STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 43039 Based on record review, staff and resident interviews, and policy review, the facility failed to provide residents with access to their personal funds on the weekends for 8 of 10 residents reviewed for financial managment by facility staff (Residents #19, # 26, #29, 36, #43, #46, #49, and #50). The facility reported a census of 50 residents. Findings: The Trial Balance statement dated 10/27/21 by the facility's Resident Trust Management Service documented that 42 residents opted to have facility staff assist with management of their finances. Ten of the 42 were selected for review, which included the residents listed below. 1. The MDS (Minimum Data Set) assessment tool, dated 9/1/21, listed Resident #19's BIMS (Brief Interview for Mental Status) score as 12 out of 15 possible points, indicating moderate cognitive and memory impairment. During an interview on 11/2/21 at 11:00 a.m., Resident #19 stated she is not able to get her money on the weekend, only Monday - Friday. 2. The MDS assessment tool, dated 9/17/21, listed Resident #26's BIMS score as 15 out of 15, indicating intact memory and cognition. During an interview on 10/27/21 at 10:45 a.m., Resident #26 stated it used to be that residents could get petty cash anytime at the nurse's station but can't anymore. If the resident wanted money, call and ask the BOM (Business Office Manager) to come down so you can ask her for the money. 3. The MDS assessment tool, dated 9/15/21, listed Resident #29's BIMS score as 14 out of 15, indicating intact memory and cognition. During an interview on 10/27/21 at 10:45 a.m., Resident #29 stated it used to be that we could get our petty cash anytime at the nurse's station but they do not anymore. If the resident wanted money, you asked the BOM to come down and then you asked her for the money. 4. The MDS assessment tool, dated 9/22/21, listed Resident 36's BIMS score as 10 out of 15, indicating moderate cognitive and memory impairment. (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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/2/21 at 11:00 a.m., Resident #36 stated residents have to ask for petty cash before the weekend and not ask for cash on the weekend. 5. The MDS assessment tool, dated 9/22/21, listed Resident 43's BIMS score as 10 out of 15, indicating moderate cognitive and memory impairment. During interview on 10/27/21 at 10:45 a.m., Resident #26 stated it used to be that residents could get petty cash anytime at the nurse's station but not anymore. To get money, the resident called and asked the BOM to come down and so you can ask her for money. 6. The MDS assessment tool, dated 10/8/21, listed Resident 46's BIMS score as 14 out of 15, indicating intact memory and cognition. During an interview on 11/2/21 at 11:00 a.m., Resident #46 stated residents are unable to get money on the weekend with the BOM not there. 7. The MDS assessment tool dated 10/6/21, listed Resident #49 BIMS score as 14 out of 15 During an interview on 10/27/21 at 10:45 a.m., Resident #49 stated it used to be that residents could get petty cash anytime at the nurse's station but not anymore. To get money, the resident called the BOM to come down and so you can ask for money. 8. The MDS assessment tool dated 10/6/21, listed Resident #50 BIMS score as 15 out of 15, indicating intact cognition. During an interview on 10/27/21 at 10:45 a.m., Resident #50 stated it used to be that residents could get our petty cash anytime at the nurse's station but not anymore. If you want money, you call and ask the BOM to come down and then ask for money. An interview with BOM on 10/27/21 at 10:45 a.m. revealed the residents should have access to their money 24/7 but they have to come to her office if they need cash recently so she has not kept the black box (for money storage) in the medication cart for weeks. The BOM stated the residents have not been able to get money on the weekends, as she has not refilled the black box. During an interview with Director of Nursing (DON) on 11/10/21 at 12:00 p.m. she stated the expectation that all residents have access to their funds at all times, even on the weekends. The facility has a black box with cash kept on the medication cart. The DON had never verified the black box is in the med cart. The facility's undated policy titled Business Office-Resident Trust Fund Policy and Procedure, instructed: a. Residents of a Skilled Nursing Center are to have their funds managed and personal spending money available to them. b. When the Resident Trust Cash Box is replenished, funds should be used from the Resident Trust Bank account (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Residents shall be able to make withdrawals from their account at any time.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on observations, staff and resident interviews, and facility policy review, the facility failed to provide a clean, comfortable and homelike environment. The facility identified a census of 50 residents. Findings include: 1. Observations revealed the following: a. On 10/25/21 at 12:25 PM, a mechanical lift sat next to the wall in Resident # 32's room. The mechanical lift foot platform had brown, sticky debris, and what appeared to be Cheerios and other food particles. b. On 10/27/21 at 12:30 PM, the mechanical lift foot platform continued to have a dark brown and sticky substance, and food particles. In an interview on 10/28/21 at 10:20 AM, Staff M, Housekeeper, reported the housekeepers cleaned resident equipment such as the mechanical lifts. Staff M stated they had a list of items they cleaned daily and weekly. In an interview 11/3/21 at 11:10 AM, the Housekeeping and Laundry Supervisor reported they had a schedule for disinfecting surfaces, and a daily and weekly cleaning list for staff to fill out and date when completed. The Supervisor stated the certified nurse assistants (CNA's) cleaned the mechanical lifts and resident care equipment. In an interview 11/4/21 at 9:14 AM, Staff C, MDS (Minimum Data Set) nurse, reported the CNA's are assigned to clean equipment such as the mechanical lifts. Staff C stated she could provide no documentation of when the resident care equipment had been cleaned for the past 3 months. The facility's Disinfecting Surface Schedule recorded surfaces are disinfected twice a day. The schedule had no signature, date or time listed next to all lift equipment. A Primecare Drive Sit to Stand Lift owner's manual instructed that all gross and solid contaminants should be removed from the sit to stand lift, then all components washed and sanitized, using isopropyl alcohol 70% solution or a cloth moistened with lanolin and water. 2. Observation on 10/27/21 at 1:15 PM revealed Staff H, CNA, wheeled Resident # 31 in a wheelchair to the 100 hall shower room. The shower room floor had missing and broken tile, and the floor tile and grout appeared dirty. The wall and baseboard around the shower stall had a brown, black and yellow substance. Observation on 11/2/21 at 1:15 PM with Staff N, Housekeeper, revealed missing and broken floor tile in the 100 hall shower room, and the shower room stall wall above the baseboard had a brown/black/yellow substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/2/21 at 1:05 PM, Staff E, CNA, reported if something was broken, she let her charge nurse know, and then they notified Maintenance to fix the equipment. In an interview on 11/2/21 at 1:15 PM Staff N, Housekeeper, reported she cleaned the shower room and other areas of facility daily. Staff N reported broken floor tile in the shower for at least a month. Staff N stated she did her best to clean the shower area but unsure what else she could do to clean the area better. In an interview on 11/3/21 at 11:10 AM, the Housekeeping and Laundry Supervisor reported if something is broken or needed repaired or looked at, she let Maintenance know. In an interview on 11/3/21 at 11:40 AM, the Administrator reported she was aware of the broken floor tile in the 100 shower room and floor tile in need of repair. The Administrator reported a plan for facility renovation. In an interview on 11/4/21 at 10:20 AM, the Administrator reported the Maintenance person said staff needed to enter work requests in the TELS system. The Administrator reported when she asked staff about using the TELS, they told her they had never been trained or didn't have time to enter a work order into the TELS system. The Administrator confirmed she didn't know how to use the TELS system. 43039 3. During an environmental tour of the facility on 10/25/21 from 1:02 to 3:54 PM, observation revealed: a. The upstairs dining room wall with patched white pain on tan walls. b. The upstairs dining room with bent blinds on window. c. The upstairs dining room with large hole exposing insulation and duct work. d. The upstairs dining room ceiling tiles with blackened tiles surrounding them. e. room [ROOM NUMBER] had a stack of blankets under the sink which appeared saturated. f. room [ROOM NUMBER] had scratched paint the length of the bed closest to the window. Follow up observation of room [ROOM NUMBER]'s sink on 10/28/21 at 10:48 AM revealed multiple saturated and discolored white blankets. Observation on 11/1/21 at 9:11 AM revealed Staff N, Housekeeper removing discolored and saturated blankets from under room [ROOM NUMBER] sink with floor tiles loose and border unglued and away from wall. During an interview with Staff O, Social Worker (SW) on 10/25/21 at 1:02 PM revealed that the large hole in the dining room that exposed duct work and insulation has been there for as long as she remembered. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/26/21 at 8:06 AM Resident #49 revealed the sink in his room had been leaking for over a week. During an interview with Staff P, Maintenance on 10/28/21 at 10:48 AM, he stated that they had the sink in room [ROOM NUMBER] serviced on 9/22/21 and it temporarily stopped leaking. Staff P stated he has not done anything else to fix the leak. During an interview on 11/22/21 at 2:22 PM, Staff P stated the facility lacked maintenance policies and procedures. Staff P stated facility staff verbally notify him when something is broken as they do not know how to use the TELS system. During an interview on 11/4/21 at 12:30 PM, Staff C, Licensed Practical Nurse (LPN) stated staff do not use the Maintenance book located at the nurse's station when something needs repaired. Staff C stated staff call or text maintenance. On 11/4/21 at 1:00 PM, the Administration stated staff are in survival mode and Staff P will fix what needs to be fixed at the time. 44972 4. The MDS assessment dated [DATE] recorded Resident #53 had diagnoses including hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The MDS documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. During interview and observation on 11/3/21 at 11:35 AM, Staff T, CNA, gave Resident #53 a shower. Resident #53 reported frequently throughout his shower that he was cold. Resident #53 stated the water felt warm enough but the air was cold. At the time, only one heat lamp on in the shower room area. Observations on 11/3/21 revealed the following: a. The first floor east shower room temperature right after the shower at 68 degrees Fahrenheit (F). b. Only one of the red heat lamp lights in working condition c. The lower level west shower temperature measured 80.2 degrees F at 11:40 AM. d. The first floor east shower room temperature measured 67.1 degrees F at 11:42 AM with the facility Administrator present. In an interview on 11/4/21 at 10:20 AM, the Director of Nursing (DON) stated it was the expectation that staff turn in any environmental concerns by utilizing the maintenance book. However, she stated many of the staff just stop the maintenance man in the hall or in passing and let him know of their concerns. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/4/21 10:25 AM, the Administrator acknowledged the shower room temperature needed to be warmer than 67 degrees. The Administrator stated there were plans to remodel and revamp the shower rooms but until then she planned to have maintenance put both heat lamps in and have them start the shower, turn on the heat lamps and let the room warm up prior to bringing a resident in to the area. She also planned to put a thermometer in the room so staff were aware of the temperature before bringing the resident in and to ensure that room is comfortable for the resident. Per the Genesis Care Center Air temperature test log, all buildings are required to maintain an ambient temperature throughout resident areas in a temperature range of 71 to 81 degrees F or at a more restrictive range required by state or local requirements. The air temperatures were checked once according to the log on 10/29/21 and the temperatures at that time ranged from 71 to 74 degrees throughout the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43039 Based on clinical record review, staff and family member interviews, and facility policy review, the facility failed to report to the State Department of Inspections and Appeals and thoroughly investigate missing personal property for 1 of 19 (#151) residents reviewed. The facility reported a census of 50 residents. Findings include: The MDS (Minimum Data Set) assessment tool, dated [DATE], listed Resident #151's BIMS (Brief Interview for Mental Status Score) as 12 out of 15, indicating moderate memory and cognitive impairment. The assessment documented the resident's diagnoses included anemia, high blood pressure, kidney disease, diabetes and chronic lung disease. The MDS of [DATE] documented Resident #151 died in the facility. An interview with Staff C, Licensed Practical Nurse (LPN) on [DATE] at 9:09 a.m. revealed the facility did not use a Resident Inventory Log when new admissions arrive to the facility. During an interview with the Power of Attorney (POA) of Resident #151 on [DATE] at 1:09 p.m., she reported Resident #151 arrived to the facility with a wallet, a $100 dollar bill, and a rosary. The POA stated facility staff did not complete an admission log. Resident #151 expired at the facility on [DATE]. On [DATE], the POA called the facility and reported to the Social Worker (SW) of missing items and the SW informed the POA staff could not locate the missing items. The POA stated she had not received additional information from the facility. During an interview with the SW on [DATE] at 2:46 p.m. she stated she and the Business Office Manager (BOM) checked the safe for Resident #151's missing possessions but were unable to locate them. The SW did not complete a grievance form. The SW stated she notified the Administrator (ADM) and department heads at their daily morning meeting. The Department of Inspections and Appeals (DIA) should be notified if items were not found and the ADM instructed the SW to report the incident; the SW did not notify DIA. During an interview with the ADM on [DATE] at 9:58 a.m she stated she assumed her role in August, 2021. The ADM stated she completed Resident #151 admission on [DATE] and did not complete an inventory log of personal possessions. The ADM stated if personal possessions are reported missing, the SW or Abuse Coordinator (the Director of Nursing [DON]), would file a grievance. All grievances are discussed at the department heads' daily morning meeting. The ADM stated she did not report Resident #151 missing possessions to DIA. During an interview with Business Office Manager (BOM) on [DATE] at 10:10 a.m. BOM stated she was informed by the SW of #151's POA-reported missing items and she checked the safe for the items. The BOM stated department heads did not discuss Resident #151's missing items in their daily morning meeting. The BOM stated the SW or ADM would be the staff to notify DIA. During an interview with DON on [DATE] at 10:28 a.m., DON stated the SW did not notify her of Resident #151's missing items. The DON stated she did not notify DIA of missing possessions. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic health record and paper chart revealed no resident personal possessions log upon admission for Resident #151. The facility policy on Abuse Prevention, dated [DATE] instructed: a. Investigation: The Administrator, or designee, shall report any allegations of abuse, neglect, or misappropriation of resident property as well as report any reasonable suspicion of crime in accordance with Section 1150B of the Social Security Act to the Department of Health as required. b. Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source and misappropriation of resident property are reported immediately, but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency, and local law enforcement as required. c. Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident. d. All staff and others who may have unsupervised access to residents will read and have maintained in their facility personnel file, signed Abuse Prevention Policy. The facility policy titled Grievance/Missing Property, dated [DATE] directed: a. All residents, resident representatives and families have the right to report property/items that may be missing. b. The Administrator, Grievance Official & Department Heads will follow up on issues noted: 1. Grievances will be shared with other involved departments as needed. c. Social Service/Grievance Official is responsible for notifying resident representative, and Ombudsman, as appropriate, of resolution. d. If the investigation reveals suspected misappropriation, proceed in accordance with the Abuse Prevention Policy & Misappropriation of Property. e. Supervisory personnel will be responsible for notifying the resident, resident representative and/or family outcome of missing property investigation.

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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** 34817 43039 1. The MDS assessment dated [DATE] revealed Resident #32 had cerebral palsy, non-Alzheimer's dementia, anxiety disorder, schizophrenia, and mild intellectual disabilities. The MDS documented the resident as totally dependent on one staff for dressing, and totally dependent on two staff for bed mobility and transfers. The MDS documented the resident had no falls and no skin problems during the look-back period The care plan revised 7/9/21 revealed the resident required assistance with activities of daily living related to dementia, schizophrenia, and weakness, and had a potential for impaired skin integrity. The staff directives included perform a head to toe assessment weekly, report any bruises or open areas to the nurse, and apply TED hose in the morning and remove at bedtime (HS). The Order Summary Report dated 9/3/21 revealed TED hose on during the day and off at HS for edema (swelling), and weekly skin checks by a licensed nurse every 7 days on day shift. Indicate Y if skin intact and N if skin not intact. The treatment administration record (TAR) 9/1 - 9/20/21 and 10/1 - 10/31/21 revealed no staff initials documented for TED hose application 10/22 - 10/26/21 and 10/28/21, and only a checkmark documented on 10/27/21. The TAR revealed no staff initials documented for weekly skin checks by a licensed nurse on 9/13/21, 9/20/21, 9/27/21, 10/6/21, 10/13/21, 10/20/21 Review of the facility's EHR revealed staff completed the last initial wound assessment on 10/11/2020 and provided a weekly wound assessment on 10/20/20. The most recent skin observation tool assessment dated [DATE] revealed no new skin issues found. The paper chart and EHR lacked documentation to show staff completed any other skin assessments. Observation on 10/25/21 at 12:33 PM revealed Resident #32 wore fuzzy yellow and black striped socks on his feet and had a dark bruised area on his left shin/lower leg. During observation on 10/27/21 at 12:30 PM, Resident #32 sat in a high back wheelchair. His feet rested on the wheelchair pedals and he wore bootie socks on his feet but no TED hose. In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported staff should document skin assessments every week on the TAR if a resident had no open wounds or skin issues, and should document a weekly wound assessment or use the skin observation tool in the EHR if a resident had a skin problem. In an interview 11/8/21 at 3:05 PM, the MDS Coordinator stated she expected staff follow to physician's orders and provide treatments as ordered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The annual MDS assessment dated [DATE] revealed Resident #34 had diagnoses of Alzheimer's dementia, anemia, malnutrition, and cellulitis to her left lower limb. The MDS revealed the resident had a risk for pressure ulcer but had no skin conditions during the look-back period. The MDS documented the resident as totally dependent on one staff for bathing and dressing. The care plan revised 3/3/20 revealed the resident had a risk for skin issues and pressure ulcer development related to thin fragile skin, anemia, and protein-calorie malnutrition. The staff directives included inspect the resident's skin weekly, administer medications and treatments as ordered, and follow facility policies and procedures for prevention of skin breakdown. The order summary report dated 11/4/21 revealed A & D ointment to BLE's BID at bedtime for dry skin had a start date 7/8/17, skin prep to bilateral heels at bedtime for prophylaxis had a start date 2/4/18, and weekly skin checks performed by a nurse every Monday on night shift had a start date 9/26/16. The TAR dated 10/1-10/31/21 lacked the following documentation: No A & D ointment applied to BLE's at bedtime 18 of 31 times, No weekly skin checks documented on Mondays on 10/4, 10/11, 10/18, 10/25/21 No skin prep to bilateral heels at bedtime for 18 of 31 times. 3. The MDS assessment tool, dated 7/21/21, listed diagnoses for Resident #3 that included coronary heart disease, heart failure, diabetes, hypertension (high blood pressure), urinary tract infections, diabetes, hyperkalemia (high potassium), hyperlipidemia (high cholesterol), non-Alzheimer's dementia, multiple sclerosis, depression, schizophrenia, asthma, and respiratory failure. The MDS listed his BIMS (Brief Interview for Mental Status) score as 10 out of 15, indicating moderately impaired cognition. The resident required assistance of 1 staff for bed mobility, transfers, and toilet use. The Medication Administration Record (MAR) dated 10/1/21-10/31/21 revealed: a. Insulin Detemir 100 unit/milliliter(ML) subcutaneously (SQ) at bedtime for diabetes. Inject 40 units at bedtime. The facility failed to administer insulin, assess resident blood sugar prior to administration, or document the site of the injection 14 of 31 doses. b. Novolog insulin 100 unit/ML, inject 13 units SQ three times per day (TID) for diabetes. The facility failed to administer Insulin, assess resident blood sugar prior to administration, or document the site of the injection for 11 out of 93 doses. c. Lisinopril tablet 10 milligram(MG), give 10 MG by mouth in the morning for high blood pressure, hold if systolic blood pressure (SBP) <100 or heart rate (HR) <60. The facility failed to follow parameters and hold medication, document SBP, HR, or to administer Lisinopril as prescribed for 11 of 31 doses. d. Albuterol Sulfate Nebulization Solution 1.25 MG/ML. 1 application inhale orally via nebulizer every morning and at bedtime for COPD. The facility failed to administer 4 doses out of 62 and failed to document failed to monitor resident vital signs while administering nebulizer 16 out of 62 doses. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Metoprolol Tartate tablet 25 MG. Give 1 tablet by mouth two times(BID)per day for hypertension, hold if SBP <100 or HR <60. The facility failed to follow parameters and hold medication, document SBP, HR or to administer Metoprolol for 39 out of 62 doses. The MAR dated 11/1/21-11/15/21 revealed: a. Insulin Detemir 100 unit/ML SQ at bedtime for diabetes. Inject 40 units at bedtime. The facility failed to assess resident blood sugar prior to administration for 1 of 15 doses between the dates 11/1-11/15/21. b. Novolog insulin 100 unit/ML, inject 13 units SQ TID for diabetes. The facility failed to administer Insulin, assess resident blood sugar prior to administration, or document the site of the injection for 21 out of 45 doses. c. Lisinopril tablet 10 MG, give 10 MG by mouth in the morning for high blood pressure, hold if SBP <100 or HR<60. The facility failed to follow parameters and hold medication, document SBP, HR, or to administer Lisinopril as prescribed for 11 of 15 doses. d. Albuterol Sulfate Nebulization Solution 1.25 MG/ML. 1 application inhale orally via nebulizer every morning and at bedtime for COPD. The facility failed to administer 1 dose out of 15 and failed to document failed to monitor resident vital signs while administering nebulizer 1 out of 15 doses. e. Metoprolol Tartate tablet 25 MG. Give 1 tablet by mouth BID per day for hypertension, hold if SBP <100 or HR <60. The facility failed to follow parameters and hold medication, document SBP, HR or to administer Metoprolol for 14 out of 30 doses. Physician Order Summary dated 10/25/21 listed the following medications: a. Insulin Detemir Solution 100 unit/ML, Inject 40 unit SQ at bedtime related to diabetes. b. Lisinopril Tablet 10 MG Give 10 mg by mouth in the morning related to hypertension hold if SBP or HR <60. c. Novolog Solution 100 unit/ML (Insulin Aspart) Inject 13 unit SQ TID related to type 2 diabetes mellitus. d. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth BID related to hypertension hold if SPB less than 100 or pulse less than 60. e. Albuterol Sulfate Nebulization Solution 1.25 MG/3 ML 1 application inhale orally via nebulizer every morning and at bedtime related to COPD with acute exacerbation. The facility did not have specific policies for nebulizer treatments or blood glucose monitoring. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #50 had a diagnosis that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The resident had a BIMS score of 15 of 15, indicating she is cognitively intact. Resident #50 required the assistance of 1 staff with bed mobility, transfers, toileting, and set up assistance for eating. Resident #50 had moisture related skin damage during lookback period with ointment application. Physician order for weekly skin check by licensed nurse every day shift, every 7 days, start date of 6/10/21. Physician order dated 7/9/21 revealed: Apply Dermaceptin to gastric tube (GT) site BID. TAR dated 7/1-7/31/21 (start date of 7/19/21) revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 18 out of 24 doses, and 2 out of 5 weekly skin checks documented. TAR dated 8/1-8/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 12 out of 62 doses, and 4 of 4 weekly skin check assessments. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). All scheduled dressing changes completed as ordered. TAR dated 9/1-9/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT zero out of 62 doses, and 3 out of 5 weekly skin check assessment. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). The facility failed to change the dressing 48 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 9/1/21-9/30/21 revealed: a. Bactrim DS tablet 800-160 MG, give 1 tablet via GT BID for GT site infection until 9/26/21. Facility failed to administer medication 2 out of 19 doses. b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 6 out of 31 doses. c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 16 out of 124 doses. Physician Order Summary (POS) dated 9/3/21 revealed: a. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). b. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TAR dated 10/1-10/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 10/1/21-10/30/21 revealed: a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. Facility failed to administer medication 10 out of 31 doses. b. Clodidogrel Bisulfate (Plavix)tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 10 out of 31 doses. c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 36 out of 124 doses. d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. Facility failed to administer medication 9 out of 31 doses. e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. Facility failed to administer 9 out of 31 doses. Physician Order Summary (POS) dated 10/11/21 revealed: a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. TAR dated 11/1-11/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 11/1/21-11/30/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 3 out of 60 doses (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician Order Summary (POS) dated 11/9/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. 44514 6. Review of the MAR for Resident #23 revealed a doctor's order for norvasc and to hold the medication for systolic blood pressure (SBP) less than 100 and/or a heart rate lower than 60. Record review of Resident #23's [DATE]/1 - 10/31/21 for the medication norvasc revealed 6 times medication refusal but without documentation, and 5 days without vitals completed prior to administering the medication. In September, Resident #23 had 2 days without vitals completed with one day not receiving medication. In August, Resident #23 had one day with no vitals and medication not given that day. In July, Resident #23 had 2 days of no complete vitals with medication not given. In June, Resident #23 had 7 days without full vitals and 8 days unclear if medication was given. In May, Resident #23 had 10 days without complete vitals and 7 days unclear if medication was given. In April, Resident #23 had 20 days without vitals on the MAR and 8 days of vitals could not be found in the electronic MAR and Treatment Administration Record (TAR), and 11 days unclear if medication was given. In an interview on 11/04/21 at 11:54 AM, the DON, stated they had no Plans of Service (POS) for Resident #23 for the months of April, May, June, and July. A POS is a document a physician signs to state what cares are to be done for medications and treatments for a resident. The DON stated the orders are good for 60 days and she expected the POS be done at least every 60 days. In an interview on 11/04/21 at 09:16 AM, the MDS coordinator stated she entered orders when she worked and there was no double check system in place. 7. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #50 had a diagnosis that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The resident had a BIMS score of 15 of 15, indicating she is cognitively intact. Resident #50 required the assistance of 1 staff with bed mobility, transfers, toileting, and set up assistance for eating. Resident #50 had moisture related skin damage during lookback period with ointment application. Physician order for weekly skin check by licensed nurse every day shift, every 7 days, start date of 6/10/21. Physician order dated 7/9/21 revealed: Apply Dermaceptin to gastric tube (GT) site BID. TAR dated 7/1-7/31/21 (start date of 7/19/21) revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 18 out of 24 doses, and 2 out of 5 weekly skin checks documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TAR dated 8/1-8/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 12 out of 62 doses, and 4 of 4 weekly skin check assessments. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). All scheduled dressing changes completed as ordered. TAR dated 9/1-9/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT zero out of 62 doses, and 3 out of 5 weekly skin check assessment. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). The facility failed to change the dressing 48 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 9/1/21-9/30/21 revealed: a. Bactrim DS tablet 800-160 MG, give 1 tablet via GT BID for GT site infection until 9/26/21. Facility failed to administer medication 2 out of 19 doses. b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 6 out of 31 doses. c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 16 out of 124 doses. Physician Order Summary (POS) dated 9/3/21 revealed: a. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). b. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. TAR dated 10/1-10/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 10/1/21-10/30/21 revealed: a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. Facility failed to administer medication 10 out of 31 doses. b. Clodidogrel Bisulfate (Plavix)tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 10 out of 31 doses. c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 36 out of 124 doses. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. Facility failed to administer medication 9 out of 31 doses. e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. Facility failed to administer 9 out of 31 doses. Physician Order Summary (POS) dated 10/11/21 revealed: a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. TAR dated 11/1-11/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 11/1/21-11/30/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 3 out of 60 doses Physician Order Summary (POS) dated 11/9/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Based on record review and staff interviews, the facility failed to ensure residents seen by a physician/provider at least every 60 days for 4 of 4 residents reviewed for physician visits. The facility reported a census of 50. Findings include: Documentation revealed the physician signed the physician order summary (POS) for Resident #50 on 9/21, 10/21, and 11/21 and lacked documentation the prior 3 months. Documentation revealed the physician signed the POS for Resident #46 on 9/21, 10/21, and 11/21 and lacked documentation the prior 3 months. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documentation revealed the physician signed the POS for Resident #31 on10/21 and 11/21 and lacked documentation the prior 4 months. Interview on 11/04/21 at 11:54 AM the Director of Nursing (DON) stated they had no POS for Resident #23 for the months of April, May, June, and July. A POS is a document a physician signs to state what cares are to be done for medications and treatments for a resident. The DON stated the POS orders good for 60 days and she expected the POS completed at least every 60 days. Interview on 11/17/21 at 12:13 PM the DON stated they only had the POS for a few of the months in the past 6 months for Resident #50, Resident #46, and Resident #31.

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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** 43039 Based on clinical record review, observation and resident and staff interviews, the facility failed to follow the plan of care to provide bathing assistance at least twice per week for 3 of 19 residents reviewed (#29, #50, and #53). The facility reported a census of 50 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #29 had diagnoses that included hypertension (high blood pressure), chronic lung disease, gastroesophageal reflux disease (GERD), hyperlipidemia (high cholesterol), arthritis, anxiety, depression, schizophrenia, asthma, respiratory failure, chronic pain syndrome. The resident had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact memory and cognition. Resident #29 required supervision for personal hygiene activities and physical assistance during part of bathing. During observation and interview with Resident #29 on 10/26/21 at 8:54 a.m., she stated she does not receive showers routinely as the facility is short of staff. The observation revealed the resident appeared disheveled with greasy hair and an odor of urine. During observation and interview with Resident #29 on 10/27/21 at 10:17 a.m., the resident stated she had not received a shower, but today was her day. Resident #29 stated she required the assistance of 1 for showers. Resident #29 stated she can brush her teeth at her sink but is unable to wash herself, as staff does not routinely pass out clean towels and washcloths. The resident was dressed but appeared disheveled. Interview on 10/27/21 at 10:39 a.m. with Staff B, Licensed Practical Nurse (LPN) revealed Resident #29 could not change her scheduled day or time of showers. At 1:36 PM, Staff B reported the facility did not have not enough staff present to assist Resident #29 with a bath today. Interview on 10/28/21 at 10:45 a.m. with Resident #29 revealed she did not shower yesterday on the evening shift. Observation at the time of the interview revealed the resident wearing clean clothes and with continued greasy hair. The resident's Care Plan dated 9/28/21 documented Resident #29 required the assistance of 1 staff member for bathing/showering twice weekly and as necessary. Resident #29 may refuse to take a shower, has been educated on why it is important to take a shower but per preference, may not want to with an initiation date of 8/20/18. The facility lacked documentation that Resident #29 refused showers. The form titled Baths/Shower, for 10/21, recorded Resident #29 as scheduled to bathe/shower every Wednesday and Saturday and the resident received 1 bath out of 9 for the month. Upon request, the facility could not provide a Bath/Shower log for the resident for 11/21. Review of the resident's Progress Notes of 10/1 - 11/23/21 and the monthly Bath/Shower forms revealed no documentation that Resident #29 refused offered showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] indicated Resident #50 had diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain The resident had a BIMS score of 15 of 15, indicating intact memory and cognition. Resident #50 required supervision and set up for bathing. Resident #50 had moisture related skin damage during lookback period with ointment application. Observation and interview with Resident #50 on 10/25/21 at 3:38 p.m. revealed she does not receive two baths per week as staff told her they are short of help. Resident #50's clothes appeared clean without odor. Interview with Resident #50 on 10/27/21 at 1:17 p.m. revealed staff do not deliver washcloths or towels. She stated she showered on 10/26/21. Resident #50 stated she does not receive a shower twice per week. Observation on 11/2/21 at 12:45 p.m. revealed Resident #50 with uncombed hair and clean clothes. Interview revealed that today was her shower day. During an interview on 11/4/21 at 9:09 a.m., with Staff C, LPN revealed residents might ask for a shower on any day regardless if scheduled or not. Staff C stated if the shower aide does not have time to bathe all of the assigned residents they report to the following shift to complete. During an interview on 11/4/21 at 2:20 p.m., Resident #50 stated she did not receive a shower this week. The resident's Care Plan dated 9/28/21 recorded Resident #50 required staff assistance of 1 for bathing/showering twice weekly and as necessary. The form titled Baths/Shower for 10/21 documented Resident #50 as scheduled every Tuesday and Friday for a bath/shower. Resident #50 received 4 showers out of 9 for the month. The form titled Baths/Shower for 11/21 recorded Resident #50 as scheduled every Tuesday and Friday for a bath/shower. The resident had received 1 shower out of 5 planned for the month. Review of the resident's Progress Notes of 10/1 - 11/23/21 and the monthly Bath/Shower forms revealed no documentation that Resident #50 refused offered showers. 44972 3. The MDS assessment dated [DATE] for Resident #53 recorded the resident admitted to the facility on [DATE]. The resident's diagnoses included hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The MDS identified a BIMS score of 5, indicating severe cognitive impairment. The MDS indicated the resident required the assistance of one staff person for bed mobility, transfers, toilet use, dressing, personal hygiene, and bathing. The resident's Care Plan dated 10/21/21 for Resident #53 did not address his need for assistance with activities of daily living (ADL) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The forms titled Baths/Shower indicated the resident scheduled for showers on Wednesday mornings and Saturday evenings. Review of the 10/21 form indicated Resident #53 refused a shower/bath on 10/27/21, and no other initials documented for the month. The resident received a shower on 11/3/21. The Progress Note dated 10/9/21 at 3:13 AM recorded Resident #53 admitted to the facility and had a diagnosis of failure to thrive. The resident was alert and oriented and able to make his needs known. Resident #53 required minimal assistance with activities of daily living and stand by assistance of one with a walker to use the bathroom. The resident's skin had areas of dirt and he had very dry skin on his lower extremities. His oral care was poor. Staff provided hygiene supplies but resident declined to use them. Observation on 10/25/21 at 2:19 PM revealed the resident's hair appeared greasy and unkempt. During interview at the time, the resident stated the staff helped wash him up and dress him. The resident denied that staff offered him a bath but stated he didn't need one because he was clean. Observation on 10/26/21 at 8:35 AM revealed resident appeared unshaven and unkempt, and his hair greasy and standing straight up, and he had a lot of facial hair. The resident reported he had not had a shower since his admission to the facility. The resident stated staff washed his up and washed his hair with a wash rag. The resident reported he declined a shower because he didn't like them. Observation on 10/27/21 at 10:49 AM revealed resident wore a hospital gown and lying in bed. The resident's hair appeared greasy and messy, and facial hair and food on his face. Resident stated the staff had him sign a sheet stating he did not want a shower today. Resident reported he didn't want a shower because he could not walk or stand for a shower. The surveyor explained to resident he could sit on a shower chair with wheels and have a shower that way. He then acknowledged that would feel good. He stated he showered at home but had not showered since coming to the facility because he thought he would have to walk and stand for it. Observation on 11/2/21 at 11:40 AM revealed the resident as unshaven and had dried food particles on his face and around his mouth. Observation on 11/3/21 at 8:59 AM revealed resident to be unkempt in appearance, with a dirty blanket and bed linens. Staff reminded him it was a shower day for him and the resident shook his head in acknowledgement. On 11/3/21 at 11:17 AM, Staff T, Certified Nursing Assistant (CNA) gave Resident #53 a shower as he sat in a wheeled shower chair. Staff T performed the shower by washing resident's hair and body thoroughly. Resident #53 tolerated the shower well but complained of feeling very cold. In an interview on 11/2/21 at 10:35 AM, Staff J, CNA reported they documented shower/bath in a bath/shower book. Staff J provided the bath/shower book that included a schedule of days when residents were scheduled to receive their bath/shower. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/9/21 at 10:12 AM, the Director of Nursing (DON) stated she expected residents to be offered a shower/bath a minimum of 2 times per week. The resident baths/showers were scheduled and placed on a calendar in the shower book at the nurse's station. If a resident declined their scheduled bath/shower, she expected staff to re-approach the resident and encourage a bath/shower at a later time, however never forcing them to complete. It was her expectation staff were minimally recording baths/showers and any refusals on the Monthly Baths/Showers sheets. The DON stated a Shower Day Skin Audit needed to be completed as well with their showers/baths but felt it most important for the Shower Day Skin Audit to be completed with any new skin areas or prior areas of concerns noted. She stated the facility did not have a bathing policy but they did utilize a shower aide for consistency and to ensure baths were being completed. The DON reported staffing sometimes required the bath aide gets pulled to cover the floor. When this happened she expected the evening shift to assist completing showers the day shift did not complete. The DON concluded that staffing on the evening shift was often worse than on the day shift. 44514 5. The MDS assessment dated [DATE] reveals Resident #4 had diagnosis of COVID-19, weakness, and major depressive disorder. The MDS revealed the resident had a BIMS score of 7, indicating severely impaired cognition. The MDS revealed the resident required supervision of one staff for eating. The care plan revised 5/18/21 revealed the resident had a history of dysphasia (difficulty swallowing) and weakness. The care plan indicated the resident had a choking episode in the past. The MDS assessment dated [DATE] revealed Resident #10 had diagnoses of Type 2 diabetes, heart failure, major depressive disorder, and chronic kidney disease. The MDS indicated the resident had a BIMS score of 15, indicating cognition intact. The MDS revealed the resident required supervision of one staff for eating. The care plan revealed the resident had COVID-19 and an ADL deficit related to limited mobility. The staff directives included to provide set up assistance and monitor for signs and symptoms of dysphasia. The MDS assessment dated [DATE] revealed Resident #23 had diagnoses of dementia, anxiety disorder, and dysphagia. The MDS indicated the resident had a BIMS of 11, indicating moderately impaired cognition. The MDS documented the resident required supervision of one staff for eating. The MDS assessment dated [DATE] revealed Resident #40 had diagnoses of Alzheimer's disease, dementia, major depressive disorder, aphasia (loss of ability to understand or express speech), anxiety disorder, and dysphasia. The MDS indicated the resident had a BIMS of 4, indicating severely impaired cognition. Resident #40's care plan revealed the resident needed assistance of one staff for eating, and required a mechanical soft diet with pureed meats. The care plan revealed staff to observe Resident #40 at meals for signs of aspiration or choking and report to the physician as indicated. The MDS assessment dated [DATE] revealed Resident #48 had diagnoses of dementia, major depressive disorder, and dysphasia. The MDS indicated the resident's BIMS score 6, indicated severely impaired cognition. The MDS revealed Resident #48 required supervision of one for eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/25/21 01:56 PM revealed Resident #40was in her room with had food in front of her from lunch and eating small bites. The resident was in her room without supervision. Observation on 10/27/21 at 12:51 PM revealed Resident #40 ate ice cream and unsupervised by staff. Observation on 10/28/21 at 09:17 AM Staff I, CNA, entered an area near rooms [ROOM NUMBERS] and brought food and check on residents (Resident #4, Resident #10, Resident #23, and Resident #48). Observation on 10/28/21 at 09:34 AM staff left the area by rooms [ROOM NUMBERS], where residents reside, and Resident #4, Resident #10, Resident#23, and Resident #48 still eating breakfast unsupervised. Interview on 11/03/21 at 09:50 AM the DON stated she expected staff CNA watched residents in Covid area and/or assisted residents that were care planned as requiring assistance. Interview on 11/09/21 at 11:02 AM the MDS coordinator stated if a resident care planned as needed supervision or assistance with eating, she expected staff watch the resident, even if the resident resided in the Covid area.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, and resident and staff interviews, and policy review, the facility failed to consistently provide and document skin and other assessments, failed to consistently provide and document physician ordered treatments (including dressing changes) and medications (including but not limited to diuretics, heart medications, insulin, and antibiotics), and obtain and document daily weights. Due to these failures Resident #101 underwent three hospital admissions for such conditions as edema, congestive heart failure, maggots in his wounds, cellulitis, urinary tract infection, and sepsis. The resident passed away in the hospital after the emergent transfer on 9/24/21. These factors constituted an Immediate Jeopardy to resident health and safety. The facility reported a census of 50 residents. Findings include: 1. The admission Minimum Data Set (MDS) assessment tool dated 7/19/21 revealed Resident #101 admitted to the facility on [DATE] from the hospital with diagnoses that included debility, heart failure, atrial fibrillation, hypertension (HTN), diabetes, chronic obstructive pulmonary disease (COPD), weakness, and urinary retention. The MDS documented the resident scored 13 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated intact cognitive abilities. The MDS revealed the resident required extensive assistance of one staff for transfers, ambulation (walking), dressing, personal hygiene, toilet use, and bathing. The MDS documented Resident #101 as at risk for pressure ulcers although he had no skin conditions or issues during the 7 day lookback period (07/13/21 - 7/19/21). The MDS also documented the resident experienced shortness of breath (SOB) upon exertion, when lying flat and at rest, used oxygen, and took no medications such as diuretics. The 5 day MDS assessment dated [DATE] revealed the resident admitted from the hospital 8/9/21 and had difficulty walking and weakness. The MDS documented the resident had no skin conditions and took no medications such as diuretics or antibiotics during the 7 day lookback period (8/10/21 - 8/16/21). The MDS assessment dated [DATE] revealed the resident readmitted to the facility on [DATE] from the hospital. The resident had a BIMS of 11 (moderately impaired cognitive abilities). The MDS documented the resident required extensive assist of 1 staff for bed mobility and extensive assist of 2 staff for transfers, toilet use, and bathing. The MDS revealed the resident had open lesions other than ulcers, and took a diuretic during all 7 days of the lookback period. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan initiated on 7/23/21 revealed the resident had a diagnosis of congestive heart failure (CHF), COPD, and HTN. The staff directives included give cardiac and antihypertensive medications as ordered, monitor vital signs, and notify the physician of significant abnormalities. Other interventions included monitor/document/report as needed (PRN) any signs or symptoms of CHF such as dependent edema of legs and feet, SOB upon exertion, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, increased heart rate, lethargy, and disorientation. The care plan also documented the resident had potential/actual impaired skin integrity related to fragile skin. The staff directives included encourage good nutrition and hydration in order to promote healthier skin, and follow facility protocols for treatment of injury. Staff added the resident's weight fluctuated up and down due to fluid and edema to the care plan on 8/16/21. The staff directives included to weigh resident weekly for 4 weeks, then monthly unless ordered otherwise, and monitor and report significant weight loss of 3 pounds (lbs.) in one week. The electronic health record (EHR) census list revealed Resident #101 admitted to the facility on [DATE], admitted to the hospital 8/4/21, readmitted to the facility 8/9/21, admitted to the hospital 8/21/21, readmitted to the facility 8/26/21, and admitted to the hospital 9/24/21. Review of hospital discharge orders dated 7/12/21 revealed Resident #101 had diagnoses that included heart failure with reduced ejection fraction (measurement of the percentage of blood leaving the heart each time it squeezes), diabetes Type 2, atrial fibrillation, COPD, and HTN. Discharge orders directed staff to weigh Resident #101 daily, complete vital signs per facility guidelines, give medications as prescribed, and call the physician if the resident gained 3 lbs., or exhibited SOB, or any other symptoms. The document included the following education regarding heart failure: -Heart failure means the heart muscle doesn't pump as much blood as the body needs. -Fluids start to build up in the lungs and other parts of the body and cause SOB at rest, swelling/edema in the legs, ankles, and feet, weight gain over a day or two, and feeling bloated. -Treatment for heart failure includes taking medications, checking weights and symptoms daily, and management of other health problems such as diabetes and high blood pressure. The Nursing Admission Screening assessment dated [DATE] revealed the resident admitted to the facility for therapy with diagnoses that included diabetes and anemia. The assessment documented the resident weighed 171.5 lbs., had normal lung sounds, and had no pitting edema. Staff had left blank the assessment area under Section L. A Pressure Injury Risk assessment dated [DATE] documented a score of 13, which meant the resident had a moderate risk for developing a pressure ulcer. The medication administration record (MAR) dated 7/1 - 7/31/21 lacked documentation of the following: -No diuretic listed on the MAR. -No daily weights from 7/13 - 7/31/21 (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-No pravastatin (medication for cholesterol) administered on 7/14-7/16, and 7/30/21 -No amiodarone (for atrial fibrillation) administered on 7/30/21 x 1 dose -No albuterol nebulizer treatment administered on 7/12/21 x 2 doses, 7/13/21 x 2 doses, and 7/31/21 x 1 dose. In addition, staff had circled their initials 8 times with regard to the scheduled albuterol medication, but failed to document the description or reason why they held or did not give the medication as ordered on the reverse side of the MAR or in the medical records. The MARS dated 8/1 -8/31/21 had admitted s 7/12/21, 8/9/21, and 8/26/21. The MARS lacked documentation for the following: No daily weights 8/1, 8/2, 8/11-8/21/21, 8/27, 8/29, 8/30/21 No Keflex (antibiotic) twice a day (BID) for cellulitis on 8/14/21 x 1 dose (Keflex ordered on 8/13/21) No sulfa for infection on 8/27/21 x 2 doses (sulfa ordered on 8/27/21 but NA (not available) circled on [DATE]/27/21) No metoprolol for HTN on 8/1- 8/4/21, and 8/27/21 No amiodarone on 8/1 - 8/4/21 No Lasix (diuretic) 20 milligrams (mg) on 8/19/21 No albuterol nebulizer treatment administered 8/14/21 x 2 doses, 8/19/21 x 2 doses. The MAR dated 9/1- 9/30/21 lacked documentation for the following: No daily weights - 9/8/21, 9/11/21, 9/14/21, 9/19/21, 9/22/21 No metoprolol on 9/19/21 No potassium chloride on 9/14/21 and 9/19/21. No amiodarone given 9/19/21 (AM dose) and 9/22/21 (PM dose) No Lasix 40 mg given on 9/19/21 No albuterol nebulizer treatments 9/11/21 x 1 dose, 9/19/21 x 3 doses, 9/20/21 x 2 doses, 9/22/21 x 1 dose, 9/23/21 x 3 doses The treatment administration record (TAR) dated 7/1 - 7/31/21, 8/1-8/31/21, and 9/1-9/20/21 lacked documentation for the following: No entry for oxygen tubing change 7/13/21-7/31/21 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No oxygen tubing change on Wednesdays 8/11/21, 8/18/21 No neomycin/polymycin ointment to left eye 7/12-7/15, 7/19/21, 8/3, 8/10, 8/11, 8/13-8/16, 8/18, 8/27/21 (total of 18 of 40 doses not administered). In addition, staff initials circled 6 times but no description or reason documented on reverse side of MAR or in the medical records why medication not administered. Treatment to cleanse bilateral lower extremities (BLE) and cover with Kerlix daily for cellulitis (started 8/14/21) left blank /not done on 8/14, 8/17, 8/27, 8/30, 8/31/21, 9/1, 9/3/21 Treatment to cleanse BLE with soap and water, apply ABD pads to absorb drainage from legs, Kerlix, and secure with tubigrip BID- left blank/not done on 9/11, 9/12, 9/16, 9/17, 9/18, 9/19, 9/20, 9/22, 9/23/21 = total of 9 of 34 times not documented/done Assess left arm for sign/symptoms of infection and note appearance BID and change dressing PRN -left blank /not done 6 out of 20 times on 9/16, 9/18. 9/19, 9/22, 9/23, 9/24/21 Staff B wrote on TAR new order to cleanse BLE daily and apply A & D ointment, cover with ABD pads, wrap with Kerlix and ace wraps per nursing order, but entry not dated and had no initials for dates when the treatment completed. The MAR and TAR lacked documentation for weekly skin assessments. The EHR lacked documentation for skin observations or weekly wound assessments. The monthly bath/shower schedule revealed Resident #101 admitted on [DATE] and scheduled for shower on Wednesdays and Saturdays on the 6-2 shift. The schedule revealed no bath or shower given 7/12 - 7/20/21, or 8/7/21. The Shower Day Skin Audit forms documented no skin abnormalities, open areas, unusual skin conditions, or reddened areas 7/24/21, 7/28/21, 9/6/21, 9/13/21, 9/16/21, and 9/23/21. The shower skin audit form 9/11/21 documented the resident had an abrasion, skin tear, and unusual redness but no nurse signature listed as reviewed the report and looked at the skin issues noted by the certified nursing assistant (CNA). The records lacked shower day skin audit forms for the month of 8/2021. The EHR revealed the following weights recorded: 7/12/21 at 4:11 PM 171.5 lbs. 7/20/21 at 12:22 PM 171.0 lbs. 7/27/21 at 10:53 AM 192.5 lbs. 7/28/21 at 4:04 PM 179.5 lbs. 8/12/21 at 11:25 AM 176.6 lbs. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8/20/21 at 2:07 PM 176.0 lbs. 9/3/21 at 3:33 PM 184.6 lbs. 9/5/21 at 2:10 PM 189.2 lbs. A chest x-ray (CXR) report dated 7/18/21 revealed the resident had SOB and low oxygen saturations. The findings revealed hyper expanded lungs that could be seen in COPD, a small right pleural effusion, and evidence of pulmonary congestion. The CXR also showed scattered bilateral opacities compatible with pulmonary edema versus atypical infection. Daily skilled summary notes included the following: On 8/2/21 temperature (T) 98.3, pulse (P) 64, respirations (R) 20, blood pressure (B/P) 138/74, pulse oximeter (PO) 95%. The resident had generalized scabs (no location listed) but no open areas, and pitting edema to BLE's. Weight stable. On 8/3/21 - same vital signs listed from 8/2/21. Resident had generalized scabs, no open areas, and pitting edema to BLE's. Weight stable. On 8/4/21 - same vital signs listed from 8/2/21. Resident had open areas, generalized scabs, and pedal edema. Weight stable. An Emergency Department (ED) provider note dated 8/4/21 revealed the resident presented to the ED with bilateral leg swelling and leakage, and the swelling had spread to his abdomen. The resident denied chest pain, SOB, or chills. Weight 189 lbs. The resident had 3+ edema to lower legs extending to his abdomen. The resident previously hospitalized ,d+[DATE] - 7/12/21 for CHF exacerbation and atrial fibrillation. Ejection fraction 30 %. No diuretic listed on patient medication list although there is reference he was on bumex (diuretic) in the discharge summary. A chest x-ray showed worsening CHF with pulmonary edema vs. superimposed pneumonia and probable small right pleural effusion. Treatment included IV Lasix drip. An After Visit Summary dated 8/9/21 revealed an order to start taking furosemide (Lasix) 40 mg BID and potassium chloride 20 milliequivalents (meq) daily. A medication list included the medications to start and the medications to continue, except no Lasix listed. Care instructions included to take medications as prescribed, weigh daily, and call physician if resident had weight gain 2-3 lbs. in a day or 5 lbs. in a week. The Nursing Admission Screening assessment dated [DATE] revealed the resident admitted to the facility from the hospital with heart failure. The assessment indicated the resident had normal lung sounds, slight pitting edema, lower extremity swelling, and scabs to his upper and lower extremities. Weight 179.5 lbs. A physician order dated 8/13/21 revealed to start Lasix 40 mg for 5 days, then Lasix 20 mg daily, start Keflex 500 mg BID for 10 days for cellulitis, cover open areas on BLE's, and wrap with Kerlix daily until healed. The progress notes revealed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On 7/13/21 at 3:12 PM, nurse practitioner (ARNP) saw resident on 7/12/21 after resident admitted to the facility from the hospital. Resident seen in the ED on 7/5/21 for weakness and falls. Diagnoses included atrial fibrillation and CHF. Resident had history of diabetes type 2, COPD, and coronary artery bypass graft (CABG). No lymphadenopathy or bruising noted. Lungs clear to auscultation. Plan included to perform skin checks per protocol. b. On 7/17/21 at 3:33 AM, resident awake most of the night and needed encouragement to lay down and wear oxygen as his oxygen level dropped whenever he got up without oxygen. c. On 7/17/21 at 10:54 AM, staff found resident on floor lying on his right side with a large amount of blood from his right forehead. Assessment done. Sent to the ED. d. On 7/18/21 at 10:15 AM, resident complained of SOB and feeling trapped in his body. B/P 112/58, T 97.7, P 53, R 24, PO 87% on oxygen at 3 liters per nasal cannula (L/NC). Resident refused to go to the ED. ARNP notified and ordered a stat CXR. e. On 7/18/21 at 12:00 PM, ARNP notified of CXR report and ordered Prednisone 40 mg for 5 days. f. On 7/19/21 at 7:47 PM, seen by ARNP due to SOB and hypoxia. CXR on 7/18/21 showed COPD exacerbation, scattered opacities, and a small right pleural effusion. Order to continue prednisone. g. On 7/27/21 at 4:15 AM, antibiotic arrived early this AM and will start on day shift 7/27/21. Drainage continues at this time. h. On 8/2/21 at 3:37 AM, has BLE edema 1+. Resident encouraged to elevate extremities. i. On 8/4/21 at 5:50 PM, resident admitted to hospital for exacerbation of CHF. j. On 8/5/21 at 11:20 AM (late entry), certified medication aide (CMA) brought to nurse's attention the resident appeared to be filling up with fluid. Resident had edema up past abdominal area. ARNP notified and order received to send resident to the ED for evaluation. K. On 8/10/21 at 5:41 AM, resident on oxygen at 3 L/NC. Pulse ox 92 %, lungs sound clear. On nebulizer treatment every 4 hours. Has 2-3+ pitting edema and redness to lower legs. l. On 8/11/21 at 5:45 AM, resident encouraged to elevate BLE but noncompliant. BLE reddened, has 2-3 + pitting edema, and legs draining serous fluid. j. On 8/13/21 at 8:22 PM, seen by ARNP for increased edema to BLE and weeping from open areas. Has pitting edema 3+ to BLE. Weeping clear fluid to the point his socks are saturated. Skin around open area had redness and warmth. diagnosed with cellulitis to bilateral lower limbs. New orders included: Lasix 40 mg daily for 5 days, then Lasix 20 mg daily. Keflex 500 mg BID for 10 days for cellulitis. Cover open areas to BLE and wrap with Kerlix daily until area healed, monitor edema, vital signs per protocol, and skin checks per protocol. k. On 8/20/21 at 8:29 AM, seen by ARNP. New order for Lasix 40 mg BID. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	l. On 8/21/21 at 11:29 AM, Staff B, Licensed Practical Nurse (LPN), called to the shower room. Resident #101 sat in a shower chair, dressing from lower legs and feet lying on floor. Dressing saturated with yellow fluid and smelled strongly of ammonia, and covered with maggots. Maggots observed in various stages of growth on resident legs and heels bilaterally. The dressing removed had date 8/17/21. Corporate Nurse and ARNP notified. Order received to send to the ED for evaluation and treatment of infested wounds. Resident was showered and legs wrapped in dry rolled gauze. Sent to the ED. m. On 8/22/21 at 11:40 AM, resident admitted to hospital for wound care. On IV vancomycin and rocephin (antibiotics for bacterial infections), and wound care consulted. n. On 8/29/21 at 8:39 PM, seen by ARNP on 8/27/21 for readmission to facility. Resident sent to ED on 8/21/21 after staff reported a strong ammonia smell and maggots to BLE. Treated with IV antibiotics and returned to the facility. Plan included orders to continue Bactrim, wound cares as ordered, Lasix as ordered, and skin checks per protocol. o. On 9/2/21 at 3:20 PM, attempted to place bilateral foam boots on resident to offload due to feet on pedals and he requested a blanket under his feet. p. On 9/3/21 at 6:48 AM, left heel wound 3 centimeters (cm) x 3 cm open area and behind right great (toe) a 1.4 cm x 1 cm superficial area. q. On 9/5/21 at 2:12 PM, BLE weeping secondary to edema. BLE cleansed with wound cleanser, A & D ointment applied to BLE's and ABD pads wrapped around calves, then rolled gauze and ace bandages applied to aide with edema. Resident encouraged to elevate his legs but he reported it is painful. r. On 9/14/21 at 2:00 PM, resident has bilateral edema in lower extremities. Lower legs weeping and treated BID. s. On 9/20/21 at 6:55 PM, seen by ARNP for edema and CHF. Edema worsened. Staff reported resident drinks fluids constantly and not always compliant with keeping legs elevated. Has 3+ pitting edema to BLE and weeping clear fluid. Lung sounds clear. Plan included: start 1500 ml fluid restriction, Lasix as ordered, vital signs per protocol, and monitor edema. t. On 9/24/21 2:40 AM, resident had notable change in status. Complained of nausea, respiratory effort increased, increased fluid retention, and had decreased level of consciousness. Vital Signs included T 96.6, P 42, R 24, B/P 90/58; ARNP notified via phone and message left. Family notified. Transferred to the hospital. Daily skilled summary included the following: a. On 8/19/21, resident had open areas but no pressure ulcers. NA (not applicable) documented under section 4b for wound assessment. Resident had pedal edema but weight stable. The assessment lacked lung sounds and location of open areas. b. On 8/20/21, resident had open areas with generalized scabs, and pitting edema to BLE's. The bilateral lung bases had wheezing on expiration. The EHR/paper chart lacked a daily skilled summary assessment on 8/21/21. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician order dated 8/21/21 directed staff to send resident to the ED for evaluation and treatment of infected wounds. An ED provider note dated 8/21/21 revealed the resident presented to the ED for evaluation of lower extremity pain from his feet to his upper lower legs, wounds, and increased drainage to his lower legs. A few open areas had purulent drainage, and had macerated areas between his toes on bilateral feet. Resident reported uncertain how long he had wounds but had increased redness and pain to his lower extremities. The resident reported his legs had only been wrapped once at the nursing facility. EMS reported concern for maggots to his lower extremities. Resident admitted to hospital for BLE cellulitis with open wounds. IV antibiotics vancomycin and ceftriaxone administered, and a wound nurse consulted. A hospital history and physical dated 8/21/21 revealed the resident sent to the ED with lower extremity wounds. The resident complained his legs were very painful the past couple of days. The resident told the physician his legs had only been wrapped once at the nursing facility. EMS brought the resident to the ED, and reported maggots but no maggots observed by ED staff. BLE's had erythema with open wounds, maceration around the toes, and purulent drainage. Weight 185 lbs. Diagnoses included BLE cellulitis with open wounds. Treatment included IV vancomycin and ceftriaxone, furosemide 40 mg BID, oxygen at 2 L/NC, and wound consult. The resident was previously hospitalized ,d+[DATE] - 8/9/21 for diagnoses of CHF, and diuresed after he had IV Lasix. A physician's verbal order dated 9/7/21 included to cleanse bilateral legs with soap and water, paint left great toe and bilateral heels with betadine, and apply ABD pads to absorb drainage from legs from shin to knees, apply Kerlix, and tubigrip. Specialty Wound Physician notes documented the following: a. On 7/22/21, resident had a bruise/contusion to right upper arm and a wound (2 cm x 1 cm x 0.2 cm) to the side of his nose due to eye glasses. No edema to LE's. b. On 8/12/21, resident status post hospitalization for CHF exacerbation. Resident had a wound (2 cm x 1 cm x 0.1 cm) to the side of his nose due to eye glasses, and skin tear to lateral elbow. Right distal elbow wound resolved. c. On 8/19/21, resident asked about swelling in his legs. BLE's had severe edema, heavy weeping, and the dressings on his legs soaked. No evidence of any open areas. Diagnoses included chronic venous insufficiency and diabetes. Treatment recommendations included elevation of legs, utilize absorbent pads with Kerlix wrap dressings, monitor for moisture associated wounds given the large amount of weeping, and consider compression with tubigrip to LE's BID. d. On 9/2/21, resident had a left posterior ankle wound 2 cm x 3 cm x immeasurable. The wound had heavy serous drainage and black necrotic tissue to the wound bed. He also had an unstageable pressure wound to his right lateral first toe 1.5 cm x 1.5 cm with 90 % necrotic tissue. Recommendations included to float heels, elevate BLE's, and apply tubigrip socks every AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. On 9/9/21, BLE's had moderate edema and stasis dermatitis. Wounds and moderate edema present. Right lateral first toe wound resolved. The left posterior heel wound measured 2 cm x 3 cm and had 50 % black necrotic tissue. Right anterior knee wound measured 2 cm x 1.5 cm x 0.1 cm and had moderate serous drainage. Right proximal medial shin wound measured 1 cm x 2 cm x 0.1 cm and had moderate serous drainage. Left anterior knee wound measured 1.5 x 1.5 x 0.1 cm and had moderate serous drainage. Daily skilled summary assessment notes dated 9/20/21 and 9/23/21 revealed resident had fragile skin and open areas. The assessment included under Section 4-2b regarding skin condition to see skin sheets. BLE had arterial ulcers and edema. An ED provider note dated 9/24/21 revealed resident brought to the ED by EMS for wet lungs and 4+ pitting edema. The resident had diminished lung sounds bilaterally, and chronic bilateral leg wounds. Diagnoses included acute cystitis, bradycardia, hyperkalemia, and acute kidney injury secondary to urinary retention. A hospital history and physical note dated 9/24/21 revealed the resident presented to the ED (on 9/21/21) for complaint of SOB, bradycardia (heart rate 40-50's), and hypotension. The resident had wounds on bilateral leg and pitting edema from his abdomen to his extremities. Weight 187 lbs. CXR showed a small pleural effusion and mild pulmonary edema or atypical infection. A hospital discharge summary dated 9/30/21 revealed Resident #101 passed away on 9/30/21. In an interview 10/28/21 at 10:45 AM, Staff L, agency CMA, stated she had worked at the facility 3 months. Staff L reported Resident #101 had a lot of wounds all over his hands, face, and arms. The resident had a hard time breathing and incoherent at times. Some weeks he barely would eat food or drink fluids, then other times he would [NAME] himself with food and fluids. Staff L stated she assisted the nurse whenever a treatment and bandages applied to his legs. The resident had edema in his buttocks and legs, and his legs had fluids that seeped out. In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported skin assessments documented weekly on the TAR if a resident had no skin issues. The DON stated she expected staff document in the EHR a weekly wound assessment or use the skin observation tool if resident had a skin concern noted. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview 11/1/21 at 2:35 PM Staff B, Licensed Practical Nurse (LPN) reported she had worked at the facility since 7/2019. Staff B stated each resident supposed to have a skin assessment performed at least weekly, and skin assessment typically performed during resident cares or on their shower day. Staff B reported skin assessments documented in the treatment book by initialing the TAR if no areas of concern identified. If a skin issue or concern noted, then the nurse documented a skin note in the nursing progress notes on the EHR. Staff B stated if a resident had diagnosis of CHF, the standard of cares included apply oxygen, encourage resident to sit with feet elevated due to dependent edema, monitor lung sounds, administer diuretic as ordered, monitor for edema, and monitor weights daily to weekly depending upon the resident. Staff B stated obtaining weights considered a nursing intervention, and no physician order needed for weights. Staff B stated the CNA's wrote weights on paper and the nurse recorded the weights on the TAR, but the nurse had to remind staff to obtain weights on residents. If a resident took a medication such as Lasix prior to going to the hospital, and returned to the facility not on a diuretic medication, it would be a red flag, and the nurse needed to call the physician and check if he/she wanted Lasix or a diuretic continued or discontinued. Staff B stated a number of agency staff worked at the facility, and not as familiar with residents or realized a resident took a diuretic or other medication or the treatments prior to hospitalization and thus it would not be a red flag or as obvious to agency staff. Staff B reported changes for care plan not always communicated. Staff B reported Resident #101 had edema so bad, fluid leaked out of his legs. They applied A & D ointment, a nonstick dressing, ABD dressing, Kerlix, and ace wraps on his legs. However, she thought the treatment and dressing changes not done as often as it should've been. On the day Resident #101 went to the hospital, one of the CNA's requested Staff B to come to the shower room right away. When Staff B arrived to the shower room, the resident's dressing from his legs lay on the floor covered with maggots. Staff B reported she saw the maggots crawling on his leg, and feet in-between his toes. Staff B reported she rinsed his legs off then applied a Kerlix dressing to his legs, and sent him to the hospital. Both of his legs appeared red and macerated, and looked like hamburger, and his heels and calves looked macerated and wet. Staff B reported 8/21/21 as the date of the incident. The date listed on the dressing was 4 days old (8/17/21). The resident's treatment should've been on the paper MAR for staff to perform the treatment but doesn't think it was listed on his TAR or MAR. His legs got progressively worse, and nobody was brave enough to call the physician or follow up and get his treatment changed. In an interview 11/02/21 at 10:35 AM Staff J, agency CNA, reported they had a bath/shower book for the CNA to document whenever they gave a resident a shower/bath. Staff J showed the surveyor the bath/shower book that also included a schedule in the front of the book for days/shift when a resident scheduled for a bath/shower. In an interview 11/02/21 at 10:40 AM, Staff C, LPN, reported shower sheets filled out with a skin assessment. The completed paper shower/bath sheets located in medical records. In an interview 11/02/21 at 11:44 AM, Staff C, LPN, reported skin assessments documented under the assessment tab in the EHR. Staff C reported no other areas where staff documented skin assessments other than the bath audit sheets. Staff C stated she also documented skin check in the MDS section M whenever a MDS assessments completed. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview 11/03/21 at 11:20 AM, Staff F, CNA, reported she had worked at the facility since 10/2020 and assigned as shower aide and CNA. Staff F stated she notified the nurse whenever a resident had a change in condition or had a skin issue. Staff F reported she filled out a shower skin audit form whenever she gave a resident a shower, and marked on the body map if she noticed any kind of skin issue. She gave the shower sheet to the nurse, and initialed the shower book whenever a shower completed. Staff F reported Resident #101 had very fragile skin and always had fluid leaking from his legs. During his shower, she used disposable wipes on his legs because the washcloths were rough and tore the skin on his legs. The nurses wrapped his legs with gauze. In an interview on 11/3/21 at 1:45 PM, an ED nurse stated when Resident #101 came to the ED on 8/21/21, his legs were extremely weepy, and stuck to the blankets. His legs were supposed to be wrapped at the care facility but looked like they hadn't been changed in weeks. The ED nurse stated no date listed on the dressings when he came to the ED. She asked the resident if someone at the care facility was supposed to help him get ready and the resident said yes. The ED nurse reported if staff at the care center helped him put his pants on they would've seen his soiled and wet dressings. The ED nurse reported when they removed the dressings on Resident #101's legs, his legs were very edematous, had blisters, pitting edema, and his legs were weeping. EMS reported there were maggots in the wound but she did not see any maggots. Resident #101 admitted to the hospital with cellulitis to both legs and a urinary tract infection (UTI), and received IV antibiotics. The ED nurse reported the resident discharged [DATE] and sent back to the care facility, but then came back to the ED on 9/24/21. He later went into arrest and passed away. On 11/04/21 at 09:50 AM, the administrator reported no other shower or bath sheets were found for Resident #101. In an interview 11/4/21 at 11:10 AM, Staff V, agency LPN, reported weekly skin check documented on the TAR. Staff V stated if a resident had any open areas or skin issues, document under assessment tab on the skin observation tool in the EHR. If a resident had no skin issues, then documented a note on the skin observation tool no skin issues. The MDS nurse entered orders in the EHR whenever a resident came from the hospital. Staff V stated the admission assessment usually done by the MDS nurse. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview 11/4/21 at 1:20 PM, Staff I, agency CNA, reported she had worked at the facility for 3 months. Staff I stated whenever a resident had a change in condition or a skin issue, she let the nurse know right away. Staff I reported she had a horrible experience one day when she took Resident #101 to the shower room. She gave Resident #101 a shower on his previous shower day before 8/21/21, and a nurse put bandages on his legs after she gave him his shower. The resident was supposed to have dressing changed on his legs every shift, but she noticed the date on the dressing she saw on 8/21/21 was over 3 days old. Resident #101's legs were usually wet from his knees down. On 8/21/21, the nurse told her to remove the bandages on his legs in the shower. When she removed the bandages, they were dripping with fluid and there were what appeared to be maggots on both of his legs - it was horrible! When she removed his socks, there were maggots that fell out of his heel, and they were coming out of the sores on his legs. She requested Staff B, LPN, come to the shower room right away. The dressing had the date and initials of when the dressing was changed last. The nurse took pictures, she was so upset. Staff B told her to wash his legs off, so she tried to clean his legs as much as possible. The resident complained of his legs burning. EMS came into the shower room and took him to the ED. Resident #101 had open sores everywhere. He had sores and maggots on his right leg at the top of the calf, right shin, left shin, and the majority of maggots came out of his left [TRUNCATED]

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	165175	A. Building B. Wing	12/07/2021

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on clinical record review, observation, facility policy review and staff interviews the facility failed to a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 of 2 residents reviewed for pressure ulcers (Resident #53). The facility failed to assess Resident #53's sacrum wound after first identifying the area upon admission on 10/8/21 and failed to treat the area to aid in healing and prevent further deterioration of the wound. The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment tool identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue), may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. Review of Resident #53's hospital record revealed he admitted to the facility on [DATE] from the hospital. He had reported to the emergency department on 10/1/21 for weakness and failure to thrive. Resident's family decided he required increased assistance with activities of daily living (ADL) and opted for long term care placement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The MDS dated [DATE] revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 5, indicating he demonstrated severe cognitive impairment. The MDS documented Resident #53 had diagnoses that included: hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive and cystitis. The MDS revealed the resident experienced bladder and bowel incontinence; although the resident admitted to the facility with an indwelling catheter, the MDS did not reflect its use. The MDS revealed the resident required extensive assist of one person for bed mobility, transfers, dressing, toilet use and personal hygiene and total assist of one person for bathing. The MDS revealed the resident had a risk for development of pressure ulcer/injuries and had moisture associated skin damage (MASD). The MDS documented the resident had a pressure reducing device for his chair and bed. The MDS coded the resident took an anticoagulant. The MDS Care Area Assessment (CAA) Summary triggered concerns for cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, and pressure ulcer. The CAA's revealed staff planned to develop care plans for these areas. The care plan dated 10/21/21 lacked documentation of a focus area, goals or interventions for ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls or pressure ulcer. Pressure Injury Risk form dated 10/8/21 completed by Staff Z, Registered Nurse (RN) revealed a Braden score of 14, which assessed Resident #53 as at moderate risk for pressure injuries. Pressure Injury Risk form dated 10/10/21 completed by Staff Z, RN revealed a Braden score of 15, which assessed Resident #53 as at moderate risk for pressure injuries. Pressure Injury Risk form dated 10/17/21 completed by Staff C, Licensed Practical Nurse (LPN) and MDS nurse revealed a Braden score of 12, placing Resident #53 at high risk for pressure injuries. A Nursing Admission Screening/History form dated 10/8/32 at 12:00 PM completed by Staff C, LPN and MDS nurse documented Resident #53's height as 67 inches and weight as 100.5 pounds. Staff C documented an open area on the resident's sacrum measuring 1 centimeter (cm) in length, 1 cm in width, and 0.1 cm in depth. The note defined it as a moisture related breakdown to the sacrum area and revealed staff applied house barrier to the area. When the resident arrived from the hospital, staff found the area covered with an undated patch, which they removed and identified a foul odor emanating from the area. A Skin Observation Tool dated 10/9/21 at 4:40 PM by Staff D, LPN, documented a Stage III pressure wound to the coccyx area measuring 3 cm in length, 5 cm in width, and 0.2 cm in depth. The documentation on the tool identified the resident admitted to the facility with a pressure ulcer that contained slough and a small amount of drainage was noted. A Daily Skilled Summary form dated 10/10/21 revealed Resident #53 had an open area to his coccyx staff documented as a pressure ulcer. The October 2021 Medication Administration Record (MAR) and Treatment Administration Record (TAR) contained no documentation of any prescribed treatments or other interventions to care for the pressure ulcer on Resident #53's sacrum/coccyx area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The electronic health records (EHR) lacked any physician progress notes related to the pressure area on the resident's sacrum/coccyx area. The nursing progress notes in the electronic health records revealed the following: a. On 10/9/21 at 3:13 AM, the resident was admitted to facility with diagnosis of failure to thrive; the resident is alert and oriented and able to make his needs known and required minimal assistance with ADL. Staff assessed the resident's skin as warm and dry with areas of dirt on his skin and the skin on his lower extremities very dry. b. On 10/10/21 at 4:11 AM, skin very dry, lotion applied liberally over entire body. Area noted on coccyx - moisture barrier applied - see wound sheet. c. On 11/3/21 at 11:20 AM, during his shower, the resident complained that his bottom hurt, and his skin burned when staff changed his brief. Staff noted 1.3 cm by 0.3 cm open area with a pale red wound base. Call placed to provider to notify of area, then utilized wound formula - Dermaview 11 applied to coccyx. d. On 11/3/21 at 4:53 PM, the social worker notified the resident's son of a small wound found on his coccyx. e. On 11/5/21 at 1:01 AM, staff completed a dressing change as ordered to the resident's coccyx and he voiced no complaints. f. On 11/5/21 at 9:07 AM, the dressing to the resident's coccyx remained intact with no redness or swelling noted to surrounding area and the dressing remained clean and dry. g. On 11/5/21 at 3:52 PM, Resident #53 seen by wound physician and received orders to change wound treatment to collagen pad to wound bed, cover with bordered gauze and apply house barrier to surrounding area. Staff documented they updated the TAR, faxed pharmacy and communicated the new orders to Resident #53. h. On 11/6/21 at 12:18 AM, staff noted the dressing applied by wound physician remained intact to coccyx. i. On 11/7/21 at 12:29 AM, staff documented they applied the dressing to coccyx wound as ordered and saw no drainage on the old dressing - the resident voiced no complaints j. On 11/7/21 at 9:52 AM, staff found the dressing to resident's coccyx clean, dry and intact. Resident #53 denied pain or discomfort. k. On 11/8/21 at 4:38 AM, staff changed coccyx dressing due to the dressing peeling and coming off skin. Area cleaned with normal saline, collagen applied and staff dressed the wound. Staff documented the wound as negative for drainage or odor, healing well, and pink. l. On 11/8/21 at 2:00 PM, staff noted the dressing to coccyx remained clean, dry and intact and the resident denied any pain or discomfort. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	m. On 11/9/21 at 4:09 AM, staff noted dressing intact to coccyx and the resident denied any pain or discomfort to the area - will continue to monitor. n. On 11/9/21 at 2:27 PM, the dressing to coccyx remained clean, dry and intact and the resident denied any pain or discomfort. o. On 11/10/21 at 4:22 AM staff documented the coccyx dressing remained intact and the resident denied pain or discomfort to the area - will continue to monitor. Clinical record review revealed the resident's EHR and hard or paper chart lacked assessments, treatment, and documentation of Resident #53's coccyx area pressure wound from 10/10/21 to 11/3/21. A physician order dated 11/3/21 at 1:28 PM directed staff to apply Dermaview II daily to the open area on Resident #53's coccyx. Change daily at bedtime and as needed. Another physician's order dated 11/8/21 at 3:20 AM directed apply collagen pad to coccyx wound bed, cover with bordered gauze, and apply house barrier cream to surrounding area every day at bedtime and as needed for coccyx wound. On 11/3/21 at 12:36 PM, the DON completed an Initial Wound Assessment tool that documented the facility identified the wound on 11/3/21 and deemed it a facility acquired Stage II pressure wound on the sacrum that measured 1.3 cm (length) x 0.3 cm (width) with an immeasurable depth. She assessed the wound as 95% granulation tissue and 5% epithelial tissue with no exudate noted. The form reflected the resident had predisposing factors of bowel incontinence and pendulous buttocks. The DON recorded the ulcer had a treatment ordered and the resident's bed and chair contained pressure reduction devices. The DON identified the resident reported burning when staff provided incontinence care. The form showed the facility notified the physician on 11/3/21 at 11:45 AM, the son at 11/3/21 at 3:00 PM, and also notified the dietician. On 11/3/21 Staff T, Certified Nursing Assistant (CNA) completed a Shower Day Skin Audit that showed Resident #53 had an open area on the coccyx/sacrum area and noted she reported her finding to the nurse. Observation on 11/3/21 at 11:17 AM, revealed Staff T, CNA, gave Resident #53 a shower while he sat on a shower chair. The resident flinched when staff washed his bottom, and he kept saying his bottom hurt and was tender to the touch. The resident, Staff T, CNA and the DON were unaware of any open areas on resident's bottom. Once back in his room, staff transferred him to the bed and the DON assessed his bottom. When the resident's buttocks were separated an open area was noted on the coccyx. The wound bed was red and had depth. The resident stated the area burned and was painful whenever he had a soiled brief and staff provided incontinence care. In an interview on 11/4/21 at 8:39 AM, Resident #53 stated his bottom felt better. He reported he had a bandage on the area. Observation revealed an approximately 1 inch cushion in his wheelchair seat, but nothing extra noted on the mattress for pressure relief. In an interview on 11/4/21 at 8:44 AM, Staff C, LPN and MDS nurse, reported all of the mattresses at the facility were pressure reducing mattresses and that is why she coded the resident's MDS to reflect a pressure relieving device for his bed. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/10/21 at 8:43 AM, the DON stated she expected staff to conduct a weekly skin assessment including a head-to-toe assessment of every resident in the facility set up on the TAR. If staff identified an area of concern they should initiate a Skin Observation tool if was a skin tear, shearing or moisture related issue. If the areas identified were a pressure related, vascular, arterial or any stageable wound, staff should complete a Wound Assessment. The DON added the CNA would notify the nurse if they identified a wound and she expected the nurse to complete a wound assessment, notify the physician, and initiate a treatment in accordance with the wound care protocol. The physician would then review the plan and set up a treatment for the area, although any nurse can initiate the treatment per the facility standing orders. They would then contact the wound nurse regarding the issue. Staff C, LPN was the facilities certified wound nurse and she completed rounds with the wound physician weekly or every other week to follow the wounds in the facility. The DON stated it was her expectation that all wounds would be assessed and documented weekly. A Wound Assessment should be completed on all arterial, venous or pressure areas weekly and Skin Observation tool completed for all other wounds. The physician would be notified initially and with any changes of concern in the wound. The physician would then determine if further intervention or a change in treatment was indicated. The physician/nurse practitioner reviewed notes in the electronic health system and reviewed the notes entered by the facility wound physician. The DON stated the staff get education and training on-line through Health Care Academy, including wound care training annually. She added the facility had specific training related to wound care for the licensed staff and more general skin care information for the non-licensed staff. She stated staff should complete Braden Scales for each resident upon admission and then at least quarterly thereafter. The Skin Management Guidelines dated 7/2017, revealed upon admission, all residents are assessed for skin integrity by completing an assessment and documenting in the electronic health record. Following admission; the Braden Scale is completed quarterly, annually and with a change of condition, for their risk for development of pressure injury. Nurse aides complete body audits. The body audits are given to the licensed nurse to review for changes in skin condition post shower. Appropriate preventative measures implemented on all resident identified at risk, and interventions documented on the care plan. Residents admitted with skin impairments will have appropriate interventions implemented to promote healing, a physician order for treatment, wound location and characteristics documented in the electronic health record, referral to rehabilitation services, Registered Dietician to assess nutritional needs, their family notified of presence of skin impairment and care plan implemented. A care plan is developed upon admission, identifying the contributing risks for breakdown, including history of skin impairment and the interventions implemented to promote healing and prevent further breakdown. At-Risk Review Meetings will be conducted to review/discuss: new admission with wounds present, resident identified at risk or with compromise, treatment modalities and interventions, recommendations based on interdisciplinary evaluation and weights will be monitored and dietary consumption reviewed. According to the Skin Management Guidelines dated 7/2017, residents who are at risk or with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. A pressure injury is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure injuries are usually over bony prominences and are staged to classify the degree of tissue damage observed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Per education provided to the facility staff on 5/21/21, each resident was to have a skin assessment/observation completed weekly. The measurements and assessments were being done weekly by wound care but staff were to look at the rest of their skin to make sure they do not have other open areas. This did not include things like skin tears and bruises as they show up on the Skin Observation Tool. The manufacturer's guidelines for the Therapeutic 5 Zone Support Mattress documented the mattress provided pressure redistribution and shear/friction reduction. The deluxe horizontal, cross cut foam mattress provided comfort, support and pressure redistribution over 5 therapeutic pressure zones.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44514 Based on clinical record review, observations, staff interviews, facility policy review, and review of manufacturer's directions, the facility failed to secure medications, keep alarmed doors closed to and from the outdoors for 10 residents (Residents #2, #4, #10, #23, #24, #33, #40, #41, #42 and #48), failed to ensure foot pedals on wheelchairs while transporting residents for 1 of 8 residents reviewed (#32), and failed to lock the brakes on wheelchair when staff transferred a resident (#32) for 1 of 8 residents observed for transfers. The facility reported a census of 50. Findings include: 1.a. The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #4 had diagnoses of weakness, history of falling, dysphasia (difficulty swallowing), and major depressive disorder. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. Resident #4's care plan documented the resident required assistance of one staff for transfers and ambulation. b. The MDS assessment dated [DATE] documented Resident #23 had diagnoses of dementia, anxiety disorder, unsteadiness on feet, dysphagia, muscle weakness, and difficulty in walking. The resident had a BIMS of 11, indicating moderately impaired cognition. Resident #23's care plan recorded the resident required assistance of one staff for transfers and ambulation, and as non-compliant with asking for assistance for transfers. c. The MDS assessment dated [DATE] revealed Resident #33 had diagnoses of dementia, schizoaffective disorder, history of falling, and cognitive communication deficit. The resident had a BIMS of 3, indicating severely impaired cognition. Resident #33's care plan revealed the resident had a history of wandering, had a wander alert bracelet, and transferred and ambulated independently with a walker. d. The MDS assessment dated [DATE] revealed Resident #40 had diagnoses of Alzheimer's disease, dementia, major depressive disorder, aphasia (loss of ability to understand or express speech), anxiety disorder, and dysphasia. The resident had a BIMS of 4, indicating severely impaired cognition. Resident #40's care plan revealed the resident transferred with assistance. e. The MDS assessment dated [DATE] revealed Resident #48 had diagnoses of dementia, major depressive disorder, and dysphasia. The resident had a BIMS of 6, indicating severely impaired cognition. Resident #48's care plan revealed the resident used a 4-wheeled walker and ambulated independently. Observation on [DATE] at 1:43 PM revealed the treatment cart located in the COVID designated area (for COVID positive residents) left unlocked. Medications including insulin, trazadone, finasteride, and various other medications were inside a cardboard box. The box sat on top of the treatment cart. An orange box which contained insulin for Resident #2 sat on top of the treatment cart. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 2:02 PM revealed Staff U, Certified Medication Aide (CMA), entered the COVID area and looked at the medications on the treatment cart. Staff U brought medication cups with names listed on them and pills from the Non-COVID area. Staff U pulled medications from the treatment cart and placed pills in the labeled medication cups. At 2:04 PM, Staff U left the labeled medication cups on the treatment cart and started to hand out medications to residents in their rooms. Staff U left all of the other labeled medication cups on the treatment cart unsecured. At 2:15 PM, Staff U continued to pass medications to residents in the COVID area and left medications on the treatment cart as she passed the medication to residents. At 2:28 PM, Staff U left the COVID area. Staff U left medications and the treatment cart unlocked. During observation on [DATE] at 2:35 PM, the medications sat on top of the treatment cart and treatment cart unlocked in the COVID designated area without staff present. During interview on [DATE] at 2:44 PM Staff V, Licensed Practical Nurse (LPN) stated medications were not normally left out on carts. Staff V stated did not know who left the medications on top of the cart in the COVID designated area. Staff V then placed the medications into the treatment cart. Observation on [DATE] at 12:59 PM revealed Staff B, LPN, entered the COVID designated area, and pulled medications out of the treatment cart for residents no longer in the COVID area. Staff B left the medications on the treatment cart and then went and passed pills to current residents in the COVID area. Medications left on the treatment cart included 8 pill packs and insulin for Resident #2. The treatment cart remained unlocked while Staff B passed medications. At 1:11 PM Staff B locked the treatment cart. 2. On [DATE] at 9:13 AM, the surveyor entered the building from an unlocked exterior door on the [NAME] side. No alarm sounded and no staff were present in the area. The area separated a COVID designated side from a and Non-COVID designated side, near rooms [ROOM NUMBERS]. Observation on [DATE] at 9:17 AM revealed Staff I, Certified Nurse Aide (CNA), entered the building from an unlocked exterior door on the [NAME] side, by rooms [ROOM NUMBERS], and brought breakfast for residents. Observation on [DATE] at 9:29 AM revealed the treatment cart unlocked and with medications inside for residents in rooms [ROOM NUMBERS]. Observation on [DATE] at 9:34 AM revealed staff exited a door and no alarm sounded by the door. The door to the outside is the only way to get to the area where 200 and 201 rooms are located. The door to this area remained unlocked and cracked open. Residents ate breakfast throughout the observation. Observation on [DATE] at 9:42 AM, no staff in the isolation hall or by rooms [ROOM NUMBERS]. Observation on [DATE] at 9:47 AM revealed a staff member entered the isolation hall to check on residents in that area. A plastic barrier wall separated the isolation area from rooms [ROOM NUMBERS]. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on [DATE] at 10:00 AM of revealed the door to room [ROOM NUMBER] remained closed for residents, and no visual of residents can be done by staff from the isolation area. room [ROOM NUMBER] was located around a corner and staff are unable to see into the room from the isolation area. The door to room [ROOM NUMBER] open. During observation on [DATE] at 10:14 AM Staff V entered to check treatment cart in the area where rooms [ROOM NUMBERS] are located. Staff V started taking treatment items and looking at medications. Staff V then then exited without checking on residents. Staff V left the treatment cart unlocked. The door did not alarm upon exit. Observation on [DATE] at 11:10 AM revealed Staff V entered to look at treatment cart. At 11:11 AM Staff V left the area by rooms [ROOM NUMBERS], and left the exterior door cracked open. No alarm sounded when Staff V left the area and no other staff were in the area. Staff V did not check on residents and left the treatment cart unlocked. Observation on [DATE] at 11:50 AM revealed staff entered the 200 and 201 area to check on residents. Review of current orders for Resident #10 and Resident #48 revealed they would like to have cardiopulmonary resuscitation (CPR) and Resident #4 and Resident #23 preferred no resuscitation. Review of current Care Plans for Residents #10, #48, #4, and #23 revealed all at risk for falls. During interview on [DATE] at 11:02 AM, the MDS Coordinator reported she expected medications to be stored in a locked cart. The facility's policy entitled Medication Storage in the Facility, Storage of Medications dated ,d+[DATE] instructed that medications and biologicals to be stored safely, securely, and properly. Medications are stored in a medication cart or other designated area except for those requiring refrigeration or freezing. 34817 3. Review of the MDS assessment dated [DATE] revealed Resident #32 had diagnoses of cerebral palsy, Non-Alzheimer's dementia, anxiety disorder, schizophrenia, and muscle atrophy. The MDS indicated the resident had a BIMS score of 8, which indicated moderately impaired cognition. The MDS documented the resident required total dependence on two staff for transfers, and locomotion on and off the unit. The resident's Care Plan updated on [DATE] recorded he had weakness and a risk for falls related to cognition and unawareness of safety needs. The resident's Fall Risk assessment dated [DATE] revealed a moderate fall risk. During observation on [DATE] at 12:22 PM, Staff E, CNA, wheeled Resident #32 in a high back wheelchair from the upper dining room to his room approximately 50 feet. The wheelchair had no wheelchair pedal on the right side. The resident's right leg and foot dangled in the air approximately 6 inches from the floor during the transport. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on [DATE] at 8:27 AM, Staff F, CNA, wheeled Resident #32 in a high back wheelchair from his room to the shower room located on the 100 hall without foot pedals at least 100 feet. The resident's legs and feet hung down toward the floor while Staff F pushed him. During observation on [DATE] at 8:55 AM, Staff K, CNA, wheeled the resident in a high back wheelchair from the 100 hall shower room to his room without foot pedals on. The resident's heels and feet were within , d+[DATE] inches off the floor during the transport. During observations [DATE] at 12:33 PM, Staff E and Staff I, CNA, placed an EZ stand lift in front of the resident's high back wheelchair. Staff placed the resident's feet on the EZ stand platform, then placed a sling behind the resident's back and attached the sling straps to the EZ stand lift. Staff I used the remote to lift the resident up. Staff left the wheelchair brakes unlocked on the wheelchair. After Staff E provided incontinence cares for the resident, Staff I positioned him in the EZ stand in front of a lift recliner. Staff E positioned the lift recliner in the highest up position and had the resident's bottom seated on the front edge of the recliner seat. As Staff I used the remote to lower the resident, Staff E then started to lower the lift recliner, until they had the resident seated in the recliner. Staff then removed the sling behind the resident's back. In an interview [DATE] at 12:10 PM, the Director of Nursing (DON) reported she expected that staff locked the brakes on the wheelchair whenever they transferred a resident from the wheelchair. The DON stated it depended upon how large the resident was and whether or not the recliner lift seat was kept in the up or down position when a resident transferred into the lift recliner. A larger resident, may need to have the recliner seat up in order to position the resident further back in the recliner. In a Primecare Drive Sit to Stand Lift owner's manual revealed wheelchair brakes locked whenever transferred a resident from a wheelchair and used the sit to stand lift. Ensure the desired surface (such as a chair) ready and whenever transferred the resident, position the resident over the chair or commode, press the down button on the remote, and lower the resident onto the desired surface. Then lock the rear swivel casters on the lift and unhook the sling from the lift.

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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** 34817 Based on clinical record review, observation, staff interview, and facility policy review, the facility failed to provide complete pericare and incontinence cares in a manner to prevent cross contamination and potential infection for 2 of 6 residents observed for incontinence cares (Residents #31 and #32). The facility reported a census of 50. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had diagnoses of Non-Alzheimer's dementia and cerebrovascular accident (stroke). The MDS documented the resident had impaired short and long-term memory, and required total dependence on one staff for bed mobility, dressing, toileting and personal hygiene. The MDS indicated the resident had incontinence, and had moisture associated skin disorder (MASD). The resident's Care Plan, updated 5/11/21, identified bowel and bladder incontinence and she required assistance with ADL's (activities of daily living) related to hemiparesis (paralysis on one side of the body) and dementia. The Care Plan documented a history of urinary tract infections (UTI) and directed staff to check and change resident frequently and as required for incontinence, wash, rinse and dry perineum, and observe skin for breakdown. During observation on 10/28/21 at 9:48 AM, Staff G, certified nurse assistant (CNA), and Staff E, CNA, washed their hands and donned a pair of gloves. Staff E removed the resident's brief as the resident lay in bed, then Staff E changed her gloves. Staff E took a disposable wipe and cleansed across the resident's lower abdomen and the upper creases of her groin using the same wipe. Staff G instructed Staff E she needed to change her gloves and only to use one wipe for each time she cleansed. Staff E removed her gloves, hand-sanitized, and donned another pair of gloves. Staff G took a disposable wipe and cleansed the vaginal area from back to front, then used the same wipe and cleansed the area again from back to front. Staff G rolled the resident onto her left side. Staff E took a disposable wipe, and cleansed the buttocks area in a downward and then an upward motion. Staff E continued to cleanse the buttock area with another disposable wipe in the same fashion. Staff E changed her gloves, sprayed the buttocks area with perifresh spray, then took a disposable wipe and cleansed the resident's buttocks area again front to back. Staff E changed her gloves, rolled the underpad under the resident's bottom, placed a clean pad and clean brief under the resident, then rolled the resident onto her right side. Staff G removed the soiled pad under the resident, rolled the resident onto her back, attached the tabs on her brief, then removed her gloves. Staff C, MDS Nurse, observed the cares as well. In an interview 10/28/21 at 10:15 AM, Staff C, Licensed Practical Nurse /MDS Nurse, reported she had a concern with how incontinence and pericare was performed on Resident # 31 on 10/28/21 Staff C reported she expected staff cleansed front to back whenever pericare/incontinence care was performed. Staff C stated Resident #31 had a high risk for UTI's and the potential for acquiring an infection easily. Staff C reported she needed to provide education to staff on the proper technique for pericares. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 11/4/21 at 9:10 AM, Staff C reported the facility had not completed audits regarding residents cares such as handwashing or pericares. Staff C reported she expected that staff washed their hands before and after cares, and expected gloves to changed after staff completed cares and whenever gloves dirty or soiled. The facility's policy titled Perineal and Incontinence Care, revised 1/1/14, directed that incontinence care is provided for cleanliness and comfort for the resident and to prevent infections and skin irritations. The procedural steps included: a. Gather equipment and place on a clean surface b. Perform hand hygiene and apply gloves c. Remove soiled brief/underpad by rolling the brief and underpad d. Cleanse perineal area from front to back, and use a clean cloth for each area cleansed. For females, separate the labia and cleanse on one side, then the other side, and then the center of the labia toward the rectal area. For males, retract the foreskin and cleanse the tip of the penis using a circular motion starting from the urethra and work outward. Cleanse the shaft and scrotum. e. Cleanse rectal area and buttocks. f. Assure all areas affected by incontinence have been cleansed. g. Remove gloves, and perform hand hygiene. h. Apply clean gloves. i. Apply protective ointment j. Remove gloves and perform hand hygiene. Apply clean gloves. k. Apply clean brief and reapply clothing. l. Remove gloves and perform hand hygiene. 2. Review of the MDS assessment dated [DATE] revealed Resident #32 had diagnoses of cerebral palsy, Non-Alzheimer's dementia, mild intellectual disabilities, and infectious gastroenteritis. The MDS documented the resident had moderately impaired cognition. The MDS indicated the resident had incontinence and displayed total dependence on two staff for bed mobility, transfers, and toilet use, and total dependence on one staff for dressing and hygiene. The resident's Care Plan revised on 7/9/21 recorded he had bladder incontinence daily related to dementia, bladder muscle dysfunction, and impaired mobility, and potential for impaired skin integrity related to incontinence and immobility. The staff directives included to check the resident for incontinence frequently and change as required and provide good pericare. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 10/25/21 at 12:33 PM, Staff E and Staff I, CNA, donned gloves, and provided incontinence cares for Resident #32 as he stood on a platform of a sit to stand lift. Staff I removed the resident's soiled brief; the brief had brown stool present. Staff E took disposable wipes, reached under the resident's bottom, and cleansed his buttocks in an upward and downward motion, and used the same disposable wipe to cleanse each buttock. Staff E took two disposable wipes and cleansed the resident's groin in an upward and downward motion on each side. Staff I then placed a clean brief on the resident's buttocks, pulled the brief between his legs and up toward the groin area, and attached the tabs on the brief. Staff removed their gloves. In an interview 10/28/21 at 10:15 AM, Staff C reported she expected staff cleanse front to back whenever pericare or incontinence care is performed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42441 Based on clinical record review, staff interviews, and facility policy review, the facility failed to monitor a resident with who experienced significant weight loss for 1 of 19 residents reviewed (Resident #102). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #102 had diagnoses that included Non-Alzheimer's dementia, cancer and depression. The MDS assessment identified a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further revealed Resident #102 required supervision with transfers and set-up with eating. The resident's Care Plan with a revision date [DATE] documented Resident #102 had a nutritional problem with a goal to maintain adequate nutritional status by maintaining current weight, having no signs or symptoms of malnutrition and consuming at least 50% of meals thorough next review with a target date of [DATE]. The Care Plan directed staff to provide, serve diet as ordered, monitor intake and record every meal, weigh and record per facility protocol Weight records documented the following weights for Resident #102: a. [DATE] 109.0 pounds b. [DATE] 102.0 pounds c. [DATE] 103.0 pounds d. [DATE] 100.0 pounds e. [DATE] 100.5 pounds f. [DATE] 100.5 pounds g. [DATE] 100.5 pounds The Progress Note dated [DATE] at 1:32 PM, the Registered Dietician documented Resident #102 had a significant weight loss of 9 pounds or 9% in the past month with staff direction to continue to monitor the resident's weekly weights. The clinical record lacked weights obtained following [DATE]. Review of facility policy titled Weight and Hydration Overview with an issue date February 2016 recorded a resident's nutritional status will be monitored on a regular basis. The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significant gain or loss is a crucial part of the assessment process. Significant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Progress Notes revealed Resident #102 expired [DATE] at 7:10 PM. During an interview [DATE] at 12:29 PM, the Administrator stated the facility could not locate documented weights for Resident #102 following the weight obtained on [DATE].

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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** 34817 Based on clinical record review, observations, staff interviews, and facility policy review, facility staff failed to ensure a gastrostomy tube (g-tube) as connected properly for one of three residents observed for g-tube use (Resident #31). The facility reported a census of 50 residents. Findings Include: The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident # 31 had diagnoses of cerebrovascular accident (stroke), hyponatremia, anemia, Non-Alzheimer's dementia, and dysphagia (difficulty swallowing). The resident had total dependence on one staff for eating and required a feeding tube. The MDS indicated the resident received 51% of more of their total calories and 501 milliliters (ml)/day or more average fluid intakes via tube feeding. The resident's Care Plan revised on 9/16/21 documented the resident had dysphagia and required a G-tube for nutrition. The staff directives included provide tube feeding and water flushes as ordered, check tube replacement, and monitor for signs of tube dislodgement or dysfunction. The Order Summary Report dated 9/3/21 instructed staff to change the g-tube tubing with each new bottle of tube feeding hung, starting 3/5/21. The resident's Medication Administration Record (MAR) dated 10/1 - 10/31/21 directed staff to: a. Check tube placement every morning and at bedtime. b. Tube feeding at 75 cc (cubic centimeter)/hr (hour) via g-tube start at 3:00 PM and end at 5:00 AM. c. Flush tube with 200 cc water every 6 hours for g-tube and hydration. The MAR had no documentation of water flushes on 10/3, 10/4 (12 AM and 4 AM), 10/10 (6 PM), 10/16 (6 PM), 10/17 (12 AM and 4 AM), 10/18 (12 AM and 4 AM). d. Change tubing with each new bottle last documented as changed on 10/26/21. e. Record the amount of water flush daily at noon and clear the pump after intake recorded. The MAR showed no documentation of water flush amount 10/5, 10/6, 10/7, 10/8, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/25. During observation on 10/25/21 at 1:01 PM and 2:56 PM, Resident #31 lay in bed on her back. A bottle of Jevity 1.5 tube feeding formula and a bag of water hung on a pole near the resident's bed. The tubing was draped and hung over the top of the pole, and the end of the tubing had no cap and was exposed to air, and the tubing had no date listed on it. During observation on 10/27/21 at 9:05 AM, a bottle of tube feeding formula and tubing hung on a pole near the resident's bed. The end of tubing was uncapped and exposed to air. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 10/27/21 at 12:25 PM, the resident's feeding pump had a water flush running at 200 ml/hr. A bottle of Jevity formula had 200 ml left in the bottle. The Jevity 1.5 bottle had the date and time of 10/25/21 at 2200 (10 PM) written on the bottle. The water reservoir bag had no date listed. Resident #31 lay in bed on her back and the head of her bed was elevated at 20 degrees. At the time, the MAR documented Staff B's initials for infusion of the water flush. During observation on 10/27/21 at 1:08 PM, Staff C, Licensed Practical Nurse (LPN), donned a pair of gloves, obtained a syringe, and uncovered the resident. Staff C found a plug attached to end of the resident's g-tube port, and water flush infusing onto the pad under the resident. Staff C stated the pad under the resident appeared wet. Staff C stated the tube feeding was not hooked up and she didn't know why a plug for the tubing was attached to the resident's g-tube. Staff C planned to look into what happened and who attached the plug to the g-tube. When informed the tube feeding and water flush were not connected that morning and the date on the Jevity bottle 10/25/21 at 10:00 PM., Staff C confirmed this would have been the date the bottle had been hung. Staff C stated the tube feeding should be changed out at 3:00 PM whenever staff hung a new bottle of formula. Staff C reported a new bottle of Jevity sat on the shelf by the resident's bed and apparently was not hung or changed out 10/26/21 at 3:00 PM when scheduled. Staff C reported enteral formula needed to be changed out every 24 hours. On 10/27/21 at 1:35 PM, Staff C stated she looked at the MAR for Resident #31. Staff V, an agency LPN, documented she hung Jevity on 10/25/21. Staff C reported that Resident #31 had an order for her Jevity infusion to start at 3:00 PM and end at 5:00 AM. The nurse who worked 10/26/21 didn't change the Jevity bottle at 3:00 PM. Staff C stated she wasn't sure who started the infusion on 10/27/21. In an interview 10/27/21 at 1:54 PM, Staff B, LPN, reported she hooked up the water flush for Resident # 31 at 12:00 PM on 10/27/21 because the resident got a 200 ml water flush every 6 hours, and they record the volume according to reading on the pump. At the time, Staff C told Staff B she found a cap attached to Resident #31's g-tube and the flush infusing into the pad under the resident. Staff B reported she was responsible for the infusion not being hooked up correctly. Staff C also stated the date listed on the Jevity bottle was 10/25/21. Staff B then stated she hadn't even looked at the date on the bottle when she connected the water flush. Staff B stated it's good the tubing wasn't connected to the resident's g-tube because the water in the bag was probably moldy or not good. The facility's Medication Administration General Guidelines policy dated 12/17 revealed the individual who administered a medication dose recorded the administration on the resident's MAR after giving the medication. The person who administered the medication initialed on the MAR in the space provided under the date, and on the line for the specific medication administered. If a dose of regularly scheduled medication is withheld, refused or not available, or given at a time other than the scheduled time, initial and circle in the space on the front of the MAR. The physician would be notified if a vital medication was withheld, refused or not available.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43039 DESCRIPTION: Based on clinical record and policy review, observations, and staff, resident, and family interviews, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person- centered care plan, and the residents' goals and preferences for 1 of 2 residents reviewed (Resident #50). The facility reported a census of 50 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #50 had diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The MDS documented the resident scored 15 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant she demonstrated intact cognitive abilities. The MDS also documented Resident #50 required assist of 1 staff with bed mobility, transfers, and toilet use, and set-up assist for eating. Resident #50 had moisture related skin damage and ointments applied during the lookback period. Review of the resident's Care Plan revealed a lack of information, planning, interventions, and staff directives related to management of the resident's pain. In an observation on 10/25/21 at 3:42 p.m., Resident #50 sat in her recliner. The resident reported she often had to wait a long period for staff to bring her pain medication for gastric tube (GT) site pain. She stated she had a scheduled a pain pill at 8 a.m. today but did not receive a pain pill until noon, and described her current pain level as 8 out of 10 (0=Nothing. 10=the worst pain ever felt). The resident appeared to be in pain with facial grimacing observed whenever she moved. On 10/27/21 at 1:11 p.m., Resident #50 reported her current pain level as 5 out of 10. The resident stated she received a pill at noon and commented the nurses do not try to keep my pain controlled and not all nurses apply Dermaceptin as ordered twice per day. She added when staff needed to change her dressing, her pain increased and she now required a Fentanyl patch plus the Hydrocodone for pain. Resident #50 stated since the physician started the Fentanyl patch, the nurses do not seem to think she needed the Hydrocodone and took longer to medicate her. On 11/1/21 at 11:00 a.m., the resident's tube feeding (TF) infused through her GT. Observation revealed the resident in visible pain and alternating her position while she sat. Resident #50 reported she had a rough weekend; the facility ran out of her pain medicine and the nurse did not change her dressings as ordered. She specified that the primary source of her pain is her GT and abdominal wounds when not treated with ointment. During an interview on 10/27/21 at 2:34 p.m., Staff C, LPN, explained the nurses documented skin assessments in the electronic health (EHR), under the assessments tab tilted Skin Observation Tool. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0697 Level of Harm - Actual harm Residents Affected - Few	In a subsequent interview on 11/01/21 at 11:30 a.m., Staff C, Licensed Practical Nurse (LPN) reported the facility did not have a process for reordering medication, but usually when a medication runs low, the certified medication aide (CMA) or LPN will place a sticker on the reorder form and fax it to the pharmacy. During an interview on 11/1/21 at 11:35 a.m., the Administrator (ADM) reported the facility had no specified process for reordering medication; it is not one person's responsibility to reorder narcotics or other frequently used medications. During an interview on 11/1/21 at 1:15 p.m., the Director of Nursing (DON) stated Staff C, LPN gave Resident #50 Hydrocodone at 7:00 a.m. on 11/1/21. At 2:50 p.m., the DON added the resident received a Hydrocodone at 7:30 a.m. today, but she failed to sign out the narcotic and Staff C gave the resident Tylenol at noon. During an interview on 11/1/21 at 3:30 p.m., Staff C, LPN reported the DON had removed Hydrocodone from the facility Emergency Kit (E-kit) 11/1/21 and administered the medication to Resident #50. Staff C stated the facility ran out of Hydrocodone for Resident #50 over the weekend and since the facility pharmacy is located in Minnesota, the refill will not arrive until 11/2/21 at approximately 2 a.m. On 11/01/21 at 3:30 p.m., the resident reported an improvement of pain from 10 out of 10, to 9 out of 10 after Staff C, LPN changed her abdominal dressing. Resident #50 stated the dressing change decreased her pain level more than the pain medicine did. On 11/1/21 at 3:40 p.m., Staff C, LPN, stated she gave the resident Tylenol at noon today, but did not sign the medication record. She also said she was not aware the resident did not have a physician order for Tylenol. On 11/1/21 at 3:45 p.m., the DON reported she placed a call to the facility physician to obtain Hydrocodone from the E-Kit for Resident #50. On interview on 11/2/21 at 9:39 a.m., Staff C, LPN said nursing staff are to document the effects of pain medicine in the progress notes. During an interview on 11/4/21 at 9:09 a.m., Staff C, LPN, stated the facility wound physician would visit Resident #50 11/4/21. She explained the physician visits the facility every week and had not seen Resident #50 prior to 11/4/21, as she had not needed a wound doctor. Staff C stated she updated the Care Plan for each resident quarterly or PRN and added that wound cares would be on a Care Plan if ordered. Staff C reported she looked at Activities of Daily Living (ADL) sheet, History & Physical (H&P), and physician orders to update Care Plans, which were updated within 24 hours. During an interview on 11/03/21 at 9:50 a.m., the DON stated she expected Staff C, PLN to update the residents' Care Plan within 24-48 hours. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/3/21 at 12:00 p.m., the DON revealed the Certified Nurse Assistants (CNA's) Shower Day Skin Audit is where staff document the resident skin on shower days. DON stated the Certified Nurse Assistants (CNA's) would have been aware of Resident #50's abdominal wounds and therefore did not make mention of them on the tools. DON stated the expectation would be for staff to draw on the body diagram Resident #50's abdominal wounds. During an interview on 11/04/21 at 2:23 p.m., Staff C, LPN stated she could not locate prior documentation of Resident #50's abdominal wounds in her medical records. During an interview on 11/22/21 at 5:45 p.m., Wound Physician stated she has been rounding on residents at the facility since September 2021. Wound Physician made an initial round on Resident #50 on 11/11/21. During an interview on 12/6/21 at 10:00 a.m., Power of Attorney (POA) stated Resident #50 admitted to the facility with abdominal wounds present. POA stated the wounds have gotten worse and she had asked for a wound doctor to see Resident #50 in September. The DON told the POA that Staff C, LPN was a wound nurse. The MAR dated 10/1/21-10/31/21 lacked documentation to show staff gave Hydrocodone for pain on 10/25/21. The Individual Residents Controlled Substance Record for Hydrocodone-Acetaminophen (APAP) 5/325 mg, 1 tablet by mouth every 4 hours as needed for pain, revealed the documentation on 10/25/21 appeared altered from 12:00 p.m. to 8:00 a.m.; documentation dated 10/31/21 revealed 1 remaining Hydrocodone at 3 p.m. A MAR, dated 10/1/21-10/31/21 lacked documentation to show staff administered the resident's Fentanyl patch on 10/19/21 and 10/22/21. A Physician Order Summary (POS) dated 10/11/21 revealed: a. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet via GT every 4 hours as needed for pain. b. Fentanyl patch 72 hour 25 microgram (MCG)/hour, apply transdermally every 72 hours related to acute ischemia of intestine. Review of the MAR, dated 11/1/21-11/3/21 revealed no documentation to indicate staff administered Hydrocodone as needed for pain on 11/1/21-11/3/21. The MAR dated 11/1/21-11/30/21 revealed staff gave Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet two times per day for pain on 11/1/21 at 7:30 a.m. and 8:30 p.m. The Individual Residents Controlled Substance Record, dated 11/1/21 revealed: a. 6:03 p.m.: Zero Hydrocodone on hand, 1 received from E-kit, 1 given, 0 remaining b. 10:05 p.m.: Zero Hydrocodone on hand, 2 received from E-kit, 1 given, 1 remaining (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	c. 11/2/21 2:00 a.m.: 1 Hydrocodone on hand, 0 received, 1 given, 0 remaining The MAR, dated 11/1/21-11/30/21 lacked documentation of staff administration of Fentanyl patch on 11/1/21. The Physician Order Summary dated 11/4/21 revealed the following orders: a. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet via GT every 4 hours as needed for pain. b. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet by mouth two times per day for pain b. Fentanyl patch 72 hour 25 microgram (MCG)/hour, apply transdermally every 72 hours related to acute ischemia of intestine. The Baseline care plan dated 6/9/21 lacked documentation of current or past skin integrity issues. The resident's Care Plan lacked staff directives related to cares and interventions from skin breakdown. A physician order dated 6/9/21 directed licensed nurse to complete weekly skin check. A Skin Assessment Tool, dated 10/14/21 in the EHR revealed Resident #50 had one excoriated area around the GT site only. The resident's record did not have any other Skin Assessment Tools documented. The facility documents in the EHR titled Weekly Wound Observation, dated 10/28/21, revealed blank documentation. The resident's record did not have any other Weekly Wound Observations. The facility policy titled Medication Ordering and Receiving from Pharmacy, dated 12/2017 directed: a. Reorder medication five days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand. b. The refill order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. The pharmacy label is pulled and transmitted to the pharmacy. Resident #50 chart lacked a physician order for Tylenol. A Shower Day skin audit form for 10/1-10/29/21 revealed Resident #50 did not have any open areas noted six times by three different staff members. Facility document titled Medication Administration -Preparation and General Guidelines, dated 12/2017 revealed: Documentation: the individual who administers the medication dose records the administration. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	When PRN meds are administered: Date, time of administration, dose, route of administration; complaints or symptoms for which the med was given; results achieved from giving the dose and the time results were noted; signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medications. Resident #50 Progress Note, from date range of 6/21/21 through 11/20/21 revealed: a. 6/21/21 Nurse Practitioner (NP) requested to see resident for increased pain at GT site with redness and irritation, green/yellow drainage from insertion site on gauze and around tube. Plan to start on Keflex 500 milligrams (MG) x 7 days. Resident #50 stated Tylenol has not controlled pain. b. 6/21/21 NP documented to start Keflex 500 MG twice per day (BID) x 7; monitor GT site; monitor pain; skin checks per protocol c. 6/22/21 Staff DD, Registered Nurse documented she received nurse order to start Keflex 500 MG BID for x 7 days for skin infection and to start Hydrocodone-Tylenol (APAP) 1 tablet every 6 hours as needed (PRN) for pain. Faxed to Pharmacy at 2:15 a.m. d. 6/27/21 Staff Z, RN documented she changed GT dressing and noted 3 centimeter (CM) by 2 CM open abrasion approximately 1 inch above the left side of GT, no drainage from wound, Resident #50 stated tender to touch and pain med given e. 6/27/21 Staff EE, LPN documented open, red areas remain on abdominal creases f. 6/29/21 Staff FF, LPN documented Resident #50 on antibiotics for skin infection surrounding GT, red and raw in some areas, painful per Resident. 7/4/21 NP ordered Dermaceptin BID to GT site BID 7/19/21 NP documented Resident #50 reported increased pain localized to GT site. Wound culture showed no growth. Resident evaluated in emergency department. 7/20/21 Staff CC, RN documented to start Hydrocodone-APAP 1 tablet every 4 hours for GT pain. 8/31/21 NP documented to see Resident #50 for increased pain. 9/6/21 Director of Nursing (DON) documented to start Bactrim (antifungal) BID for 10 days 9/10/21 Staff GG, LPN documented Resident #50 cried in pain during the night from pain at GT site. 9/17/21 Staff GG documented on Physician Progress Note for Bactrim DS tablet 800-160 MG, 1 tablet by GT for GT site infection until 9/26/21 9/26/21 Staff D, LPN documented GT site raw and extremely painful. Resident needs seen for pain management. 9/28/21 NP documented Resident #50 with increased pain at GT site, staff state red with odor, started Diflucan 150 MG x 3 days. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	10/13/21 Staff HH, RN documented Resident #50 upset that the nurse had to call the pharmacy for more pain medicine. 11/4/21 Staff V, LPN documented Resident #50 Fentanyl patch increased, resident taking scheduled and PRN Hydrocodone with continued complaints of pain. 11/11/21 Wound Physician rounded on Resident #50 11/13/21 Staff B, LPN documented GT skin dark pink and draining, continued to be tender and Resident appeared to be in pain. 11/20/21 Staff D, LPN documented GT site very red, raw, and painful. Facility policy titled Interdisciplinary Care Plan Meeting, dated 1/24/2019 directed: The initial Interdisciplinary Care Plan Meeting will be scheduled post completion of the initial Resident Assessment Instrument (RAI). Subsequent meetings will take place quarterly, upon significant changes, and as needed. Facility policy titled Comprehensive Person Centered Care Plan, dated 1/24/2019 directed: a. Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. b. For each problem, need, or strength a resident-centered measurable goal is developed. c. Upon change in condition, the Comprehensive Person Centered Care Plan or baseline Care Plan will be updated if: to reduce the risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, observations, and staff interviews, the facility failed to ensure staff responded and answered a resident's request for assistance within 15 minutes, and met residents needs in a timely manner for one of nineteen residents reviewed (Residents #11). The facility reported a census of 50 residents. Finding include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS indicated the resident had diagnoses of cerebral palsy, anxiety disorder, and seizure disorder. The MDS recorded the resident displayed total dependence on two staff for transfers and toilet use, and total dependence on one staff for locomotion on and off the unit. The resident's Care Plan, revised 6/8/21, documented the resident as at risk for falls and that she required assistance with activities of daily living. The staff directives included to anticipate and meet the resident's needs, and encourage resident to call for assistance. Observations on 10/27/21 revealed the following: a. At 10:45 AM, Resident #11 sat in a wheelchair at a table in the upper dining room, and hollered out why it took so long to find someone to help her. A dietary staff person was visible in the kitchen, but no other staff were in the area. The resident had no call light or way to call for assistance other than to yell. b. At 10:57 AM, Staff G, certified nursing assistant (CNA) walked by the resident and told Resident #11 she would help her in a little bit. Staff G then walked into another resident's room on the 100 hall. c. At 10:59 AM, Resident #11 cried out if you don't lay me down, I'm not going to eat, then started to cry. d. At 11:01 AM, Staff H, CNA, wheeled Resident #11 in her wheelchair from the dining room to her room, then left the resident's room. e. At 11:04 AM, Staff H walked by Resident #11's room and told her staff was on the way, then went to obtain the mechanical lift and wheeled the lift into the resident's room. In an interview 11/4/21 at 9:10 AM, Staff C, Licensed Practical Nurse/ MDS Nurse reported she expected call lights to be answered within 15 minutes. Staff C reported no audits done for call lights and staff response times. In an interview 11/10/21 at 9:15 AM, the Administrator reported she expected staff responded to call light or assistance of a resident within 10-15 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	5608 SW 9th Street Des Moines, IA 50315

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35437 Based on facility record review and staff interviews, the facility failed to provide eight consecutive hours of Registered Nurse coverage seven days a week. The facility reported a census of 50. Findings include: Review of the facility forms titled Nursing Staff Assignment from 10/1 - 10/27/21 revealed no Registered Nurse scheduled to work on 10/3, 10/10, 10/16 and 10/17/21. Interview on 10/27/21 at 2:30 pm with Staff A Certified Nursing Assistant/Scheduler revealed that staff had set schedules and verified that on the above dates there were no Registered Nurse scheduled or who worked at the facility. During interview on 10/28/21 at 10:01 am with the Director of Nursing verified that she was not in the facility on the above listed dates. The Director of Nursing stated she expected that the CMS guidelines related to the 8 hours of RN coverage a day be followed.

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	165175	A. Building B. Wing	12/07/2021

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the residents were free from significant medication errors for two of eight residents reviewed with diagnoses of COVID-19 (Resident #16 and #34). The failure resulted in Resident #16's decline in condition and required admission to a higher level of care. The facility reported a census of 50 residents. Findings include: 1. The annual Minimum Data Set (MDS) assessment tool dated 11/5/21 revealed Resident #16 had diagnoses that included non-Alzheimer's dementia, anemia, pulmonary embolism (PE), chronic obstructive pulmonary disease (COPD), atrial fibrillation, breast cancer, and diabetes. The MDS revealed the resident had impaired short and long-term memory, poor appetite for 12-14 days during the 14 day look-back period, and was totally dependent on one staff for eating and activities of daily living (ADL's). The care plan revised 11/11/21 revealed the resident had diagnoses that included COPD, anemia, dementia, diabetes and hypertension (HTN). The care plan documented the resident as at risk of contracting COVID-19 due to nursing facility and community living and had a risk of fatal complications of infection due to her advanced age and a compromised immune system. The care plan showed the resident moved to a transitional private room on 10/25/21 due to exposure to a COVID-19 positive resident. On 11/1/21, the resident tested positive for COVID-19 and moved to the COVID unit, and on 11/11/21, the facility deemed the resident recovered from COVID-19. Staff directives included administer medications as ordered and monitor for elevated temperature, respiratory symptoms such as cough, sore throat, and shortness of breath. The physician's progress notes dated 11/8/21 and entered on 11/9/21, revealed Resident #16 tested positive for COVID-19 on 11/1/21. The treatment plan included start vitamin C 500 milligrams (mg) daily (qd) for 30 days, vitamin D 5,000 international units (IU) qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days. The physician's progress notes dated 11/12/21 and entered on 11/14/21, documented the facility moved the resident was removed from isolation on 11/11/2021. The treatment plan included continue the vitamin D, vitamin C, aspirin, and zinc medications as ordered. Review of the physician order summary and electronic health record (EHR) revealed it lacked orders for vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days. The medication administration record dated 11/1 - 11/30/21 failed to contain documentation regarding the vitamin C 500 mg qd, vitamin D 5,000 IU qd, zinc 220 mg qd, and aspirin 325 mg qd ordered by the physician. The progress notes revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

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F 0760 Level of Harm - Actual harm Residents Affected - Few	a. On 10/26/21 at 11:26 AM, resident moved to transitional hall due to roommate tested positive for COVID-19. Resident #16 tested negative for COVID-19. b. On 10/30/21 at 6:58 PM, resident seen by provider due to 14 residents and 3 staff at the facility tested positive for COVID-19. Resident #16 at high risk for COVID-19 due to history of COPD, PE, breast cancer, heart disease, dementia, diabetes, and HTN. c. On 11/1/21 at 7:19 AM, The resident's COVID point of care test is positive - resident moved to COVID unit. d. On 11/2/21 at 7:54 AM, Resident's PCR test (used to detect genetic material from a specific organism, such as a virus) results positive for COVID. e. On 11/9/21 at 10:35 PM, resident on droplet and contact precautions due to positive COVID-19 test. The resident had poor appetite and didn't want to eat supper, and not drinking fluids when offered - respiration easy and unlabored. No cough observed. Pulse oximeter 94% on room air. f. On 11/12/21 at 7:46 AM isolation discontinued on 11/11/21. g. On 11/13/21 at 11:34 AM, lungs sound diminished bilaterally in bases and transient wheezes audible. h. On 11/17/2021 at 4:55 PM, resident up for breakfast but would not stay awake and refused to eat. Resident asked to lie down. Staff returned resident to bed. Blood Pressure (B/P) 98/69, temperature (T) 97.9, pulse (P) 103, respirations (R) 13. Resident also refused lunch and asked to be left alone. i. On 11/18/2021 01:48 resident up for evening meal and had a fair appetite. Resident assisted to lie down after dinner. j. On 11/18/2021 at 04:00, resident has not voided this shift. Gave resident 240 cubic centimeters (cc) water. Resident skin pale white and bluish in color on hip and in between knees and skin blanched poorly. Resident repositioned off of her right side. j. On 11/18/2021 at 11:53 AM nurse summoned to resident's room. Resident less responsive and had significant change in her condition. B/P 106/56, P 94, R 23. Provider notified and attempted to notify family. Resident sent to the emergency department (ED). k. On 11/19/2021 at 05:33, nurse from hospital contacted facility and advised Resident #16 passed away. In an interview 11/23/21 at 09:31 AM, Staff D, Licensed Practical Nurse (LPN), reported usually the nurse that received the physician's order entered the order into the EHR, but it also depended on which nurse had time to enter the orders. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In an interview 11/23/21 at 09:46 AM, Staff Z, Registered Nurse (RN), reported the nurses entered physician orders whenever they received the orders. In an interview 11/23/21 at 11:35 AM, Staff JJ, RN, reported the nurses entered orders whenever they received new physician orders. In an interview 11/23/21 at 12:50 PM, the Director of Nursing (DON) reported the facility had no policy for physician's orders. The DON stated physician's orders were just standard procedure. The DON explained whenever staff obtained an order, she expected them to enter the orders into the EHR, and process the orders. The DON reported the order summary report dated 10/11/21 were the most current orders for Resident #16. The DON provided a report of orders entered into the EHR after 10/3/21 for Resident #16; the report revealed only an order for a pain assessment entered on 11/4/21 but no medication orders entered. In an interview 11/23/21 at 01:15 PM, the nurse practitioner (NP) confirmed she ordered the following for Resident #16 on 11/9/21: Start vitamin C 500 mg qd for 30 days, Start vitamin D 5,000 IU qd for 30 days Start zinc 220 mg qd for 30 days Start aspirin 325 mg qd for 30 days The NP reported these medications were the standard cocktail of medications prescribed whenever a resident had COVID-19. The NP confirmed no staff contacted her about orders staff failed to order or administer as prescribed for Resident #16. The NP stated the resident didn't have many signs or symptoms of COVID-19 but had tested positive for COVID-19. The resident then stopped eating and had a decline in health, and was sent to the hospital. A facility policy for Medication Administration Preparation and General Guidelines dated 12/17, directed staff to administer medication as prescribed in accordance with the prescriber's orders. 2. The annual MDS assessment dated [DATE] revealed Resident #34 had diagnoses of Alzheimer's dementia, anemia, malnutrition, and vitamin D deficiency. The MDS revealed the resident had impaired short and long-term memory and was totally dependent on one staff for ADL's. The care plan revised 11/9/21 revealed the resident had a risk of contracting COVID-19 due to nursing facility community living and at risk of fatal complications of infection due to her advanced age and a compromised immune system. The care plan revealed the resident moved to a COVID unit on 10/25/21 due to positive COVID-19 and symptoms of fatigue and malaise. The care plan documented the resident deemed recovered from COVID on 11/4/21 and directed staff to administer medications as ordered and monitor for elevated temperature, respiratory symptoms such as cough, sore throat, and shortness of breath. (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A physician's progress note dated 10/30/21 for date of service 10/29/21 revealed resident tested positive for COVID-19 on 10/26/21 but had no symptoms. The treatment plan included to: start vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days. The order summary report revealed aspirin 325 mg qd, vitamin C 500 mg qd, vitamin D 5,000 IU qd, zinc 220 mg qd had an order date 10/26/21 and an end date 11/26/21. The MAR dated 10/1 - 10/31/21 lacked medication entries/orders 10/29 - 10/31/21 for aspirin 325 mg qd, vitamin C 500 mg qd, vitamin D 5,000 IU qd, and zinc 220 mg qd In an interview 11/23/21 at 09:31 AM, Staff D, LPN, reported the nurse who received the physician's order entered the order in the EHR but it also depended on who had time to enter the orders. In an interview 11/23/21 09:46 AM Staff Z, RN, reported the nurses usually entered orders in the EHR. In an interview 11/23/21 at 12:50 PM, the DON reported the facility had no policy for physician's orders. The DON stated physician's orders were just standard procedure. The DON explained whenever an order obtained, she expected orders entered into the EHR, and the orders processed. In an interview 11/23/21 at 01:15 PM, the NP confirmed she ordered to start vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days on 10/29/21. The NP reported the medications were a standard cocktail she prescribed whenever a resident had COVID-19. The NP confirmed no staff contacted her about orders not implemented or medication not administered as prescribed.

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	165175	A. Building B. Wing	12/07/2021

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 35437 Based on observation, staff interviews, and facility policy review the facility failed to properly monitor the storage of refrigerated medications for 1 of 1 medication refrigerators, and failed to dispense medications from manufacturer labeled container. The facility identified a census of 50. Findings include: 1. Review of the medication storage room in the downstairs area on 10/27/21 at 12:44 PM revealed a document titled Freezer/Refrigerator Temperature Log attached to the front of the refrigerator. Staff C, MDS Nurse was present during the inspection of the medication storage room and verified that the Refrigerator Temperature Log sheet had not been documented since 5/9/21. Staff C stated the refrigerator temperature checks should be done by night shift as it is assigned to their duty list and temperatures should have been logged. Medication in the downstairs storage room refrigerator during the inspection included: a. Bisacodyl suppositories 10 mg (milliigrams) in an opened box. b. Levemir (insulin) 3 bottles for Resident #20. c. Basaglar (insulin) 4 pens for Resident #2. d. Lorazepam 3 vials for Resident #36. e. Lantus (insulin) 3 vials for Resident #49. f. Lantus (insulin) 3 vials for Resident #5. In an interview on 10/27/21 at 1:00 PM, the Director of Nursing (DON) stated she expected medication refrigerator temperature logs be filled out. In an interview on 10/28/21 at 10:11 AM, Staff C stated the medications in the refrigerator eventually would be used for the residents. Review of a form titled 6 PM-6 AM Nurse Duties indicated that refrigerator temperatures needed to be logged every day. Review of a Medication Storage facility policy dated 11/18 indicated the facility should maintain a temperature log in the storage area to record temperatures at least once a day. 44972 (continued on next page)

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	165175	A. Building B. Wing	12/07/2021

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication pass observation on 10/26/21 at 11:40 AM, Staff X, Certified Medication Aide (CMA) reported she planned to administer an extra strength (ES) Tylenol 500 mg tablet to Resident #15. When Staff X obtained the medication from the medication cart it was noted that the medication was not in a manufactured labeled bottle or individually dispersed packet or bubble pack. The medication was in a denture cup and Tylenol ES 500 mg written in marker on the lid of the denture cup. At the time, Staff X stated she knew it wasn't legal but she used a denture cup to store the ES Tylenol. The CMA proceeded to get the ES Tylenol tablet out of the container and added to the rest of the resident's medication she prepared for the resident. In an interview on 11/4/21 at 10:15 AM, the DON stated she expected stock medications to be administered from a manufacturer's labeled bottle. The DON stated for resident specific medications, the facility utilized bubble cards or medication packets but all stock medications should be in their original manufacturer's bottles and labeled with a date when they were opened. The DON stated it would never be okay for staff to pass medications out of a denture cup. Per the policy on Medication Storage in the Facility, dated 11/18, the policy directed the provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medications to the original container. It further states drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached.

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	165175	A. Building B. Wing	12/07/2021

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44514 Based on clinical record review, observations, staff interviews, and facility policy review, the facility failed to ensure staff prepared food by methods that conserved nutritional value for pureed food for 1 of 1 residents sampled on a pureed diet (Resident #40). The facility reported a census of 50 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] recorded Resident #40 had diagnoses of Alzheimer's disease, dysphagia (swallowing difficulties), and anoxic brain damage. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS revealed the resident required assistance of one person for eating. Observation on 10/26/21 at 11:07 AM revealed Staff Q, Cook, added a cup of hot water to meat in a blender. Staff Q continued to add thickener and stated she added the thickener in case she had added too much water to the pureed meat contents. At 11:10 AM Staff Q scooped the pureed meat into a pan to be served to Resident #40. Interviews on 10/26/21 at 01:01 PM with the Dietician and Dietary Manager revealed they expected staff to use something with nutrition or flavor instead of just water for pureed diets. Review of the facility policy on Pureed Diet Guidelines, updated 10/4/21, Section 3 instructed staff to add milk, broth, or other liquid as needed for product consistency (usually 2-3 tablespoons per serving), and never puree with water.

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	165175	A. Building B. Wing	12/07/2021

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44514 Based on observation and staff interview, the facility failed to ensure staff sanitized their hands after contamination in order to prevent food borne illness and handle food in a sanitary fashion for 1 of 2 dining observations. The facility reported a census of 50. Findings include: Observation on 10/26/21 at 11:45 AM Staff Q, Cook, started serving lunch. At 11:46 AM, Staff Q grabbed a grilled cheese sandwich by hand and placed it on a plate to serve to a resident. At 11:54 AM, without hand hygiene, Staff Q held meat with her hand and cut a portion of burnt meat off, then placed the meat on a plate to serve a resident. The Dietary Manager then gave Staff Q tongs to dish up meat, and Staff Q started using the tongs. At 11:55 AM, Staff Q threw the tongs into the meat and the handle touched the meat. Staff Q's phone rang at 12:23 pm, she took the phone out of her pocket and threw it under the tray cart. Without hand hygiene, at 12:24 PM Staff Q used her hand to hold the inside of Styrofoam boxes where she was going to serve the food. Staff Q repeated this 3 times. Interview on 10/26/21 at 1:03 PM the Dietician and Dietary Manager both stated the expectation that staff not touch food and plates with their hands, and staff used tongs when served food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34817 Based on facility record review and policy review, and staff interview, the facility failed to have an effective quality assurance (QA) program in place to assist in the provision of quality care for residents. The facility identified a census of 50 residents. Findings include: Review of CASPER (Certification and Survey Provider Enhanced) report and facility records revealed repeated deficient practices identified during the facility's annual survey 7/24/19, complaint investigations completed 7/27/21, and the current survey and complaint investigations. The facility's QAPI (Quality Assurance Performance Improvement) policy reviewed on 8/20/20 described how the facility ensured care and services delivered met accepted standards of quality, identified problems and opportunities for improvement, and ensured progress toward improvement was achieved and sustained. Performance improvement is a proactive and continuous process with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and implementing new approaches to resolve systemic problems. In an interview 11/30/21 at 2:35 PM, the Administrator reported they had a turnover in administrative staff and department heads, and were working to build their team. The Administrator reported she was aware of deficiencies and planned to put together a plan to address concerns identified, provide staff training and education, and start auditing resident records for accuracy and completeness. The Administrator reported a number of gaps in their records and processes, and planned to work through the whole problem. The Administrator reported the facility had no QA meeting minutes since the previous administrator left 8/21 and since the Director of Nursing took over the QAA role.

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	165175	A. Building B. Wing	12/07/2021

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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** 44972 Based on clinical record reviews, observations, staff interviews and facility policy reviews, the facility failed to utilize infection control techniques to protect against cross contamination and potential infection when handling gastrostomy tubes, catheters, and performing hand hygiene for 3 of 19 residents reviewed (Residents #30, #50 and #53). The facility reported a census of 50 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #53 had diagnoses that included hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive and cystitis. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired memory and cognition. The MDS coded the resident always had bladder and bowel incontinence. The MDS lacked documentation of a catheter but had a Foley (urinary) catheter on admission. The MDS documented the resident required the assistance of one staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Physician Order dated 10/12/21 instructed use of a 16 French/10 milliliter bulb Foley catheter to straight drainage for Resident #53's urinary retention. The Care Plan dated 10/21/21 lacked a focus problem, goal or any interventions for the Foley catheter Resident #53 had in place. A Progress Note dated 10/9/21 at 3:31 AM recorded the resident's Foley catheter as patent and draining clear yellow urine via gravity without difficulty. Observations revealed the following: a. On 10/26/21 at 8:38 AM, the Foley catheter bag was attached to the bottom of the resident's wheelchair and a puddle of urine on the floor below the catheter bag. b. On 10/27/21 at 10:49 AM, the catheter bag sat on the floor. d. On 10/27/21 at 1:30 PM, the catheter bag continued to sit on the floor at the resident's bedside. e. On 10/27/21 at 2:40 PM, the catheter bag continued to sit on the floor at his bedside. f. On 10/27/21 at 3:00 PM, the catheter bag now inside a pillow case and hung from the bed frame. g. On 11/3/21 at 8:56 AM, the catheter bag sat on the floor. h. On 11/4/21 at 8:39 AM, the catheter bag hung on the bed frame and inside a pillow case. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

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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	In an interview on 11/10/21 at 8:43 AM, the Director of Nursing (DON) stated staff no longer needed to worry about keeping the catheter bag below the bladder due to valves in the catheter bag that prevented reflux of urine into the bladder. She stated it was her expectation that catheter bags be hung under the seat of the wheelchair on the cross bars or on the side of the wheelchair if cross bars were not present. The catheter bag hung from the bedframe whenever a resident in bed. The DON stated staff were trained on catheters and catheter care during their orientation. The DON stated it would never be acceptable to have a catheter bag left on the floor due to the high potential for contamination and possible subsequent infection. The facility's Policy and Procedure for Catheter Care, dated 10/16, instructed staff to maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function and prevention of infection and other complications. 34817 2. The MDS assessment dated [DATE] recorded Resident #30 had diagnoses of cerebrovascular accident (stroke), quadriplegia, and a gastrostomy. The MDS documented the resident required a feeding tube. The resident's Care Plan, revised 7/7/21, instructed she required a feeding tube related to a stroke and dysphagia (difficulty with swallowing), and had a history of infections. The staff directives included to administer medications as ordered. During observation on 10/27/21 at 11:49 AM, Staff B, LPN (Licensed Practical Nurse), prepared medication for Resident #30 then took the medication cup to the resident's room. Staff B placed the resident's feeding pump on hold, then donned a pair of gloves, placed the uncapped feeding tube tubing over the pole next to the bed, attached a syringe to the resident's g-tube, and checked placement of the tube. Staff B plugged the g-tube port, then opened the bathroom door with her gloved hand, turned on the faucet with her gloved hand, filled a plastic container with tap water, then turned off the faucet, and placed the container on a table next to the resident's bed. Staff B attached a syringe to the resident's g-tube, poured approximately 75 milliliters (ml) of water into the syringe, mixed the medication with 5 ml water, poured the medication into the syringe attached to the g-tube port, then poured approximately 75 ml water into the syringe. After the contents had been instilled, Staff B removed the syringe from the g-tube port, took the uncapped tubing that hung over the feeding pump and pole, and attached the tubing to the g-tube port. Staff B did not cleanse the end of the tubing prior to attaching the tubing to the g-tube. Staff B removed her gloves, set the feeding pump to infuse water and Jevity formula. Staff B then poured the left over water in the plastic container into the bag of water that presently hung on the pole. The facility's policy for Enteral Tube Medication Administration, revised 8/14, recorded the following procedural steps: a. Don gloves b. Check tube placement using air and auscultation. c. Check gastric contents for residual feeding, then return residual volumes to the stomach. Turn pump off, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	12/07/2021

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Remove plunger from 60 ml syringe and connect the syringe to clamped tubing using the appropriate port. e. Administer medication and flush tube with 15 ml of water based on facility policy f. Clamp tubing and detach syringe. g. Restart pump h. Wash hands with soap and water. The facility's policy titled Medication Administration - Preparation and General Guidelines, dated 12/17, directed the person administering medications adheres to good hand hygiene which included washing their hands thoroughly before beginning medication pass, prior to handling any medication, after coming in direct contact with a resident, and before and after administration of medications via enteral tubes. In an interview 11/4/21 at 9:14 AM, Staff C, MDS Coordinator reported she expected that staff washed their hands before and after cares, and she expected gloves to be changed after staff completed cares and whenever the gloves were soiled. 43039 3. The MDS assessment dated [DATE] indicated Resident #50 had diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain Resident #50 required the assistance of 1 staff with eating and utilized a feeding tube. The assessment also documented she had moisture related skin damage during lookback period with ointment application. The resident's Care Plan contained a focus area of Alternative Nutrition with an initiation date of 6/10/21. An intervention directed staff to provide local care to G-Tube site as ordered and monitor for signs and symptoms of infection. Observation on 10/27/21 at 1:29 p.m. revealed Staff B reviewed Resident #50's Treatment Administration Record (TAR) and physician order for Dermaceptin to the gastric tube (GT) site prior to entering Resident #50's room. Staff B donned gloves, placed a barrier on the table, placed wound supplies on the barrier, removed paper tape from around the resident's GT site secured by moistened split 2 x 2 gauze. Staff B stated the drainage appeared to be gastric fluids. The observation revealed two additional open areas above the GT site and all three sites were red and excoriated. Resident #50 grimaced in pain with removal of the dressing. Staff B applied wound cleanser to the open wounds, then she applied Dermaceptin ointment to all three wounds and covered only the GT site with a 2x2 split gauze dressing leaving the two other areas open to air. Staff B removed her gloves and washed her hands. Resident #50 stated the ointment drastically minimizes her pain as they feels like a burn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/2/21 at 12:40 p.m. revealed Staff D, LPN entered Resident #50's room and discontinued the resident's tube feeding without wearing gloves. Staff D drew up water that sat on the resident's bedside table with 30 l syringe, unclamped gastric tube with her bare hands, inserted the syringe and flushed the tube. Staff D repeated this process until she pushed a total of 250 ml of water. Staff D then hung the uncapped tubing over the pole. Staff D plugged the gastric tube and exited the room without performing hand hygiene. Observation on 11/3/21 at 2:00 p.m. revealed Resident #50's gastric tubing as uncapped, disconnected from resident and hanging from the pole next to her. During an interview on 11/4/21 at 9:09 a.m., with Staff C stated that staff expectations are to wear gloves when performing personal cares. Staff are to change their gloves if visibly soiled and sanitize in between the glove change. During an interview on 11/17/21 at 11:02 a.m. with Director or Nursing (DON)/Infection Preventionist (IP) stated she had not conducted any hand hygiene audits since arriving to facility in August, 2021. The facility's policy Infection Prevention Manual for Long Term Care - Using Gloves, dated 2009, instructed: a. Purpose is for resident and employee protection. b. Nonsterile gloves should be used primarily to prevent the contamination of the employee's hands when providing treatment or services to the resident. c. Perform hand hygiene after removing gloves. d. Disposable gloves must be replaced as soon as practical when contaminated. e. Gloves should be used: when touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin. 1. When cleaning up spills or splashes of blood or body fluids. 2. When handling potentially contaminated items. 3. When handling potentially contaminated items. 4. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious materials. The policy on Contact Precautions, dated 2009, directed: a. Hand hygiene should be completed prior to donning gloves. b. Gloves should be worn when entering the room and while providing care for the resident. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 34817 Based on observations, facility record review, and staff interviews, the facility failed to maintain an effective pest control. The facility identified a census of 50 residents. Findings include: Observation on 11/3/21 at 12:00 PM revealed a live cockroach in the employee bathroom that ran across the floor. The cockroach appeared to have entered through a crack in the baseboard. Three black roach hotels sat on the floor in the bathroom. A Maintenance Request form dated 9/27/21 recorded a request for the pest company to spray for bugs /roaches because a lot of bugs had been seen over the weekend in the dirty utility room, the nurse's station, and the bathroom on Side 1 hallway. A Maintenance Request form dated 10/28/21 documented a request to spray for bugs again as lots of baby roaches could be seen everywhere on Side 1 in the facility. In an interview on 11/4/21 at 3:15 PM, the Administrator reported an extermination company came to the facility every two weeks for pest control since she identified a problem six weeks prior to this date. In an interview 11/8/21 at 8:47 AM, the Administrator reported she discovered a problem with cockroaches in 8/21 after she found a cockroach in her backpack. At the time, she asked staff if they had seen any bugs or cockroaches. Staff told her they had seen cockroaches. The Administrator reported cockroaches were found in the dirty utility room, the nurse's station, and in the basement. The Administrator reported they had an exterminator come in and treat the areas.