

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  03/05/2026
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 0689  Level of Harm - Actual harm  Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, resident and staff interviews and record review, and policy review, the facility failed to provide adequate supervision, failed to follow policy and failed to utilize adequate assistive devices to prevent accidents or further injuries for 3 out of 4 residents reviewed (Res #2, #89 &amp; #116). The facility reported a census of 101 residents. Findings include:1.The Minimum Data Set (MDS) dated [DATE] for Resident #116 revealed diagnoses of diabetes mellitus, stroke, heart failure and required substantial assistance for transfers and moderate assistance for toileting and personal hygiene. Walking 10 or more feet did not occur due to a medical condition or safety concerns and a manual wheelchair was normally used for mobility. The MDS identified Resident #116 had an impairment of upper or lower extremities and use of a walker was not identified for a mobility aid. The MDS did not identify Resident #116 as having negative behaviors such as rejection of care and wandering did not occur. Resident #116 had a Brief Interview for Mental Status (BIMS) score of 3 that suggested severe cognitive problems with thinking and memory without signs of delirium. The MDS did not document that the resident was on a restorative program.The Care Plan for Resident #116 identified a brain injury due to a brain bleed and directed staff to offer cues, direction, redirect as needed, explain the task to be completed as she is impulsive with movements and non-compliant with directions. The Care Plan identified a risk for falls and directed staff to assist Resident #116 to ambulate with a gait belt and a front wheeled walker (initiated date [DATE]) and transfer using a non-mechanical lift (initiated date [DATE]). Restorative care: walk to dine &amp; ambulate in facility resolved on [DATE]. A document titled incident report revealed on [DATE] at 5:20 pm, Staff B, RN was notified by Staff A, CNA that Resident #116 had lost her balance and fell to the floor while ambulating to the bathroom. Resident #116 was screaming Please help me up!. The Nurse Practitioner was notified and Resident #116 was sent to the hospital. The Progress Notes for Resident #116 revealed:1. On [DATE], Resident #116 was examined by Nurse Practitioner (NP) and documented Resident #116 was stable sitting in her wheelchair, alert, oriented, no distress, cooperative, frail, with a weight of 100 pounds. Resident #116 musculoskeletal condition was documented as limited range of motion with muscle weakness.2. On [DATE], Staff B, Registered Nurse (RN) documented that Staff A, CNA alerted that Resident #116 had a fall and upon entering Resident #116's room, she was on the floor, near the wall, laying on her right side, screaming Please help me up! Staff A stated she was taking Resident #116 to the bathroom, using her walker, and she lost her balance, falling to her right side. Resident #116 was assisted to her bed by Staff A and Staff B. Resident #116 was continuously screaming, complaining of pain in her right arm and shoulder. The Nurse Practitioner was notified and ordered to send Resident #116 to the hospital. The daughter was aware of the hospital transfer. 3. On [DATE] at 10:03 am, the hospital update was that Resident #116 fractured the right shoulder and elbow and due to the multiple comorbidities, a conservative management of a sling instead of surgery. The trauma services were providing pain management.A document titled [NAME] Des Moines Emergency Medical Services (EMS) dated [DATE] for Resident #116 revealed:a. The primary impression listed as acute pain due to trauma and injury of shoulder from fall from chair. b. At 5:40 pm EMS arrived to find Resident #116 (continued on next page)</p>		

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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Previous functional ability: 1 assist with gait belt and front wheeled walker. d. Checked as injury not a major injury and signed by Staff II, Doctor of Osteopathic Medicine on [DATE] at 1500. During an interview on [DATE] at 11:42 am, Resident #2 stated on [DATE] she had walked with her walker into the bathroom and when finished she activated the call light. Resident #2 stated she required the assistance of staff to provide peri care and had waited for a while until the Certified Nursing Assistant (CNA) arrived. Resident #2 stated usually when she was assisted by facility staff and she would say she's slipping, the staff would sit her back down on the toilet. Resident #2 stated she began to slip and said that to the CNA who replied with I've got you. Resident #2 stated she went down to the floor because her legs were weak from sitting so long waiting for assistance. Resident #2 stated the CNA that was assisting her was an agency staff who said she should not even be here providing care for her as she had not been trained. When inquired if she fainted, Resident #2 laughed and replied, I've never fainted in my life. Resident #2 stated the CNA had her by the arm and not a gait belt. Resident #2 stated another CNA came into the room, who also was new agency CNA, and helped to get into the wheelchair. Resident #2 stated it was hard, they had her by the arms and her right leg hurt so she was unable to stand. Resident #2 stated then the nurse came in to help.During an interview on [DATE] at 3:15 pm, Staff CC, CNA verified her work at this facility was through an agency. Staff CC stated on her first day, she was asked to come in ahead of her start time to receive a code for the Point Click Care (PCC) computer system to chart, then failed to show her how to use it. Staff CC stated she was unaware of how to look up resident information since they did not give her details and they were aware it was her first time in the facility. Staff CC stated the staff was not helpful. Staff CC verified she had worked on [DATE], working with another new agency CNA and termed the day as Hectic as staff were sick, went home and the two were on their own with 2 halls of residents. Staff CC stated the call lights were going off and the nurse yelled at her for using the radio to call for assistance. Staff CC stated she answered a bathroom call light and she did not know the resident. Staff CC stated when the leaving, staff conduct the walking round at the beginning of the shift, they didn't give details. Staff CC stated during the peri care, the resident was starting to fall. Staff CC stated she called for the other CNA who came in immediately and they tried to get the resident into her wheelchair, describing it as very hard. Staff CC stated a 2nd nurse came into the room to helped them. Staff CC stated when she left at 2pm, no one asked her what happened, no one called her and she did not go back to this center.During an interview on [DATE] at 10:41 am, Staff DD, Agency CNA verified she worked through an agency and that [DATE] was her first day to work at this facility. Staff DD stated it was complete chaos as the staff did not tell her anything, no direction and it was the first time working with the mechanical lifts that this facility utilized stating she had no idea how to run it. Staff DD stated she was assigned to work on a hall with a staff member who went home and she was unaware that she was working alone. Staff DD stated another agency CNA (Staff CC) was down the next hall and from 10am to 2pm they were on their own. Staff DD stated they assisted each other with the residents that required two assist and was in a room when Staff CC stated she needed to go across the hall as that call light had been activated for a while. Staff DD stated her resident was on the toilet and could not be left alone but Staff CC was absent for a really long time so she secured her resident and found Staff CC with her resident on the floor in front side of the toilet. Staff DD stated Staff CC asked what (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>do I do? and it's routine if someone falls to call the nurse, used the radio for a nurse and helped to get the resident up. Staff DD stated she did not remember what happened next. Staff DD stated there were many residents, multiple two assist and both Staff CC and herself had no idea what was going on. Staff DD stated she had been trained as a CNA, worked for 8 years, and referred to that as the craziest day of her life and she would never go back as it was unsafe. Staff DD stated no one called her and she did not return to work for them. During an interview on [DATE] at 2:09 pm, Staff I, Licensed Practical Nurse (LPN) stated she was not sure how the facility on-boards agency staff, she had seen a packet but have not reviewed the content, and the staff that are leaving for the day completed a walking round. Staff I stated the agency staff can look in the computer for the Kardex but they have to navigate to the care plan. Staff I stated most of the agency staff ask to look at the therapy communication binder. Staff I stated she had good communication with the staff CNA's but there have been multiple agency CNA's and she didn't know their base line knowledge. Staff I stated she remembered a little about Resident #2's fall, it happened in the bathroom and there was an issue with the agency CNA's getting her off the floor. During an interview on [DATE] at 1:48 pm, Staff G LPN ADON stated she was unaware of any training for the agency staff as human resources (HR) and the scheduler placed them onto her unit and was not aware of who it will be until she arrives for the day. Staff G stated she was unable to remember who the agency staff were that had worked on [DATE], day shift, but when she was made aware that they were low on staffing, she notified Staff FF, Staff Scheduler and did not receive further assistance. Staff G stated the nurse on duty had responded to some activated call lights but personally no one approached her to assist. Staff G stated administration schedules staffing according to census. Staff G stated she was not aware there were new agency staff or that they were not oriented to PCC, it was a busy day. During an interview on [DATE] at 2:15 pm, Staff FF, Staff Scheduler stated the facility utilized two staff agencies, the CNAs were independent then make a post on the clipboard account so they may pick up the shifts. Staff FF stated the moment she was aware of the individual's acceptance for a shift then requests their documentation. Staff FF stated there was a packet at the nurse station they will utilize for orientation that was created in [DATE]. The agency staff will sign the four pages in the binder when they come in for their first day and leave it in the binder. Staff FF stated she would assume the staff CNA would orient and train them as it was the responsibility of the ADON's and DON to have that done. Staff FF stated Staff CC, agency CNA accepted work starting [DATE] and Staff DD, agency CNA picked up her first shift on [DATE]. Staff FF verified both agency CNAs worked on [DATE] and a staff CNA had left at 9:30 am. Staff FF stated a staff CNA was to come upstairs to work 11 am to 6 pm but was unsure if that occurred. Policy titled Fall Occurrence dated 2/2024 revealed interventions are implemented and placed on care plan based on fall risk assessment. The resident will be assessed by a licensed nurse prior to being moved after a fall. Policy Gait belts (transfer belts) When to use: Patient is weak but can bear some weight. Fall risk is present. Assisting with sit to stand or ambulation. Policy mechanical lifts (powered or hydraulic lifts) Used for patients who cannot bear weight or require full assistance. When to use: non-weight bearing patients. Total or extensive assist transfers. Staff safety concern with a manual transfer. Policy Non mechanical lifts (manual transfers) includes pivot transfers, two person lifts, and slide board transfers. When to use: patient can bear partial weight, short transfers bed to chair, patient follows commands. If a patient cannot safely bear weight, use a mechanical lift. If a patient can assist, a gait belt or non-mechanical method may be appropriate. when in doubt, get help. Safety protects both patient and caregiver. During an interview on [DATE] at 2:55 pm, the Administrator reported that he was not employed by the facility when Resident #2 had her incident. The investigations are conducted by interviewing staff and residents. The Administrator stated he would conduct interviews wi[TRUNCATED]</p>		