STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony West Des Moines	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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. 46513 Based on resident interview, staff interviews and record review the facility failed to ensure resident participation option in quarterly interdisciplinary team meetings for care planning for 1 of 3 residents reviewed regarding care plan meetings (R# 9) The facility reported a census of 95. Findings include: The Annual Minimum Data Set (MDS) assessment for Resident #9 dated 12/20/24 included diagnoses, anemia, arthritis and vision deficits. The MDS listed the Resident's BIMS score of 15 out of 15 indicating intact cognition The Care plan, initiated goal on 6/26/23 relayed will activity participate in independent leisure activities of choice daily and group activities as desired, documented resident enjoys activities included current events, reading group music and parties, residents primary diagnosis of blindness. In an interview on 2/17/25 at 11:07 AM the resident did not recall attending any recent care conference meetings or meetings to discuss concerns or changes. Resident#9 reported he had gone to resident council meetings but no recent care discussion. A Progress Note dated 10/29/24 relayed resident participated in a team meeting, had concerns about new insurance and relayed feelings. In an interview on 2/19/25 at 1:37 PM with the facility Staff D, Social Worker confirmed the team meeting on 10/29/24 was the last care conference resident #9 had participated in. Staff D relayed a performance improvement plan is in the works to change procedures to ensure resident invitations. In an interview on 2/19/25 at 1:53 PM with RN, Staff C relayed had updated the required MDS assessments and the care plan however a formal meeting was not done with Resident #9 when the last annual updates were completed in December 2024. In an interview on 2/4/25 at 3:12 PM with the Administrator acknowledged process will improve to ensure residents have options to participate their plan of care.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview, and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to accurately reflect the status of 3 of 22 residents in the Minimum Data Set (MDS) Assessments (Resident # 83, #86, #95). The facility reported a census of 95 residents. Findings include: 1. The Pre Admission Screening and Resident Review (PASRR) of Resident #83, dated 1/8/24, identified the resident to require PASRR Level II Services. (Considered by the State Level II process to have a serious mental illness and/or intellectual disability or a related condition). The PASRR identified the Resident to have a diagnosis of Major Depressive Disorder and identified symptoms the resident commonly expressed. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility. The MDS of Resident #83, dated 11/21/24 failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 2. The Census Line portion of the Electronic Health Record (EHR) of Resident #86 documented the resident enrolled in hospice care initially on 5/1/24. The Census line reflected the resident was on an unpaid hospital leave on 10/6/24, returning to the facility on [DATE]. The document titled Hospice Admission Coordination of Care from one of the facility's contracted hospice companies documented Resident #86 re-enrolled in hospice care on 10/9/24. On 2/18/25 at 2:40 pm, the Hospice Registered Nurse (RN) stated Resident #86 was discharged from hospice services on 10/6/24 due to being admitted to a local hospital. She stated he was readmitted to hospice services on 10/9/24. The Quarterly MDS of Resident #86, dated 11/6/24 failed to document the resident to have been receiving hospice services during the lookback review period. 3. The Pre Admission Screening and Resident Review (PASRR) of Resident #95, dated 12/26/24 identified the resident to require PASRR Level II Services. The PASRR identified the resident to have a diagnosis of Schizoaffective disorder and identified symptoms the resident was currently displaying. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility. The MDS of Resident #95, dated 1/20/25 failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The 2024 RAI Manual, under Steps for Assessment of question A1500, directed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point 2: Review the Level I PASRR form to determine whether a Level II PASRR was required. Point 3: Review the PASRR report provided by the State if Level II screening was required. In the next section, titled Coding Instructions, the RAI Manual directed: Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. On 2/19/25 at 11:58 am, the MDS Coordinator stated that Resident #83 was not initially a Level II, and his PASRR status had changed to a Level II. She stated a different employee completed that MDS assessment. She felt it was likely an oversight. She stated she would go through the resident's assessments and check them for accuracy. On 2/19/25 at 4:21 pm, the Administrator stated the facility does not have a policy regarding MDS completion. She stated they follow the guidelines of the RAI manual.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 46873 Based on clinical record review, resident and staff interview and facility policy review, the facility failed to implement a Baseline Care Plan in entirety within 48 hours of admission and additionally failed to provide a copy of the baseline care plan to the resident for 1 of 4 residents reviewed for Baseline Care Plans (Resident #95). The facility reported a census of 95 residents. Findings include: The Admission Minimum Data Set (MDS) of Resident #95, dated 1/20/25 identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated cognition intact. On 2/17/25 at 8:35 am, Resident #95 stated he had not seen his care plan. He stated he lives alone in a downtown apartment, and knows he will need help when he returns home. He stated he would like to discuss discharge planning, and getting help with his meals and his laundry. On 2/18/25 at 2:00 pm, the Administrator stated the baseline care plan is created from the User-Defined Assessment (UDA) for admission, and it is built into the Electronic Health Record to go into the Comprehensive Care Plan. Review of the facility document LGHC (IA) Nursing - Admission/Readmission Assessment (the UDA referred to), the information in the assessment included psychotropic medication orders, Pre-Admission Screening and Resident Review (PASRR) information, dietary orders, and use of diuretic medication. The baseline care plan failed to reflect the resident's initial goals, therapy services or any additional physician orders except psychotropic medication and diuretic medication. Review of the Comprehensive Care Plan revealed use of anticoagulation medication and additional cardiac medications were initiated on the Care Plan on 1/16/25. Discharge planning/resident goals for discharge were initiated on 1/16/25, greater than 48 hours following admission. The Comprehensive Care Plan failed to identify therapy services for the resident while in the facility. The facility form, LGHC (IA) Care Conference - V2 revealed a Care Conference was completed on 1/24/25 with Resident #95 and a member of the Nursing staff being the only people in attendance. Section B, Summary, Question 5 identified a copy of the care plan was not offered to the resident. The facility policy Care Plan, revision date 07/2023 identified the following: Point 2: The baseline care plan at a minimum should include initial goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable.

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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 - Some	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** 46873 Based on clinical record review, staff interview, guidance from the 2024 Resident Assessment Instrument (RAI) Manual and facility policy review, the facility failed to fully develop, personalize and implement Comprehensive Person Centered Care Plans for 5 residents (Res #22, #86, #7, #25, #87) The facility reported a census of 95. Findings include: 1. The Quarterly Minimum Data Set (MDS) Assessment of Resident #22, dated 1/7/25, documented diagnoses that included traumatic brain injury, anxiety disorder and depression. The MDS documented the resident received antipsychotic and antidepressant medications during the 7 day look back period of the MDS Assessment. The Comprehensive Care Plan of Resident #22, review date 1/2/25, recorded the use of multiple psychotropic medications for depression, anxiety and dementia. The interventions included attempting non-pharmacological interventions prior to the use of psychotropic medications. The Care Plan failed to specify any personalization of what non-pharmacological interventions should be used for the resident. The Care Plan listed as an intervention to monitor behaviors per facility protocol. However, it failed to detail what target behaviors of anxiety or depression the resident was being treated for or to monitor for. The Care Plan additionally failed to document the potential side effects of each medication and the need to monitor for the side effects. 2. The Quarterly MDS Assessment of Resident #86, dated 11/6/24, documented diagnoses that included non-Alzheimer's dementia, depression, psychotic disorder and post traumatic stress disorder (PTSD). The MDS documented the resident received antipsychotic and antidepressant medications during the 7 day look back period of the MDS Assessment. The Comprehensive Care Plan of Resident #86, review date 1/15/25, recorded the use of multiple psychotropic medications for PTSD, depression, agitation, psychosis and insomnia. The interventions included to attempt non-pharmacological interventions prior to the use of psychotropic medications. The Care Plan failed to specify any personalization of what non-pharmacological interventions should be used for the resident. The Care Plan directed to monitor for any changes in cognition, mood and behavior. The Care Plan failed to detail what target behaviors the resident was being treated for or to monitor for. The 2024 RAI, Pages N-5 and N-6, High-Risk Drug Classes: Use and Indication, documented the following: As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.

Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects.

Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

On 2/19/25 at 3:54 pm, the MDS Coordinator stated the admitting nurse completes the admission assessment and includes baseline information for the Care Plan. She stated on the next business day, she will complete a record review and reconcile the Care Plan. She said further revisions to the Care Plans are done via record reviews. She elaborated that if either at an interdisciplinary team meeting or meetings with the contracted behavioral health therapy services, target behaviors are identified, she will then care plan those behaviors. She said if the target behaviors are not identified by the therapy services, then nothing is needed to be updated on the Care Plans.

On 2/19/25 4:18 pm, the Director of Nursing (DON) stated her expectation is for the Care Plans to include the need to monitor resident specific behaviors and the side effects pertinent to the medications they are prescribed. She stated one resident might be on a medication due to self isolating, while another is on the same medication due to episodes of crying. She said the Care Plans should be differentiated for each resident.

47079

3. On 2/17/25 at 12:07 PM, Resident #7 stated he took medication for depression.

The Significant Change Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), Non-Alzheimer's Dementia, Bipolar Disorder, depression, anxiety disorder, insomnia, and Post-Traumatic Stress Disorder (PTSD). It also revealed the resident experienced little interest or pleasure in doing things, felt down, depressed or hopeless in the last 2-6 days, and received antipsychotic (AP) and antidepressant (AD) medications during the last 7 days.

The EHR included a physician's order for an antipsychotic medication dated 7/31/24, Aripiprazole oral tablet 20 milligrams (mg); Give 20 mg by mouth one (1) time a day for Bipolar Disorder and an antidepressant medication dated 12/19/23, Sertraline Hydrochloride (HCL) 200 mg by mouth one time per day for depression. It also included a physician's order dated 12/22/23 to monitor for side effects related to the use of psychotropic medications every shift but did not identify the resident's target behaviors that required psychotropic medication use.

The Progress Notes indicated target behaviors were not observed.

The Behavior Monitoring & Interventions document included the following behaviors staff were to document if observed:

a) Physical behaviors directed at others

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Grabbing others c) Hitting others d) Kicking others e) Pushing others f) Physically aggressive towards others g) Scratching others h) Verbal behaviors directed at others i) Accusing of others j) Cursing at others k) Express frustration/anger at others l) Screaming at others m Threatening others n) Socially inappropriate behaviors o) Disruptive sounds p) Disrobing in public q) Entering other resident's room/personal space r) Public sexual acts s) Repetitive motions t) Rummaging u) Spitting v) Throwing/smearing food w) Throwing/smearing body waste x) Other behaviors not directed at others y) Agitated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	z) anxious/restless The Care Plan revised 8/18/23 included the resident's antipsychotic medication use but did not include the resident's specific associated target behaviors for staff to monitor. It also did not include non-pharmacological interventions for staff to attempt if the behaviors were observed. On 2/18/25 at 1:41 PM, Staff E, Registered Nurse (RN) stated Resident #7's depression behaviors were self-isolating in his room and increased lethargy and his antipsychotic medication target behaviors were agitation, fidgeting, verbal aggression. She also stated target behaviors should be identified in his care plan. When queried at 1:53 PM, Staff A, RN, was not able to verbalize the resident's target behaviors but stated they should be in the resident's Care Plan. On 2/20/25 at 12:25 PM, the Director of Nursing (DON) stated Care Plans should be resident specific with target behaviors. 50500 4. The Annual MDS, dated [DATE], revealed Resident #25 with a BIMS of 0, indicating severe cognitive impairment. Diagnoses on the MDS include depression, frequent incontinence (bladder and bowel), and Non-Alzheimer's Dementia. No behavior, physical or verbal, documented during the MDS 7-day look back observation period. The Medication Administration Record (MAR) for Resident #25, for the month of February, documented orders for Aripiprazole, an antipsychotic. This is to be provided daily for aggression. The MAR did not direct staff to document monitoring of psychotropic targeted behaviors specifically related to Resident #25. The Care Plan, dated 2/7/25, for Resident #25 listed additional diagnoses of anxiety, mood disturbance, and psychotic disturbance. The Care Plan noted the use of a psychotropic mediation but lacked interventions of monitoring psychotropic targeted behaviors as well interventions for acute expressions of behaviors personalized to Resident #25. 5. The Significant Change MDS, dated [DATE], reveals Resident #87 with a BIMS of 12, indicating impaired cognition. Diagnoses on the MDS include anemia, depression, frequent pain, need for assistance with personal cares, and occasional incontinence (bladder and bowel). The MDS noted Resident #87 dependent on staff for toileting hygiene. The Care Plan, dated 1/23/25, revealed Resident #87 required assistance with activities of daily living. Interventions include a staff assistance of 2 for bed mobility, initiated on 10/16/24, as resident difficult to turn for cares and repositioning. During an interview on 2/18/25 at 1:30 PM, Staff M, CNA, voiced Resident #87 is a staff assist of 1 in bed when completing cares. During an interview on 2/18/25 at 2:14 PM, Staff N, CNA, reported providing cares on Resident #87 alone, without assistance, during their last scheduled shift on 2/9/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Care Plan, revision date 7/2023 documented the following: Point 4: After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, clinical record review, staff interviews, and policy review, the facility failed to provide eating assistance for 1 of 1 resident (Resident#32) who was not able to feed himself. The facility reported a census of 95 residents. Findings include: On 2/17/25 at 5:08 PM, Resident #32 was identified as a hospice resident. The resident's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of Congestive Heart Failure (CHF), Coronary Artery Disease, Diabetes Mellitus (DM), intracranial hemorrhage in the brain stem (a rare and fatal stroke that causes breathing, eating, and swallowing difficulty), and chronic respiratory failure. It indicated the resident required set-up assistance with eating and oral hygiene, supervision with upper body dressing, moderate assistance with personal hygiene, and was dependent with toileting, bathing, and, and lower body dressing. The Electronic Health Record (EHR) indicated the resident admitted to hospice on 8/16/24 for respiratory failure. The Progress Notes included an entry dated 2/17/25 at 4:03 PM which indicated the resident was noted to be increasingly lethargic during the shift. It revealed the resident was arousable but not able to get his words out. The Hospice Care Plan with start of care date 8/16/24 directed the Hospice Aide to assist the resident with meals each visit. The facility's Care Plan dated 1/11/24 directed staff to a) set up assist as needed, b) encourage participation on Activities of Daily Living (ADL), and allow resident independence to the best of their ability with ADL task completion. A continuous observation on 2/18/25 at 11:58 AM, revealed Resident #32's uncovered lunch tray was setup on his bedside table in front of him. The resident was observed asleep in an upright position. At 12:18 PM, Staff K, Certified Nurse Aide (CNA) entered the resident's room, called his name and stated his food was still with him. The resident mumbled mm-hmm. Staff K exited the resident's room. At 12:29 PM, Staff L, Licensed Practical Nurse (LPN) entered the resident's room and assisted the resident with drinking. She asked the resident if he needed assistance and he indicated he did. She asked Staff K to assist the resident with eating. Staff K placed a piece of meat in the resident's mouth. The resident made a muffled sound and Staff K placed the fork down on the resident's tray and asked the resident if he didn't want to eat it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At this point during observation, the State Surveyor notified Staff L that the resident's tray had been uncovered in his room for 40 minutes and asked if warming the food would encourage him to eat. At 12:34 PM, Staff L asked Staff K to reheat the resident's lunch and assist him with eating. Staff L stated the resident usually feeds himself but had presented in his current state for the past 2 days. She stated his change may be due to the progression of his illness. At 12:55 PM, Staff L stated changes to the resident's level of assistance involved contacting hospice by phone and notifying them of the need for a therapy re-evaluation. At 1:20 PM, Staff K stated the resident ate about 50% of his lunch on his own after it was heated. The EHR Response History document indicated the resident ate 51%-75% of his lunch on 2/18/25. On 2/20/25 at 12:55 PM, the Director of Nursing (DON) stated staff shouldn't have left the tray in the resident's room and reheated it when the resident was ready to eat. The facility did not have a policy specific for assisting residents with eating.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 46873 Based on observations, clinical record review, resident interview and staff interview, the facility failed to implement and maintain a Restorative Program for 3 of 4 residents reviewed who required assistance to complete their Activities of Daily Living (ADL) (Resident #22, #74, #86,). The facility reported a census of 95 residents. Findings Include: 1. The Quarterly MDS of Resident #22 dated 1/7/25, identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated cognition intact. The MDS revealed the resident required supervision/touching assistance for toileting hygiene, dressing, bed mobility, transfers and walking. The MDS revealed the resident received no Restorative Nursing services. The Care Plan of Resident #22, review date 1/2/25, documented the resident to be at risk of pain due to limited mobility and to be at risk for falls. The Care Plan failed to document any restorative nursing programs. On 2/20/25 at 8:38 am, Resident #22 stated the facility has some group exercises during morning activities. She stated it's mostly people in wheelchairs just moving their arms and things. She stated she is not comfortable participating in these activities as she prefers to be one on one or alone. She stated she enjoyed using an exercise bicycle when she was receiving physical therapy and would enjoy it if she could do that again. She stated she feels her legs are the part of her body she needs to work on and wished she could get more leg exercises. She said if she could sit in her wheelchair and pedal she would do that. 2. The Annual MDS of Resident #74, dated 12/11/24, revealed the resident to be dependent upon staff for toileting, bathing, and lower body dressing. The MDS revealed the resident to require substantial/maximal assistance for upper body dressing, personal hygiene, rolling left to right, sitting to lying, and lying to sitting. The MDS revealed the resident received no Restorative Nursing services. The Care Plan of Resident #74, review date 12/20/24, documented the resident to be at risk of falls due to weakness and limited mobility. The Care Plan documented Resident #74 required the assistance of two staff members for a full mechanical lift. The Care Plan failed to document any restorative nursing programs. 3. The Quarterly MDS of Resident #86 dated 2/4/25 coded a functional limitation in range of motion (ROM) with impairment present on both sides of the resident's body in both the upper and lower extremities. The MDS revealed the resident required substantial assistance for eating, upper body dressing, rolling left to right and sitting to lying. The MDS coded the resident to be dependent upon staff for oral hygiene, toileting hygiene, bathing, lower body dressing, and chair to chair transfers. The MDS revealed the resident received no Restorative Nursing services. (continued on next page)

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan of Resident #86, review date 1/5/25, revealed the resident to be at risk of falls. The Care Plan revealed the resident to have risk for pain related to limited mobility. The Care Plan identified the resident had a risk of impaired skin integrity due to limited mobility and incontinence. The Care Plan identified the resident to require assistance for bed mobility, dressing & grooming, eating, oral cares, and transfers. The Care Plan failed to document any restorative nursing programs. On 2/19/25 at 12:15 pm, Resident #86 was observed in the dining room sitting in a specialty wheelchair. A staff member sat next to him assisting him with food and drink. Resident #86 was not observed making any attempts to feed himself. On 2/19/25 at 12:20 pm, the Administrator stated the facility does not have any restorative programs. She stated this had been previously identified and had planned to implement restorative programming in October of 2024 but it was delayed. She stated no residents of the building have restorative nursing and the therapy department is not writing any programs at this time as residents complete physical or occupational therapy. She stated the floor Certified Nurse Aides are not trained to perform range of motion exercises as part of daily cares but that the facility has hired a Restorative aide and the program will be beginning soon. The facility stated they do not have a policy regarding Restorative Nursing Programs.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, staff interviews, record review and policy review the facility failed to follow professional standards of medication administration for 1 of 1 resident reviewed that required medications via gastric tube (Resident #47) no table barrier for filled medication cups and other supplies, did not follow Enhanced Barrier Precautions (EBP) and did not check placement or residual per the physician orders. The facility reported a census of 95. Findings include: The MDS dated [DATE] for Resident #47 coded for feeding tube. The Care plan initiated 2/3/25 for Resident #20 documented focus, tube feeding related to dysphagia (swallowing difficulty) and directed to check gastric-tube placement prior to feeding per facility protocol. In addition, the Care plan directed EBP related to feeding tube, to minimize risk for transmission during high contact care activities, directed staff to wear a gown and gloves with feeding tube cares. The Medication Administration Record (MAR) dated February 2025 documented enteral feed order every shift, check for residual of the tube before starting the feeding and every shift. Notify physician if residual is greater than 400 milliliters. During an observation of Resident #47 room revealed a sign on the door directing Enhanced Barrier Precautions (EBP). Inside of the room was a plastic container with personal protective equipment supplies, included gown and gloves for EBP. During an observation on 2/19/25 beginning at 8:00 AM, Registered Nurse (RN) Staff A entered residents' room with multiple medication cups of crushed medications and a gradient of water and a syringe, placed the items on the bed side table and proceeded to administer the medications via syringe into the gastric tube. Water splashed and spilled on the table as the water was drawn into the syringe. RN, Staff A did not provide a barrier for the supplies, did not check tube placement and did not gown per EBP guidelines. In an interview with Infection Control RN, Staff B, relayed had also observed that EBP were not followed, and would of expected a barrier for supplies especially with the spillage that occurred. RN, Staff B relayed a tube placement check is expected per policy and would educate for an improved process. Review of MAR at this time revealed an order to check for residual, agreed this is another means to ensure tube placement. Policy provided titled Medication Administration: Enteral Tubes dated 10/2023 direct to verify tube placement, check residual and flush tube minimum of 30 milliliter of water.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46513 Based on observations, clinical record review, staff interviews, resident interview and facility policy the facility failed to follow physician orders, to manage oxygen use for 1 of 1 resident sampled for respiratory care (Resident #63). The facility reported a census of 95 residents. Findings include: The Quarterly Minimum Data Set (MDS) Assessment for Resident #63 dated 12/11/24 documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further documented the resident had diagnoses of coronary artery disease, heart failure, end stage renal disease, diabetes and depression. The MDS was not coded that resident used oxygen therapy. The Physician Order dated 1/30/25 for Resident #63 documented, oxygen (O2) 2 liters per nasal cannula at bedtime. The Medication Administration Record (MAR) for Resident #63 for January and February lacked an order for oxygen. The Treatment Administration Record (TAR) orders for January and February 2025 lacked an order for oxygen. The Care Plan focus dated 6/18/22 documented cardiac disease, a goal to exhibit no acute cardiac distress such as chest pain, shortness of breath. Intervention dated 9/27/21 documented to administer oxygen as ordered. An updated intervention dated 1/31/25 directed to administer oxygen as per the physician order at hour of sleep (HS). During an interview on 2/17/25 at 3:20 PM, Resident #63 relayed he used oxygen per nasal cannula at all times when in his room, and reported he thought he needed it at all times. Resident#63 reported he was told he did not need it when out of the room and felt it did not make sense. The Resident relayed he felt that sometimes he needed it outside of the room too. Resident #63 relayed 02 is set at all times at 2 liters and used it day and night. During an observation on 2/17/25 at 3:23 PM Resident #63 was in his room, wearing nasal cannula for oxygen administration set at 2 liters per oxygen canister gauge. During an observation on 2/18/25 at 12:50 PM Resident #63 lying in bed wearing nasal cannula for oxygen administration set at 2 liters per oxygen canister gauge. During an interview on 2/19/25 at 3:30 PM with the Director of Nursing (DON) and the Administrator, confirmed the oxygen is not on the MAR or the TAR, and was transcribed incorrectly. The DON and Administrator both in agreement that staff and resident should be educated and aware of physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy titled Physician Orders, Transcription of Ordered revised 7/2023 documented, medication and treatment orders will be entered in electronic medication administration record, active orders should be followed and carried out as written/transcribed.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 46873 Based on clinical record review, staff interview, and interview with pharmacy, the facility failed to attempt a Gradual Dose Reduction of psychotropic medications for 1 of 5 residents (Res #86) reviewed for Unnecessary Medications. The facility reported a census of 95 residents. Findings include: The Minimum Data Set (MDS) Assessment of Resident #86, dated 11/6/24, documented diagnoses that included non-Alzheimer's dementia, depression, psychotic disorder and post traumatic stress disorder (PTSD). The MDS documented the resident received antipsychotic and antidepressant medications during the 7 day look back period of the MDS Assessment. The Comprehensive Care Plan of Resident #86, review date 1/15/25, recorded the use of multiple psychotropic medications for PTSD, depression, agitation, psychosis and insomnia. The Consultant Pharmacist's Medication Regimen Review Recommendations, dated 1/30/25, documented an evaluation for the antidepressant medication Sertraline, 200 mg once daily prescribed for Resident #86. The prescribing provider responded that the medication regimen at this time appeared appropriate and consistent with diagnosis, and that the resident was at an optimal dose and stable. The orders for Resident #86's Sertraline documented the start date of 4/30/24, with an admitted to the facility of 4/29/24. The dosage of the Sertraline was never changed during the 9 month period from admission to the pharmacy review. With a trial of a lower dose having never been attempted, it was unknown if the resident would be able to maintain stability on a lower dose. The Pharmacist - Medication Regimen Review documents, dated 8/27/24, 9/28/24, 10/9/24, 10/28/24, 11/27/24, and 12/29/24, all documented Resident #86 had an active order for Olanzapine (an antipsychotic medication) 7.5 mg daily. Each review documented a gradual dose reduction had not been attempted and the physician had not documented a gradual dose reduction as clinically contraindicated. On 2/19/25 at 12:29 pm, the Director of Nursing (DON) stated she had reached out to the family of Resident #86 earlier in the day. She said the family told her the resident had been in a car accident years ago, and in the past, lowering medication dosages had not been successful. She stated that as far as she was aware, the family had not ever voiced these concerns prior to this conversation on 2/19/25. On 2/19/25 at 1:20 pm, the Pharmacist Consultant for the facility stated it was her error that the resident's Olanzapine had not been recommended for Gradual Dose reduction. She stated she made a note to make that recommendation this month. She stated it should have been recommended twice in the first year of the resident's admission. The facility policy Medication Regimen Review, revision date 10/2023 included the following documentation: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point 3: The review of the medication regimen will include, but not limited to, scheduled and PRN medications, medical diagnosis, monitoring for side effects, potential for drug interactions, psychotropic medication review including considerations for dose reduction/optimal dosing, review for potentially unnecessary medication usage, and review of the medication administration records/ancillary documentation such as the physician's progress notes,nurses' notes and laboratory test results.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 50500 Based on observations, staff interview, and policy review, the facility failed to provide appropriate side dish serving sizes for 5 of 5 puree diets and failed to obtain final cooking temperatures for resident meal items. The facility reported a census of 95. Findings include: 1. During an observation on 2/19/25 at 10:45 AM, Staff G, cook, prepared 6 puree pea servings for 5 residents on a puree diet. For meal service, Staff G determined 2 scoops of a #12 scoop size should be used for an appropriate portion. Staff G laid a #12 scoop on top of the covered puree peas which were on the steam table service line. No note or communication to other kitchen staff members regarding the addition scoop for the puree peas observed prior to Staff G leaving the kitchen prior to lunch service. During a continuous lunch service observation on 2/19/25 at 11:30 AM, Staff H, Cook, prepared and portioned out the hot food for resident trays. Staff H seen using a #12 scoop size and providing only 1 scoop of puree peas for all of the puree diets. 2. During the continuous lunch service observation on 2/19/25, an unknown kitchen staff member seen preparing a frozen individual serving of macaroni and cheese. Once the item had finished cooking, the staff member plated the macaroni and cheese and provided it to the trayline staff for the resident's tray. The same known kitchen staff observed preparing instant potatoes for the lunch line. Once the potatoes were finished cooking, Staff H started to serve them for resident trays. At no time did the kitchen staff obtain a temperature of the individual macaroni and cheese or the instant potatoes prior to plating the items for resident trays. During an interview on 2/19/25 at 1:00 PM, the Certified Dietary Manager(CDM) acknowledged the lack of temperature for the macaroni and cheese as well as the instant potatoes. The CDM would expect kitchen staff to obtain final food temperatures prior to plating, reaching a temperature of 165 degrees Fahrenheit. During an interview on 2/19/25 at 1:00 PM, Staff H voiced a lack of communication between them and Staff G regarding the appropriate serving size of the puree peas. The policy Pureed Food Preparation dated 2020, states puree foods should be served with the appropriate scoop number to provide an equal number of portions. All of the puree food must be used in order to deliver the correct nutrient density of each resident. The policy Monitoring Food Temperatures for Meal Service, dated 2020, outlines food temperatures will be taken and documented for all hot and cold foods to ensure proper serving temperatures.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50500 Based on observation, staff interview, and policy review, the facility failed to ensure proper food handling practices were followed while assisting Resident #1 to eat. The facility reported a census of 95. Findings include: The Quarterly Minimum Date Set (MDS), dated [DATE], revealed Resident #1 unable to complete the Brief Interview for Mental Status. Resident #1 severely impaired for daily decision making. Diagnoses listed on the MDS include adult failure to thrive, depression, Epilepsy, and hydrocephalus (abnormal accumulation of fluid that flows around the brain and spinal cord). The MDS disclosed Resident #1 was severely impaired with vision and had moderate hearing difficulties. The MDS noted Resident #1 required supervision or touching assistance when eating. The Care Plan, dated 1/6/25, listed Resident #1 as needing staff assistance of 1 for eating. During lunch on 2/17/25 at 12:40 PM, Staff F, Certified Nursing Assistant, observed using their bare hand to give Resident #1 a sandwich and hash brown patty. Eating utensils seen laying on the resident's plate. Staff F also observed holding a paper towel in their hand while assisting Resident #1 throughout the meal. This was the same paper towel Staff F used to dry their hands off when washing prior to the start of feeding assistance. During an interview on 2/20/25 at 9:30 AM, the Director of Nursing (DON) voiced staff should complete hand hygiene before and after meal assistance. The DON would expect staff to use a barrier to physically hand a resident food, such as gloves or eating utensils. The DON would also expect staff to separate dirty items, like a used paper towel, from a clean area, like a meal place setting. The policy Food Handling, with a revision date 10/2023, noted ready-to-eat food must not be touched with bare hands. Disposable gloves, tongs, or other dispensing devices must be used.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46873 Based on review of Certification and Survey Provider Enhanced Report (CASPER) from the Centers for Medicare & Medicaid Services (CMS), staff interview, and review of the facility Quality Assurance Performance Improvement (QAPI) plan, the facility failed to ensure an effective process to address previously identified quality deficiencies. This resulted in the facility receiving an Infection Prevention & Control deficiency for the fifth consecutive recertification survey. The facility reported a census of 95 residents. Findings Include: The CASPER Report for the facility identified the facility had received a deficiency for Infection Prevention & Control in August of 2019, December of 2021, March of 2023 and December of 2023 recertification surveys. At the conclusion of the recertification survey on 2/20/25, the facility was found to again be in non compliance for Infection Prevention & Control. The Facility's QAPI Plan, dated 6/23/24, identified a monitoring process which included multiple sources of data. The QAPI Plan failed to identify a process to address previously identified quality deficiencies. On 2/20/25 at 1:53 pm, the Administrator stated the facility had provided a lot of staff education regarding enhanced barrier precautions, performing staff audits on peri care, and providing one on one education on an as needed basis to staff members on infection control issues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observation, resident and staff interview, record review, and policy review, the facility failed to implement infection control practices to prevent urinary tract infection (UTI) for 1 of 1 resident (#16). The facility reported a census of 95. Findings include: On 2/17/25 at 12:26 PM, Resident #16 was observed with an indwelling urinary catheter. He stated he wasn't sure if he had a Urinary Tract Infection (UTI) or if he was receiving antibiotics for a UTI. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Chronic Kidney Disease (CKD), Heart Failure, Obstructive Uropathy, Diabetes Mellitus (DM), and quadriplegia. It also revealed he required setup assistance with eating, moderate assistance with oral hygiene, maximal assistance with personal hygiene and upper body dressing, was dependent with all other aspects of Activities of Daily Living (ADLs). It also indicated he required touching assistance with rolling left-to-right in bed, moderate assistance with lying-to-sitting and sit-to-lying, and was dependent with all transfers. It included an indwelling catheter. The Progress Notes indicated the resident's indwelling catheter was changed 2/04/25 due to a malfunctioning urinary catheter. It also revealed the resident previously had UTIs on 11/29/23, 2/26/24, 9/27/24, and 2/04/25. The Care Plan revised 5/24/21 included the resident's indwelling catheter and directed staff to a) perform catheter care routinely and as needed, b) use Enhance Barrier Precautions (use of PPE) with cares per protocol, and c) provide incontinent care as needed. On 2/20/25 at 11:51 AM, Staff I, Certified Nurse Aide (CNA) entered Resident #16's room and prepared to perform the resident's catheter and perineal care. Staff J, Certified Medication Aide (CMA) entered the room to assist Staff I. The Director of Nursing (DON) accompanied both staff members for observation. Staff I and Staff J performed hand hygiene and donned the Personal Protective Equipment (PPE - gown and gloves). Staff J grabbed a package of peri-wipes and an incontinence brief and placed them on the foot of the resident's bed. Staff I grabbed paper towels, packets of alcohol wipes, and a graduated cylinder (a container to empty the urine). She opened the alcohol packets and placed them on the resident's window sill. She laid the paper towels on the floor under the resident's urinary bag and placed the graduated cylinder on them. No hand hygiene or glove change was performed after touching the items and arranging the paper towels on the floor. She unfastened the urine bag spigot and drained the urine into the graduated cylinder until the cylinder was full. She closed the spigot, took the urine into the resident's restroom and emptied the urine into the toilet. She came back and repeated the emptying process. She closed the spigot, grabbed an alcohol swab and wiped the spigot. She grabbed another alcohol swab and repeated the process. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She secured the spigot into the chamber and took the cylinder into the resident's restroom and emptied the urine into the toilet. No hand hygiene was performed between closing the urine bag spigot and using the alcohol swabs to wipe the spigot. At 12:00 PM, Staff I, CNA opened the peri-wipes and changed gloves. No hand hygiene was performed. Staff I and Staff J removed Resident #16's briefs and Staff I tucked the rolled-up end under the resident's scrotum. She grabbed a peri-wipe and wiped the resident's right pelvic crease. She grabbed another peri-wipe and cleaned the resident's left pelvic crease. She grabbed another peri-wipe and wiped the resident's penis from the base to the tip. She changed gloves but did not perform hand hygiene. Staff I and Staff J turned the resident onto his left side and his scrotum was noted to be lying on top of the indwelling catheter tubing at the point-of-entry into his penis. Staff I wiped the back and bottom of the resident's scrotum. The catheter tubing nor the part of the resident's scrotum that contacted the catheter tubing were not cleaned. At 12:05 PM, Staff I placed the new incontinence brief under the resident and she and Staff J turned him onto his right side. Staff J pulled the brief into place and both Staff I and Staff J fastened the brief. Both staff members removed the PPE and discarded the soiled items. At 12:10 PM, Staff I stated she should have performed hand hygiene between emptying the second cylinder of urine and accessing the alcohol swabs and between changing gloves. She also said she should have wiped the resident's penis from the tip and outward. She further added that she cleans residents' catheter tubing only if the resident had bowel incontinence. The DON explained to Staff I that cleaning the indwelling catheter tubing is required during catheter and perineal care regardless of bowel incontinence. At 12:25 PM, the DON stated staff should have followed the facility's policy for providing catheter and perineal care. At 1:12 PM, the Infection Preventionist (IP) stated she performed an incontinence care audit in December 2024 between Staff I and Resident #16. She indicated Staff I performed the procedure without any deficiencies but indicated the audit involved bowel incontinence. A policy titled Hand Hygiene dated 10/2023 Hand Hygiene using alcohol-based hand rub is recommended during the following situations: (Not limited to the following) a) Before and after direct resident contact b) Before and after performing aseptic task such as insertion of indwelling catheter or before handling c) invasive medical devices such as during insertion of peripheral IV catheter, fingerstick blood sampling, etc. d) Before and after entering isolation precaution settings unless the infectious organism is C. Difficile or Norovirus e) Before and after assisting a resident with meals (continued on next page)

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Harmony West Des Moines	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f) Before and after changing a wound dressing g) Before and after assisting a resident with toileting h) Before moving from work on soiled body site to a clean body site on the same resident i) After contact with blood, body fluids or surfaces contaminated with blood and body fluids j) After removing gloves including during wound dressing change The policy also indicated Handwashing with soap and water is recommended during the following situations: (Not limited to the following) a) When hands are visibly soiled b) After known or suspected exposure to C. Difficile spores, Anthrax spores, outbreaks caused by norovirus c) After contact with a resident with suspected or confirmed infectious diarrhea d) Before eating and after personally using the toilet A policy titled Catheter Care: Indwelling Catheter revised 12/2023 directed staff to for males, retract the foreskin, if applicable. Wash around catheter insertion site using downward strokes from meatus outward and then wash from the tip of penis down to scrotum. Use alternate sites on washcloth with each downward stroke. Rinse using same procedure and pat dry. Reposition foreskin to natural position if applicable.