STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165593	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scottish Rite Park Inc	2909 Woodland Avenue Des Moines, IA 50312

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, policy review and the Resident Assessment Instrument (RAI) Manual, the facility failed to complete and transmit a resident Minimum Data Set assessment upon a resident's discharge within the required timeframe for one of fifteen residents reviewed (Resident #14). The facility reported a census of 31 residents. Findings include: The admission Minimum Data Set (MDS) assessment tool dated 4/14/25 revealed Resident #14 admitted to the facility on [DATE]. The Discharge (assessment- return not anticipated) MDS assessment dated [DATE] revealed the assessment completed on 6/25/25. The Electronic Health Record (EHR) under the Clinical Census tab revealed Resident #14 discharged from the facility on 5/10/25. A Nursing Notification: Planned Discharge revealed the resident discharged from the facility on 5/10/25 to home. In an interview 6/25/25 at 2:10 PM, the MDS Coordinator reported she completed and submitted the MDS assessments to Center for Medicare Services (CMS). She used an excel spreadsheet to keep track of the MDS assessments that needed completed. The MDS Coordinator reported an MDS assessment completed when a resident discharged from the facility to home or another facility. At the time, MDS Coordinator reviewed Resident #14's EHR with the surveyor. The MDS Coordinator stated Resident #14 admitted to the facility, discharged to the hospital, came back to facility, and then discharged to home. The MDS Coordinator reported she missed completing the Discharge MDS for Resident #14 when she discharged from the facility to home. She normally attended the care conference meetings to know when a resident would be discharging from the facility but she was on vacation at that time. In an email on 6/26/25 at 9:50 AM, the Director of Nursing (DON) wrote we do not have an official written policy for MDS. On 6/26/25 at 9:55 AM. the MDS Coordinator reported to the surveyor she completed and submitted Resident #14's discharge MDS assessment on 6/25/25. (continued on next page)

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

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Assessment Instrument (RAI) Manual dated 10/2019 revealed a discharge assessment - return not anticipated needed completed within 14 days after the discharge date and submitted to CMS within 14 days after the MDS completion date.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to follow the resident's Care Plan for one of thirteen residents reviewed. (Residents #28). The facility reported a census of 31. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #28 had diagnoses of cerebrovascular accident (CVA) (stroke), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting left upper and lower extremity. The MDS revealed the resident scored a 15 out of 15 for the Brief Interview for Mental Status (BIMS) for no concerns with cognitive status. The MDS also documented that Resident #28 had 0 of 7 days for splint or brace applied during the look-back period. The Care Plan initiated 12/31/24 documented the following focus for Resident #28 as follows: I have decreased mobility or function because I have a history of a stroke with left sided weakness. The Care Plan directed staff to place a brace on the left wrist overnight to help with prevention of contractures. The Electronic Health Record (EHR) indicated that this directive was placed on the Kardex. It was resolved on 6/24/25. The HCC Pocket Care Plan indicated a brace placed on left wrist overnight. This was removed 6/24/25. The clinical record lacked documentation for placement and removal of the splint. Observation on 06/23/25 1:09 PM revealed resident with decreased use of left upper and lower extremities. No splint or brace was noted to the left wrist at that time. A Physical Therapy Note dated 1/17/25 revealed Staff C, Physical Therapy (PT) documented that Resident #28 stated the left wrist brace was not being worn because Resident #28 and staff forget to put it on at night. The resident also reported that the nursing staff did not use the platform walker for transfers during the day. An Occupational Therapy Noted dated 6/23/25 revealed that Staff D, Occupational Therapist (OT) documented a goal to decrease pain and consistency in carryover of recommended Left Upper Extremity (LUE) splint wear. In an interview 6/23/25 at 1:09 PM Resident #28, stated he had a stroke affecting the left side and came to this facility around Christmas. In an interview 6/24/25 at 12:38 AM Resident #28, stated he had a splint at night but did not always get it. The Resident denied refusals and stated that some staff don't know how to put it on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at approximately 1:45 PM, the Director of Nursing (DON) reported no documentation of the application of the splint for Resident #28 was found. In a follow-up interview 6/24/25 at 2:15 PM, the DON stated the resident confirmed that the splint was not being put on. The DON stated she asked Resident #28 if he wanted the splint on, and Resident #28 declined stating it was not helping. Additionally, the DON stated splint application would be removed from the care plan. On 6/24/25 at 3:34 PM, Staff B OT, stated Resident #28 had pain and tightness at the max range of motion so recommended a splint be worn. In an interview 6/24/25 at 3:45 PM, Resident #28 stated he did not remember declining to use the splint. The Resident stated the splint started not too long after he arrived, and it was started by therapy. The Resident added that Staff B OT spoke with him today around noon, and stated that the splint would keep his hand from getting worse. Resident also stated that the staff would be trained on proper application. The Resident stated he would wear the splint. On 6/25/25 at 2:45 PM, the DON reported she could not produce any documentation of the splint being placed or taken off of Resident #28. No documentation of who took the splint off, and no Nurses Notes indicated refusals of the splint. The DON stated she did not know when he stopped wearing the splint, but took the splint intervention off the Care Plan and, the pocket Care Plan yesterday. The DON stated she will have OT offer the splint again if Resident #28 stated he will wear it. The Care Plan policy updated 1/21/25 indicated that a comprehensive care plan is developed for each resident based upon their care needs and desires, and that the care plan meet's the resident's medical, nursing, nutritional, safety and psychosocial needs.