STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER: Harmony West Des Moines		STREET ADDRESS, CITY, STATE, ZIP CODE: 5010 Grand Ridge Drive, West Des Moines, IA 50265	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50500 Based on observations, staff interview, and policy review, the facility failed to provide a barrier on top of the bed's blankets or change blankets when debris was present during completion of peri-cares for 1 of 3 residents reviewed for dignity (Resident #8). The facility reported a census of 94 residents. Findings include: The Minimal Data Set (MDS) of Resident #8, dated 8/29/24 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented Resident #8's primary medical diagnosis as debility/cardio-respiratory conditions. Specific medical diagnoses listed on the MDS included heart failure, diabetes, non-Alzheimer's dementia, asthma/chronic obstructive lung disease/chronic lung disease, and morbid (severe) obesity. The MDS indicated the presence of an indwelling catheter and the resident to be occasionally incontinent of bowel. Resident #8 required partial to moderate assistance for toileting hygiene, lower body dressing, transition from sit to stand, and transfers from chair/bed to chair. The Care Plan dated 9/10/24 documented a focus area of assistance with Activities of Daily Living and risk for alteration of bowel and bladder functioning related to impaired mobility. Interventions included staff offering and assisting with incontinence and toileting as needed. On 11/19/24 at 11:30 AM, Staff A, Certified Nursing Assistant (CNA), completed hand hygiene and donned the appropriate personal protective equipment upon room entry. Staff B, Assistant Director of Nursing (ADON), was also present during the observation. Staff A approached Resident #8 and informed him that she was there to complete personal cares. Staff A performed stand-by assistance as Resident #8 self transferred from a wheelchair to the bed. Resident #8 laid on top of his daily-use blanket. Staff A did not offer or provide a towel barrier for Resident #8 to lay on during personal cares. Staff A pulled down Resident #8 shorts and incontinence briefs and proceeded to clean abdominal folds and the groin area. Flakes of dried cream were observed coming off and landing on the blanket. After cares were completed, Staff A dressed Resident #8 and transitioned to emptying a urinary drainage bag. After all cares were completed, Staff A exited the room. The dried cream flakes remained on the daily-use blanket after cares were completed. Staff A was not observed offering to or changing out the blanket at any point during cares. (continued on next page)

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: 165601	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony West Des Moines	5010 Grand Ridge Drive West Des Moines, IA 50265

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 12:15 PM, Staff B, ADON acknowledged the lack of a barrier on top of the daily-use blanket during personal cares. Staff B also acknowledged the dried cream flakes left on the blanket. Staff B stated she would have expected staff to provide a barrier if completing personal cares on a resident's bed. Staff B reported the blanket should have been changed out after cares given the flakes. The Resident Rights-Dignity and Respect policy, revised 4/2024, outlined staff to treat residents with dignity and respect and to maintain and enhance his or her self-esteem and self-worth. The policy revealed residents have the right to considerate and respectful care and to be treated with honesty, dignity, respect and with reasonable accommodations of individual needs except where the health, safety, or rights of the resident or other individuals in the facility would be endangered.

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	165601	A. Building B. Wing	11/20/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46873 Based on facility record review, hospital clinical record review, staff interviews, and facility policy review, the facility failed to notify the physician of a needed change in treatment for 1 of 3 residents reviewed for assessment and intervention (Resident #12). The facility reported a census of 94 residents. Findings include: The Minimum Data Set (MDS) for Resident #12, dated 9/24/2024 documented diagnoses that included cirrhosis and failure to thrive. The Comprehensive Care Plan documented a Focus Area of Nutrition, dated 6/10/24, which noted a diagnosis of liver cirrhosis. The Medication Administration Record (MAR) for the month of July, 2024 for Resident #12 revealed an order for Lactulose (a liquid laxative) to be given four times a day for cirrhosis. (Lactulose is used to draw ammonia and other toxins from the blood into the colon to be removed from the body. This assists the liver to remove toxins that it cannot process due to cirrhosis). The Bowel Movement Record for Resident #12 for July, 2024 showed one bowel movement on 7/11/24. The Record indicated Resident #12 had produced no bowel movements 7/12/24-7/15/24. The Order Note dated 7/15/24 at 10:33 am revealed a new order for Senna-Plus (laxative plus stool softener) to be given, one tablet a day. This note revealed the normal daily dose to be between 2 and 8 tablets a day. The Progress Notes failed to reveal any communication with a medical prescriber prior to day four of Resident #12 having no bowel movements. The General Progress Note dated 7/16/24 noted Resident #12 was sent to the emergency room due to increased confusion, being slow to process information and having hallucinations. The Discharge Summary from the hospital dated 7/19/24 revealed the hospital course as Resident #12 having a history of cirrhosis secondary to autoimmune hepatitis and was admitted for acute metabolic encephalopathy secondary to hepatic encephalopathy. The Summary further noted she had not had a bowel movement for four days prior to hospital admission and she needed to have 2-3 bowel movements daily. The Summary also noted an abdominal x-ray taken on 7/16/24 revealed a large amount of colonic stool and a diffusely distended gastrointestinal (GI) tract. On 11/19/24 at 11:42 am, the Director of Nursing (DON) stated the facility does not have a standardized bowel protocol for the residents. She stated each resident has an individualized protocol. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1:20 pm, via telephone, the Administrator stated her expectation is for the staff to notify a provider if no bowel interventions are ordered for a resident. On 11/20/24 at 1:25 pm, the Regional Licensed Nursing Home Administrator stated education was given regarding bowel patterns to all nursing staff at the end of July of 2024. She stated a bowel report is pulled every morning from Point Click Care (the healthcare software program used for each resident's electronic health record). Any resident who triggers on the report, the nurse needs to review medications and notify the provider if needed. She stated any provider notification needs to be documented in a Progress Note. The facility policy Notification for Change of Condition, review date 06/2023 included the following documentation: Point 1c: The facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a need to alter treatment significantly (i.e.; a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form or treatment).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observations, staff interview, and policy review, the facility failed to ensure wound care treatments were completed as ordered for 1 of 3 residents reviewed for wound cares (Resident #8). The facility reported a census of 94 residents. Findings include: The Minimal Data Set (MDS) dated [DATE] revealed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses reported on the MDS include heart failure, diabetes, asthma/chronic obstructive lung disease/chronic lung disease, and morbid (severe) obesity. The MDS indicated the presence of an unhealed stage 3 pressure injury. The Care Plan, revised on 9/10/24, indicated a stage 3 pressure injury to the right heel identified on 5/28/24. Interventions included: Apply wound treatments as ordered by the physician; Encourage to alternate wearing shoes on and off during the day; Monitor/Document location, size, and treatment of skin injury; Pressure relieving chair cushion and mattress; Wound physician consult. Wound care treatments to Resident #8 right heel pressure injury initiated on 5/23/24 with the following order: Cleanse with cleanser of choice, apply calcium alginate to the wound bed, cover with foam border dressing, change daily & as needed (PRN); Treatment to be completed every day shift. Daily treatments completed as ordered (5/23/24-6/4/24) upon review of the Treatment Administration Record (TAR). Wound care order changed (6/4/24-6/11/24) to cleanse with betadine, apply calcium alginate to the wound bed, cover with foam border dressing, change daily & PRN; Treatment to be completed one time a day. No documentation of completed wound care was found for 6/7/24. Wound care order changed (6/12/24-7/23/24) to cleanse with betadine, apply calcium alginate to the wound bed, cover with border gauze dressing, secure with ace wrap, change daily & PRN. Treatment to be completed every day shift. No documentation of completed wound care was found for 6/26/24 and 6/29/24 upon TAR review. Wound care order changed (7/23/24-8/27/24) to cleanse with betadine, apply collagen pad to wound bed, cover with a border gauze dressing, secure with ace wrap, change daily & PRN. Treatment to be completed every day shift. No documentation of completed wound care was found for 8/7/24 and 8/21/24 upon TAR review. Wound care order changed (8/27/24-present) to cleanse with cleanser of choice, skin prep daily & PRN. Treatment to be completed every day. No documentation of completed wound care was found for 9/11/24, 9/14/24, and 10/30/24 upon TAR review. During an interview on 11:20 AM, Resident #8 reported he does not refuse or decline wound cares to his right heel as it needs to be done. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 12:20 PM, The Director of Nursing (DON) and Staff B, Assistant Director of Nursing (ADON), both acknowledged the lack of documentation indicating wound cares were or were not completed as ordered, a total of 8 treatments. A combination of agency staff and permanent facility staff were working on the dates in question. Neither the DON or Staff B were able to verify if treatments were completed. The policy Physician Orders/Transcription of Orders revision date of 7/2023, specified that active orders would be followed and carried out as written/transcribed.

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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** 50500 Based on observations, staff interviews, and policy review, the facility failed to follow infection control practices during urinary catheter cares for 2 of 3 residents reviewed for catheter care (Resident #5 and Resident #8). The facility reported a census of 94 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] revealed Resident #8 with a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Diagnoses on the MDS include heart failure, renal insufficiency/renal failure/end stage renal disease, diabetes, and morbid (severe) obesity. The MDS indicated the presence of an indwelling catheter and was occasionally incontinent of bowel. Resident #8 required partial to moderate assistance for toileting hygiene, lower body dressing, transition from sit to stand, and transfers from chair/bed to chair. The Care Plan dated 9/10/24 noted the presence of a Foley catheter. Interventions included completing catheter cares every shift and as needed. The Care Plan also indicated the use of a diuretic due to heart failure diagnosis. During an observation on 11/19/24 at 11:30 AM, Staff A, Certified Nursing Assistant (CNA), completed hand hygiene and donned a pair of gloves and gown upon room entry to perform urinary catheter cares on Resident #8. Staff B, Assistant Director of Nursing (ADON), was also present during the observation. Staff A helped to reposition Resident #8 into his bed for cares, which included touching the bottom of his shoes and bed blankets. Once Resident #8 was situated, Staff A pulled down his pants and incontinence brief to cleanse abdominal folds & groin area. Staff A cleansed the catheter, approximately 4 inches out from entry. Once completed, Staff A redressed Resident #8 and transitioned to empty the urinary drainage bag. Staff A did not change out gloves after touching other surfaces prior to proceeding with cares and cleansing the catheter tubing. Staff A did not offer or change out the used incontinence brief once cares were completed. Staff A donned a new pair of gloves and observed touching other surfaces ensuring all supplies were present (pockets, pants). The drainage graduate was placed on the floor with a barrier and the bag emptied. The drainage bag port cleansed with an alcohol swab. Staff A emptied and rinsed out the graduate, removed the gown and performed hand hygiene prior to exiting the room. 2. The MDS of Resident #5, dated 10/29/24, identified a BIMS score of 15, indicating intact cognition. Diagnoses on the MDS included heart failure, peripheral vascular disease, obstructive uropathy, renal insufficiency/renal failure/end stage renal disease, and diabetes. Additional medical conditions included a right above the knee amputation, left fore foot amputation, and an unstageable pressure injury of the left heel. The MDS indicated the presence of an indwelling catheter and the resident to be occasionally incontinent of bowel. The MDS further stated Resident #5 to be dependent on staff for toileting hygiene. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/19/24 at 11:50 AM, Staff A completed hand hygiene and donned a pair of gloves upon room entry. Staff B, Assistant Director of Nursing (ADON), present to observe. Staff A placed a graduate on the floor with a barrier and emptied Resident #5's urinary drainage bag. The drainage bag port cleansed with an alcohol swab. Staff A emptied and rinsed out the graduate and performed hand hygiene prior to exiting the room. Staff A did not wear a gown during the procedure. During an interview after cares, Staff A indicated that a gown was not needed for catheter cares for Resident #5. When asked why, Staff A explained there were no gowns in the bathroom. Therefore it was not needed. Staff A confirmed all personal protective equipment (PPE) supplies are kept in residents' bathrooms. An Enhanced Barrier Protection (EBP) sign, with the required staff PPE was observed outside Resident #5's room. During an interview on 11/19/24 at 12:15 PM, Staff B, ADON, acknowledged the improper gloves use and lack of changing out when Staff A performed cares on Resident #8. Staff B indicated Staff A should have changed out gloves after touching shoes and pockets before handling the urinary catheter. Staff B also reported the incontinence brief should have been changed out. Staff B confirmed the use of EBP for Resident #5 given the presence of the indwelling catheter and acknowledged Staff A's lack of gown use during cares. The policy Enhanced Barrier Precautions revised 3/2024 outlined gowns and gloves to be used during high contact resident care activities that provide opportunity for multi-drug resistance organisms to be transferred to staff hands and clothes. These activities include providing hygiene, changing briefs or assisting with toileting, and device care or use (urinary catheters).