for a resident with an open pressure injury for 1 of 3 resident reviewed for pressure ulcer/injury (Residents #14). The facility reported a census of 53 residents. Findings include: The Minimum Data Set (MDS) for Resident #14, dated 3/21/25, indicated that Resident #14 had a Stage #3 pressure ulcer. The Care Plan revised on 3/24/25, revealed that Resident #14 had a pressure area to the right 4th finger. The Care Plan lacked staff directives for for EBP. During an observation 5/28/25 at 9:25 AM, Resident #14's room did not have signage outside or inside the door to indicate that EBP was in use. During an observation 5/28/25 at 9:30 AM, Staff A, Licensed Practical Nurse (LPN), performed wound care for Resident #14. Staff A did not wear a gown during the entire wound care process. During an Interview 5/28/25 at 10:00 AM, Staff A stated that the facility followed EBP in the facility. She indicated that EBP is utilized for residents with catheters and Multidrug-resistant Organisms (MDROs) She then stated that if EBP was for wounds, she was not aware. During an Interview on 5/29/25 at 11:29 AM, Staff J Registered Nurse (RN) stated wound assessments and pictures are on the phone and in PCC. States Resident #14 has a Stage 3 pressure to right 4th digit. Staff J stated they use EBP at this facility and that catheters, wounds, and MDROs are included. Gown and gloves are utilized for cares. Staff J stated that skin tears and bruises are not included in EBP. Staff J stated that DON decides who will be in EBP. When questioned if Resident #14 should be in EBP, Staff J stated, He probably should be. During an interview on 05/29/25 at 12:05 PM The Director of Nursing (DON) stated that she made the decision about who is placed in EBP. The DON stated that indwelling devices, chronic wounds that can't be covered, and MDROs are placed in EBP. Questioned why Resident #14 was not in EBP based on our conversation and the current policy. The DON stated, That's a good question. I have no answer for that. Questioned if Resident #14 should be in EBP and the DON stated, He should be and I will get him into EBP right away. Review of document titled Infection Control Program does not mention EBP utilization. Facility's undated Enhanced Barrier Precautions policy revealed EBP should be used when a resident has a wound such as a pressure ulcer and during high contact care activities such as wound care. Gown and gloves worn during high-contact care activities. The Center for Disease Control and Prevention (CDC) directs nursing facility staff to implement EBP for residents with wounds and/or indwelling medical devices, regardless of MDRO status, during high contact resident care activities to include wound cares and device care or use (https://www.cdc.gov/long-term-care-facilities/hcp/ prevent).