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	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46873 Based on resident interviews, staff interviews, and Resident Council notes, the facility failed to speak to each resident in a respectful manner for 3 of 3 residents reviewed for dignity (Resident #7, #8, #10). The facility reported a census of 69 residents. Findings include: The Minimum Data Set (MDS) for Resident #7, dated 3/17/23, identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS for Resident #8, dated 3/31/23, identified a BIMS score of 15 which indicated intact cognition. The MDS for Resident #10, dated 3/24/23, identified a BIMS score of 12 which indicated moderate cognitive impairment. Resident council notes include the following concerns: Second shift Certified Nurse Aides (CNA) do little resident care. They hide in closets and are always on their personal phones CNA's use a rude tone of voice when speaking to residents CNA's talk on their personal phones while in the resident rooms providing cares. On 4/11/23 at 10:12 am Resident #7 stated that she has never personally been mistreated. She reported she has overheard staff speaking disrespectfully to other residents. She stated she heard a CNA cursing at another resident recently. This matter was reported to the facility administration and investigated. On 4/11/23 at 10:31 am, Staff C, Licensed Practical Nurse (LPN) stated residents have complained about overhearing cursing in the hallways. She clarified the cursing was not directed at residents but it was in conversations amongst staff members who were discussing their personal lives. She said their voices were loud and carried into the resident's rooms when they were still in bed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/23 at 10:47 am, Resident #10 reported some of the CNAs have been rude to her. She stated she has asked for things like snacks that she knows are available and the staff lie to her and tell her they don't have any. She stated she thinks the staff is just lazy and does not want to get the items. On 4/11/23 at 11:07 am, Resident #8 stated some of the staff have an I'm the boss attitude. She stated they give orders such as it's time to go to bed rather than offering a choice. She clarified this is mostly on the evening shift. On 4/11/23 at 1:48 PM, Staff D, CNA stated she has not ever personally witnessed any disrespectful behavior. She reported she has had residents complain to her about other employees. She stated one resident who was a smoker wanted to go outside for a cigarette and a staff member told the resident no and that she just needed to go to bed. Another resident reported to Staff D that a CNA told her she could do more for herself and she was taking advantage of the CNAs asking them to perform cares. Staff D said the residents have only complained about the staff on the evening shift.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on record review, family interviews, and policy review, the facility failed to notify the resident representative for 2 of 3 residents who had a change of condition (Resident #3 & #4). The facility reported a census of 69. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] of Resident #3 identified a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The MDS revealed the resident independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers. The Comprehensive Care Plan, with a Target Date of 5/18/2023, for Resident #3 failed to reveal any documentation of the resident being at risk of skin impairment or having any wounds. The Care Plan failed to document any interventions for skin integrity. The Skin Observation Tool for Resident #3 dated 12/9/22 recorded a pressure ulcer with a smaller open area inside of the larger open area. The note documented the nurse had removed a dressing dated 12/1/22 of gauze wrapped around heel and ankle and purulent, foul smelling drainage was noted. On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining. The Progress Note failed to reflect any family notification made of this wound. On 12/9/22 at 12:24 Staff A, ARNP, documented Resident #3 was seen by the writer for assessment of a right heel wound which was reported to have odor and pus discharge. The Progress Note failed to reflect any family notification made of this wound. On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3. The Progress Note failed to reflect any family notification was made of the wound or the antibiotic. On 12/28/22 at 9:20 the ADON documented the resident was seen by the wound care physician with no new orders. The Progress Notes failed to reflect any family notification made of the visit. On 1/6/23 at 1:51 am Staff B, RN documented the resident was found on the floor with a skin tear injury. This Progress note documented Staff B would request family notification be made by the oncoming shift due to the time of day of the fall. On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had tested positive for COVID. She also discussed the resident's wound with her at this time. This is the first progress note in the 7.5 weeks since the first documentation of the wound which reflected any family notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/23 at 2:14 PM a family member of Resident #3 stated she did not receive any phone calls from the facility regarding the wound on Resident #3 until January 23rd. The wound was found on November 30th. She stated she received a phone call from the DON regarding the Resident testing positive for COVID and the discussion led to the wound. Review of a policy titled Notification of a Change in a Resident's Condition, dated 4/28/21 directs the attending physician/physician extender and the Resident Representative will be notified of a change in a resident's condition. Guidelines of things to be reported include, but not all inclusive: Significant Change or Unstable Vital Signs. Emesis/Diarrhea Onset of Pressure Sores Any Accident or Incident Symptoms of any Infectious Process Abnormal Lab Findings 5% Weight Gain or Loss in 30 days Repeated refusals to take Prescribed Medication (for two days) Change in Level of Consciousness Unusual Behavior Missing Resident Glucometer reading below 70 or above 200 unless specific parameters given by physician for reporting. 44972 2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 5/13/16 with a revision date of 11/25/22 revealed a focus area related to a potential for alteration in psychosocial wellbeing with a goal of her long term care placement needs being met to her and her Power of Attorney's (POA's) satisfaction. The staff were directed to encourage continued family involvement and support in the plan of care. The progress notes for Resident #4 revealed the following: 2/12/23 at 8:56 PM, Staff V, LPN documented the resident to be lying on the floor on her back with a pillow under her head and bloody fluid coming from the back of her head. Per the CNA the resident was being transferred from the wheelchair to bed by full mechanical lift and assistance of 2 staff and she fell sideways out of the lift after the Hoyer sling caught on the wheelchair arm. The sling was still on the lift and the bottom straps observed to not be crossed. Vital signs stable and neurological assessment intact. Laceration observed to the back of the head. Emergency Medical Technicians (EMT's) were notified of the need for transfer due to head injury . 2/13/23 at 1:28 AM, Staff V, LPN documented the resident returned to the facility at 1:10 AM via ambulance. Vital signs: temperature 99.1 degrees Fahrenheit (F.), heart rate 93 beats per minute, respiration rate 20 per minute and blood pressure 103/43. Documentation from the hospital stated resident was treated for injuries sustained from a fall earlier in the shift. Resident had a diagnosis of laceration of the scalp, initial encounter. Resident received 5 staples to the laceration on the back of her head. A Computed Tomography (CT) scan of the cervical spine and head without contrast completed with negative results. Hospice was notified of the residents return to the facility and a member of the team was to come to the facility to evaluate and readmit the resident to Hospice. Resident resting in bed with no complaints of distress or pain. The facility failed to notify Resident #4's POA of the fall, the transfer to the hospital, or the resident's return to the facility after the emergency room visit. In an interview on 4/25/23 at 11:37 AM, the DON stated it was the expectation that staff call the family or representative and/or leave a message for them to call back with any medication changes, new orders, hospitalization s, changes in condition, and falls. They are expected to follow the facility's Notification of Change in a Resident's Condition policy.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on clinical record review, staff and resident interviews, and policy review the facility failed to provide resident safety and well-being for 1 of 1 resident reviewed (Resident #2). The facility reported a census of 69 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder, and spinal stenosis. Resident #2's Care Plan dated 1/17/23 included a focus area for anger, history of harm to others, and poor impulse control. The Care Plan directed staff to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist with verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff when agitated. The Care Plan further directed staff to document the observed behavior and attempt interventions in the behavior log, give as many choices as possible about her care and activities. Known triggers for physical aggression included not being allowed to go outside to smoke and her behaviors were de-escalated by alone time in her room with the door closed and going outside to smoke. In an interview on 4/13/23 at 9:45 AM, Resident #2 stated on the night of 3/26/23 she had her call light on to be changed and she felt it took a long time for a staff person to answer the light so she was somewhat angry and frustrated when Staff W, Certified Nursing Assistant (CNA) entered the room. She reported they bantered a little bit about the call light taking so long to answer and that was when Staff W, CNA stated Fucking change yourself, threw a brief and a glove at her, left the room, and never returned. She reported another staff person came in right away and changed her. She recalled a couple of days later the Administrator came in and told her that after visiting with Staff W, CNA, she wanted to extend an apology for her behavior and to let her know she never should have said what she did. Resident #2 stated she had not had any trouble with Staff W, CNA prior to the incident. In an interview on 4/13/23 at 10:20 AM, the Administrator stated there had been no other reported incidents of this type of behavior with Staff W, CNA. He stated when he interviewed Staff W, CNA, she admitted to the incident and felt very badly about it. She reported she had just returned from taking the smokers out and being berated by them and then walked into Resident #2's room and was being berated by her and it was just more than she could take. The Administrator had terminated Staff W, CNA for mental abuse but stated I don't really feel it was abuse but certainly inappropriate and unacceptable behavior. The Administrator also stated Staff W, CNA had reported to him that she tossed a brief and gloves on the wheelchair but did not throw them at the resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/13/23 at 3:22 PM, Staff W, CNA reported she worked 6:00 P.M. to 6:00 A.M. on the evening of 3/26/23. She voiced she felt it was chaotic from the moment she got to work. It was dinner time so she assisted in the dining room and then with passing room trays. After supper was taken care of, the residents that smoked started lining up to go outside. She stated she took them out to smoke as it was on the schedule as one of her duties. When she came back in, one of the CNA's told her Resident #2's light had been on for an hour and asked her to go check on her. When she entered the room, the resident began to yell and curse at her about no one taking care of her and her being their last priority. She said she was using the F world a lot. Staff W, CNA stated apologizing to her wasn't effective and she just got frustrated and tossed the brief onto the wheelchair and said Fuck you! Change yourself! Then she walked out of the room. She stated Staff X, CNA did enter the resident's room after her and took care of her needs. She reports she returned to the resident's room a couple of hours later and assisted her to change her brief again but did not apologize to her as she should have. Resident #2 was fine with her and didn't seem scared of her or say anything about the earlier incident. Staff W, CNA reported as soon as she said what she said, she regretted it and she immediately called the on-call phone and spoke with Staff Y, Certified Medication Technician (CMT) who told her she knew it had been a bad night and to hang in there and they would discuss it tomorrow. Staff W, CNA stated it was her own fault and she knew she had no one to blame except herself. She stated she felt really stupid and was really sorry it happened. In an interview on 4/13/23 at 2:26 PM, Staff X, CNA stated he did work on the evening of 3/26/23 and was working with Staff W, CNA that evening. He reported he had helped with her residents and she had taken a resident outside to smoke. While she was out monitoring the smokers, others resident smokers lined up to go outside. He requested she take the others out since she was already out there. She became angry and was yelling and cursing at him. He stated she said I don't give a fuck and maybe 3 smokers were present when she cursed at him. He stated she did not take the resident he had requested out to smoke. He reported the incident to a male nurse and then to the Assistant Director of Nursing (ADON). The ADON then called him to let him know the incident was being looked in to. He doesn't speak that way and doesn't like to be around that type of language. Resident #2 did not report any issues with Staff W, CNA when he assisted her with incontinence care. He stated her call light was on and he went in and changed her. He reported he and the resident have a good rapport but she didn't mention anything about the incident with Staff W, CNA. In an interview on 4/18/23 at 9:50 AM, Resident #2 was asked to clarify whether Staff W, CNA had tossed the brief in her direction, thrown it at her, or tossed it on the chair. The resident reported she was lying in bed during the incident and Staff W, CNA threw the brief and a glove at her and hit her in the chest area. She stated she did it when she was angry with her and threw the brief at her and said Fucking change yourself! and walked out of the room. In a phone interview on 4/18/23 at 12:33 PM, Staff X, CNA reported he did not see any brief in Resident #2's room that evening after the incident with Staff W, CNA. He said he didn't note a brief in the wheelchair or on the bed. He believed he brought in new bedding and got a new brief out when he was in the room. In an interview on 4/11/23 at 10:12 AM, Resident #7 stated the call lights were bad and took 15-20 minutes to answer. The resident stated she had not been treated badly but had heard an aide cussing at the residents. Resident #7 reported around 10:00 PM she heard an aide yell You better get into the fuckin bed down the hall from her room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/11/23 at 10:47 AM, Resident #10 reported some of the aides were rude. They just didn't want to get up and do something when the resident asked for it. The resident reported he told the Administrator about one of the aides but now she's not here anymore. She reported she had never heard anyone cursing at a resident. In an interview on 4/11/23 at 1:48 PM, Staff Z, CNA, stated she had not personally witnessed it but residents have complained about staff being rude. She reported a resident that smokes said a staff member told her she could not get up to smoke and had to stay in bed and another staff member told her she could do more for herself and she was taking advantage of the CNAs. Staff Z, CNA did not name the staff members but reported it took place on the evening shift. Staff Z, CNA stated she heard but did not witness that a staff member came in 45 minutes late upset and wanted to go smoke and other coworkers told her no because she was late. A resident needed to be changed and the CNA and the resident got into an argument and she told the resident to Fucking change herself She stated the Resident was Resident #2 and she didn't know the CNA's name but she no longer worked at the facility. In an interview on 5/2/23 at 2:11 PM, the Administrator stated it is the expectation that the staff treat their residents highly and compassionately. On 4/13/23 at 10:42 AM, review of Staff W, CNA employee file revealed a hire dated of 3/8/23. A background check was completed on 2/24/23 with no concerns noted. She received social services orientation that included being kind and considerate with voice tone, smiling, good eye contact, and utilizing the privacy curtains, knocking on the door before entering for example. Abuse reporting was gone over: report immediately so that the administrator and the Director of Nursing (DON) are informed as there are only 2 hours after the allegation to file a report with the state. She signed the Abuse Prevention policy on 3/8/23. The facility provided Abuse Prevention Policy, reviewed and revised on 10/21/22, stated the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. It further identified Mental Abuse as the following: The use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation or degradation including staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s).

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 40907 Based on record review and interviews, the facility failed to run a criminal background check before hiring Staff E, Registered Nurse (RN), and failed to obtain a may work letter (ok to hire) after a criminal background check came back with misdemeanors on it. The facility reported a census of 62 residents. Findings include: On 6/29/23 employee files were requested related to an extended survey. The Human Resource Specialist provided an Action Plan that was drafted on 6/12/23 with target date of 6/30/23. The objective and goal was to ensure every employee had a background check and a DHS may work letter of approval before completing onboarding. Through review of Staff E's employee file, it was revealed that there was not a hire date in her file. An Iowa Record Check Request Form that was ran on 2/3/23 revealed that she had been charged with 2 misdemeanors. No may work letter was found. An email was sent on 6/29/23 at 4:43 p.m. to request further information that was not found in the employee files. On 7/5/23 at 12:58 p.m., the Human Resource Specialist provided a graph of items requested. On the graph it noted Staff E's hire dated was 1/4/23. It noted that Staff E's background check was not ran until 2/2/23. It noted her RN license was in probation status. The Human Resource Specialist documented on the graph that a new background check was completed on 6/30/23 to attempt to gain a may work letter. The Human Resource Specialist acknowledged that the facility waited a month to run a criminal background check along with the may work letter for Staff E that should have been run and received before Staff E worked the floor. The Administrator was present for this interaction. On 7/11/23 11:28 p.m., an email was received from the Administrator, documenting that Staff E's may work letter was obtained. It was dated 2/10/23. An undated Employment Policy and Procedure Document from the Employee Handbook, directed under the Background Investigations heading that Federal and State law require us to perform pre-employment criminal history, dependent adult abuse, and founded child abuse background checks. Offers of employment will be conditioned upon successful completion of the background checks. Employees will be required to sign an authorization allowing the facility to initiate these checks and acknowledging your receipt of this information. Employees MAY NOT begin working until the facility has received a successful background result. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Abuse Prevention policy dated 10/2022, directed that the facility was committed to protecting the residents from abuse by anyone including, but not necessarily limited to: Facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends visitors, or any other individual. Steps to Prevent, Detect and Report included the facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals or misappropriation of property. The facility will pre-screen all potential new employees for a history of abusive behavior.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on clinical record review, staff and resident interviews, and policy review, the facility failed to timely report an alleged abuse to the facility Administrator or designee for 1 of 1 resident reviewed (Resident #2). The facility staff failed to timely report the allegation of abuse toward a resident to the Administrator or designee and did not suspend the staff person involved at the time to keep the resident safe which prevented facility administration from reporting potential abuse to the Department of Inspections and Appeals within 2 hours as required. The facility reported a census of 69 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder and spinal stenosis. Resident #2's Care Plan dated 1/17/23 included a focus area for anger, history of harm to others, and poor impulse control. The Care Plan directed staff to provide physical and verbal cues to alleviate anxiety, give positive feedback, assist with verbalization of source of agitation, assist to set goals for more pleasant behavior, and encourage seeking out of staff when agitated. The Care Plan further directed staff to document the observed behavior and attempt interventions in the behavior log, give as many choices as possible about her care and activities. Known triggers for physical aggression included not being allowed to go outside to smoke and her behaviors were de-escalated by alone time in her room with the door closed and going outside to smoke. Review of the progress notes for Resident #2 revealed no documentation of the resident reporting an incident of a staff person yelling and cursing at her. No facility incident report was completed related to Resident #2's reported incident. In an interview on 4/13/23 at 9:45 AM, Resident #2 stated on the night of 3/26/23 she had her call light on to be changed and she felt it took a long time for a staff person to answer the light so she was somewhat angry and frustrated when Staff W, Certified Nursing Assistant (CNA) entered the room. She reported they bantered a little bit about the call light taking so long to answer and that was when Staff W, CNA stated Fucking change yourself, threw a brief and a glove at her, left the room, and never returned. She reported another staff person came in right away and changed her. She recalled a couple of days later the Administrator came in and told her that after visiting with Staff W, CNA, she wanted to extend an apology for her behavior and to let her know she never should have said what she did. Resident #2 stated she had not had any trouble with Staff W, CNA prior to the incident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/13/23 at 3:22 PM, Staff W, CNA reported she worked 6:00 P.M. to 6:00 A.M. on the evening of 3/26/23. She voiced she felt it was chaotic from the moment she got to work. It was dinner time so she assisted in the dining room and then with passing room trays. After supper was taken care of, the residents that smoked started lining up to go outside. She stated she took them out to smoke as it was on the schedule as one of her duties. When she came back in, one of the CNA's told her Resident #2's light had been on for an hour and asked her to go check on her. When she entered the room, the resident began to yell and curse at her about no one taking care of her and her being their last priority. She said she was using the F world a lot. Staff W, CNA stated apologizing to her wasn't effective and she just got frustrated and tossed the brief onto the wheelchair and said Fuck you! Change yourself! Then she walked out of the room. She stated Staff X, CNA did enter the resident's room after her and took care of her needs. She reports she returned to the resident's room a couple of hours later and assisted her to change her brief again but did not apologize to her as she should have. Resident #2 was fine with her and didn't seem scared of her or say anything about the earlier incident. Staff W, CNA reported as soon as she said what she said, she regretted it and she immediately called the on-call phone and spoke with Staff Y, Certified Medication Technician (CMT) who told her she knew it had been a bad night and to hang in there and they would discuss it tomorrow. Staff W, CNA stated it was her own fault and she knew she had no one to blame except herself. She stated she felt really stupid and was really sorry it happened. In an interview on 4/18/23 at 9:50 AM, Resident #2 was asked to clarify whether Staff W, CNA had tossed the brief in her direction, thrown it at her, or tossed it on the chair. The resident reported she was lying in bed during the incident and Staff W, CNA threw the brief and a glove at her and hit her in the chest area. She stated she did it when she was angry with her and threw the brief at her and said Fucking change yourself! and walked out of the room. In a phone interview on 4/18/23 at 12:33 PM, Staff X, CNA reported he did not see any brief in Resident #2's room that evening after the incident with Staff W, CNA. He said he didn't note a brief in the wheelchair or on the bed. He believed he brought in new bedding and got a new brief out when he was in the room. In an interview on 4/13/23 at 3:57 PM, Staff Y, Certified Medication Technician (CMT) reported she did get a call from Staff W, CNA on the evening of 3/26/23 to report she had yelled at Resident #2. She told her that she had said Fuck you! Change yourself! or something along that line. She reported she told Staff W, CNA to stay away from the resident for the rest of the night. She reported she texted Staff AA, Scheduler/Medical Records about the situation and Staff AA, Scheduler/Medical Records said she would handle it. She stated she had nothing further to do with it. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/17/23 at 11:47 AM, Staff AA, Scheduler/Medical Records stated she believed she was on call that evening. She was aware of an incident between Staff W, CNA and Resident #2. She could not remember if she received word from Staff Y, CMT or from Staff W, CNA or from both. She states she remembered that Staff W, CNA had reportedly refused to change the resident and cussed at her and remembers being told that it was a very stressful night for her and she was irritated with another conflict between a staff person and a resident. She reported she was not notified of the incident until the next morning. At that time she spoke with the Administrator and he told her to take her off the schedule for that night (Monday). She stated she did contact Staff W, CNA to let her know she would be taken off the schedule for that night. The Director of Nursing (DON) later came and told her to take her off the schedule for the rest of the week. She did not notify Staff W, CNA that she was removed from the schedule for the rest of the week. Once she talked to her initially and removed her from the schedule for the week as directed she had nothing further to do with the situation. In an interview on 4/17/23 at 3:20 PM, the Administrator reported it was the expectation that any report of abuse be reported to him or the DON immediately. The staff member was to be sent home immediately pending an investigation. The incident would then be submitted to the Department of Inspections and Appeals (DIA) within 2 hours but was usually sent immediately. They would complete their investigation of the report and ensure it was wrapped up within 5 days but usually before that. They would gather up all the information and upload it to DIA. If they felt it was substantiated they would go ahead and terminate the employee before DIA came. If they did not feel it was substantiated they would return the employee to duty. They would try to accommodate the residents' wishes if they did not want that specific staff person to care for them. He reported he was not notified nor was the DON notified of the incident involving Staff W, CNA and Resident #2 the night it happened. He stated he was notified the next morning by Staff Y, CMT or Staff AA, Scheduler/Medical Records. He instructed them to suspend Staff W, CNA and the investigation was initiated. He stated it was an expectation that he be notified immediately of a potential abuse situation. He said it was Staff Y, CMT's first time on-call. She was only to be on-call for staffing. She was not the nurse on-call. He stated it should have been the nurse on-call that was notified not the scheduling on-call person. He stated Staff Y, CMT was not trained on what to do and stated they try to do abuse training with staff at least semi-annually. They cover what abuse is and what and who to notify if they see any type of abuse in the facility. He stated he did not believe Staff W, CNA had completed the Mandatory Dependent Adult Abuse Reporter training yet. He reported he did not believe the nurse on-call was notified of the incident at all. In an interview on 4/17/23 at 3:33 PM, Staff BB, RN acknowledged that she was the nurse on call on 3/26/23. She reported she did not get any calls related to any altercations or regarding Resident #2 and Staff W, CNA that evening. She stated the nurse on-call was posted on the bottom of the schedule that is kept at the 1st floor nurse's station. She reports the phone numbers were right behind the schedules so staff could get the number to call. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/18/23 at 1:00 PM, Staff Y CMT reported she was on-call for scheduling the evening of this incident, not for nursing and the nurse on-call was in the building at the time. She was unsure why it wasn't reported to her. She stated she told Staff W, CNA to stay away from the resident when she called to report herself and didn't realize how bad it was. She did not ask Staff W, CNA if she had reported it to the nurse on-call but assumed she had talked to the nurse prior to calling her. She reported she thought maybe Staff W, CNA was just more comfortable with her than the nurse on-call. She reported she was unaware it needed to be reported to the DON/Administrator at that time, but knows now. In a phone interview on 4/24/23 at 1:25 PM, Staff Y, CMT stated she did not remember if she signed the abuse policy. She stated they signed a lot of things during orientation but she could not be sure if the abuse policy was one of them. She stated that if she saw or had a resident report abuse to her or suspected abuse that she would report it to her charge nurse immediately. She further stated that she had been educated by administration that if in the future someone would call her when on-call or report abuse or suspected abuse, she was to call the administrator or the DON immediately. In an interview on 5/2/23 at 2:11 PM, the Administrator stated it was the expectation that staff treat the residents highly and compassionately and that staff report any allegation of abuse to himself or the DON whether it be day or night. In a facility provided policy titled Abuse Prevention last reviewed on 10/21/22, stated the Administrator and DON must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the Administrator and DON must be called at home or must be paged and informed of such incident. It further stated any allegation of abuses, or neglect, misappropriation or exploitation against any employee must result in his/her immediate suspension to protect the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, staff interview, and the Resident Assessment Instrument (RAI) manual v1.17. 1_October 2019, the facility failed to ensure full and accurate development of a comprehensive Care Plan for 2 of 3 residents reviewed for Care Plan accuracy (Resident #3, #10). The facility reported a census of 69 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 revealed the resident was, independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers. The MDS triggered Care Areas included cognitive loss, urinary incontinence, nutritional status, dehydration, dental care, pressure ulcer, and psychotropic drug use. The MDS recorded all of the triggered items would be addressed on the Comprehensive Care Plan. The Comprehensive Care Plan for Resident #3 with a Taget Date of 5/18/2023 failed to address any of those triggered areas. The Care Plan lacked any documentation of the resident being at risk of skin impairment or having any wounds. The Care Plan failed to document any interventions to prevent impaired skin integrity. The Skin Observation Tool dated 12/9/22 recorded a pressure ulcer with a smaller open area inside of the larger open area. The note documented the nurse had removed a dressing dated 12/1/22 of gauze wrapped around heel and ankle and purulent, foul smelling drainage was noted. On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining. On 12/9/22 at 12:24 Staff A, ARNP, documented Resident #3 was seen by the writer for assessment of a right heel wound which was reported to have odor and pus discharge. On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3. On 12/28/22 at 9:20 the ADON documented the resident was seen by the wound care physician with no new orders. On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had tested positive for COVID. She also discussed the resident's wound with her at this time. On 1/24/23 Resident #3 was discharged to an acute care hospital for a Stage 4 pressure wound. On 4/18/23 at 9:10 am a physician caring for the resident during this hospitalization stated that upon admission to the hospital the wound was a very large ulceration, bone was visible. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE] of Resident #10 recorded the resident reported she experienced pain on a frequent basis and rated the pain as moderate. The MDS triggered Care Areas included pain. The MDS recorded pain would be addressed on the Comprehensive Care Plan. The Comprehensive Care Plan for Resident #10 with a Target Date of 9/20/2023 failed to reveal any documentation of the resident having pain or a daily medication regimen for pain. The RAI manual v1.17.1_October 2019, page 4-11 includes the following direction: Facilities have 7 days after completing the RAI assessment to develop or revise the resident's care plan. The resident's care plan must be revised based on changing goals, preferences and needs of the resident and in response to current interventions. The policy Comprehensive Person-Centered Care Plan, review date 10/23/19 included the following points. The Comprehensive Person-Centered Care Plan shall be fully developed within 7 days after completion of the Admission MDS Assessment. The Baseline Care Plan/Comprehensive Person Centered Care Plan is updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence. The policy Skin Evaluation dated 12/28/22 included the following point: The Unit Manager/Wound Nurse will review and sign Skin Observation Tool if documented manually. The signature indicated follow up, documentation and care plan interventions have been implemented. On 4/19/23 at 1:00 PM the Director of Nursing stated it was her expectation that any wounds would be documented on the Care Plan along with appropriate interventions. Additionally she stated it was her expectation that any item that triggered as a Care Area on the MDS would be in place on the Care Plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on clinical record review, staff interview, observation, and policy review the facility failed to update and revise 1 of 3 residents Care Plans reviewed (Resident #1). The facility failed to revise the Care Plan after the resident had falls. The facility reported a census of 69 residents. Findings Include: The Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS revealed the resident required the total assistance of 1 person for bed mobility, transfers, and toilet use. The resident was always incontinent of bowel and bladder, had 2 or more falls with no injury, and 2 or more falls with injury since the prior assessment and took an antipsychotic, antianxiety, and antidepressant medication daily. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, schizophrenia, hyperglycemia, cognitive communication deficit, and history of falling. The Comprehensive Care Plan dated 4/2/21 with a revision date of 12/26/22 for Resident #1 revealed a focus area for being at risk for falls related to the residents cognition and being unaware of safety needs, gait and balance problems, chronic knee pain bilaterally, and resident climbing out of bed independently into praying position on the mat next to the bed. Interventions instructed staff to anticipate and meet the resident's needs, provide education and reminders to call for assistance as needed, educate and provide supervision and reminders to the resident to wear appropriate, non-slip footwear, follow therapy recommendations for transfers and mobility, hipsters to prevent injury in the event of a fall, nonskid strips in place, place call light within reach while in the room, ensure gripper socks are on, physical therapy consult, and review information on past falls and attempt to determine cause of falls. Resident #1 had falls on 2/27/23 at 3:36 PM, 3/7/23 at 11:00 AM, and 3/20/23 at 12:24 PM. A progress note on 3/7/23 at 4:37 PM indicated the bed was placed in the lowest position, the call light was in reach and a fall mat was on the floor next to the bed. A physician progress note on 3/8/23 at 11:16 PM indicated the plan was to have the bed in the low position, floor mattress next to bed, to complete hourly rounding for safety, and to move the resident closer to the nurse's station when a room becomes available. A progress note on 3/9/23 at 4:05 AM indicated the resident's call light was in reach, the bed was in low position, and the fall mat was on the floor next to the bed. A progress note on 3/10/23 at 4:33 AM indicated the bed was in the low position, the fall mat was on the floor next to the bed, and the call light was in the residents reach. A physician progress note on 3/20/23 at 3:46 PM indicated the resident would require one-on-one supervision post hospital stay due to multiple falls with head injuries. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician progress note dated 3/22/23 at 6:05 PM indicated staff were to continue fall intervention currently in plan of care. The care plan lacked documentation of current interventions being used such as bed in low position, fall mat on floor next to bed, hourly rounding, move resident to a room closer to the nurse's station when one becomes available, and protective helmet when out of bed. In an observation on 4/17/23 at 11:10 AM, Resident #1 noted to be sitting in her wheelchair with her feet on the footrest at a table by the nurses station. Noted to have a helmet on her head at this time related to residents having a history of frequent falls. In an observation on 4/19/23 at 11:35 AM, Resident #1 noted to be sitting in her wheelchair out by the nurse's station. Her helmet was off and sitting beside her on the table. In an interview on 4/19/25 at 11:46 AM, the Director of Nursing (DON) stated the team had tried different things with the resident in an attempt to prevent further falls such as changing her medication times, 1:1 time provided by the social worker, giving the resident stuffed animals to hold, and helping her attend bible study and music therapy. She reported they did not find any of them to be very effective due to her poor attention span related to her dementia. In an interview on 4/25/23 at 11:39 AM, the DON stated it was the expectation the MDS Coordinator keep the Care Plans updated with any changes in condition or fall interventions. The facility provided policy titled Comprehensive Person-Centered Care Plan last reviewed on 10/23/19 stated the Baseline Care Plan/Comprehensive Person Centered Care Plan will be updated to reflect risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review, the facility failed to systemically administer medications and treatments ordered by a physician to the residents residing at the facility. Out of a sample size of 7 residents, 7 residents did not receive all of their medications as ordered (Residents #4, #14, #19, #20, #21, #23 and #30). The facility reported a census of 62. Findings include: 1. A Minimum Data Set (MDS) dated [DATE], documented that Resident #4 diagnoses included Multiple Sclerosis (MS), osteomyelitis of the vertabra (infection of the bone), and non-Alzheimer's dementia. A Brief Interview for Mental Status documented a score of 8 out of 15, which indicated moderate cognitive impairment. Resident #4 required total dependence of 2 for transfers, and personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #4 received pain medication both routine and prn (as needed) in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a moderate level and documented that she had pain occasionally. A Medication Administration Record (MAR) for the month of June 2023, directed staff to administer a Fentanyl Patch 12 mcg (microgram)/hr(hour) transdermal (absorbed through the skin) application at bedtime every 3 days for chronic pain to Resident #4. The start date was 2/20/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/2/23, it was applied the following day on 6/3/23. The resident had a patch applied on 5/5/23 and 5/8/23, then this resident did not have a patch applied again until 5/21/23. The 2023 June MAR/TAR (Medication Administration Record/Treatment Administration Record) showed that staff was to administer Liothyronine Sodium tablet (for hypothyroidism)25 mcg, 0.5 tab once daily at 6:00 a. m. From June 1 through June 16th this resident did not receive her daily dose 13 times. The MAR also showed she did not receive all of the following medications as ordered: Clonazepam (for schizophrenia), Lexapro (for depression), perphenazine (for schizophrenia), and L-Arginine (for wound healing). On 6/21/23 at 4:00 p.m., When asked if she had pain, this resident stated she did. When asked to rate the pain, she stated it was at a 5 on a scale of 1-10 and the pain was on her bottom. Resident lying in bed at the time. 2.A MDS dated [DATE], documented that Resident #14's diagnoses included diabetes, morbid obesity, and renal (kidney) insufficiency. The MDS revealed a BIMS score of 15 out of 15, which indicated intact cognition. This resident required total dependence of 2 staff for transfers and total dependence of 1 for personal hygiene. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2023 MAR for the month of June for this resident, documented that this resident was to have Warfarin (anti-coagulant) 5 mg at bedtime daily for venous insufficiency with a start date of 6/13/23. The resident did not receive 2 doses of Warfarin from 6/13/23 to 6/27/23. The MAR directed staff to administer Flonase 1 spray in each nostril at bedtime for allergies with a start date of 2/21/22. From 6/1/23 to 6/27/23, 13 doses were not given. The MAR directed staff to administer Levothyroxine 75 mcg 1 tablet daily for hypothyroidism with a start date of 6/9/22. From 6/1/23 to 6/27/23, 10 doses were not given. This MAR directed staff to administer Losartan 25 mg daily for hypertension (high blood pressure) with a start date of 4/1/22. This resident did not receive this medication from 6/1/23 through 6/7/23. This resident was not administered all doses of the following medications as well for the dates 6/1/23 throught 6/27/23: Vitamin D, Colchicine (medication for gout), lyrica (for nephropathy(diabetic kidney disease)), Omeprazole (for Gastric Esophageal Reflux Disease(GERD)) and AZO (for bladder spasms). 3. A MDS dated [DATE], documented that Resident #19's diagnoses included MS and chronic pain. The MDS revealed a BIMS score of 15 out of 15, which indicated intact cognition. This resident required total dependence of 2 staff for transfers. She required total dependence of 1 staff for personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #19 received pain medication both routine and prn in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a 5 out of 10 (0 is no pain and 10 is the worse pain you can imagine) and documented that she had pain frequently. A Medication Administration Record for the month of June 2023, directed staff to administer a Fentanyl Patch 25 mcg/hr transdermal application at bedtime every 72 hours (3 days) for chronic pain to Resident #19. The start date was 3/4/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/2/23, it was applied on 6/5/23. It revealed that she was to get a patch placed on 6/8/23 and did not have a patch applied until 6/14/23. She was scheduled to have a patch applied on 6/17/23 and did not have it applied until 6/20/23. It was documented that it was not available on 6/23/23. The MAR also revealed that an order for Oxycodone (opioid) 5 mg tablet was to be given orally 4 times a day. The order date was 6/8/23. From 6/8/23 at 5 p.m when the first dose was to be given to 6/12/23 at 6:00 a.m. the doses were not given. The 6:00 a.m. dose on 6/13/23 and all 4 doses on 6/14/23 and 6/15/23 were not available. The 8:00 p.m. dose on 6/23/23 was also not available. The 2023 June MAR/TAR also revealed this resident did not receive the following medications/treatments as ordered: Potassium tablet (for low potassium level), AZO tablet(for difficulty in urinating), and icy hot (for shoulder pain). On 6/21/23 at 4:54 p.m., Resident #19 stated she was in pain and rated it at a 9 out of 10. She stated that she needed to lie down. She stated she hurt everywhere. Resident appeared to be in pain. She was pale and did not move during the conversation. On 6/22/23 at 10:30, Resident #19 was observed to have a patch last placed on 6/20/23 on her left chest. Resident #19 rated her pain at a 9 and stated she hurt all over. She added that the medication person is going to give her pain meds now and they will help. She said she went without the patch a few days ago and she became very sick. She stated she was throwing up and everything. She stated once they were able to get a patch the sickness went away. (continued on next page)

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	165175	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. A MDS dated [DATE], documented that Resident #20's diagnoses included anxiety and chronic pain syndrome. The MDS revealed a BIMS score of 15 out of 15, which indicated intact cognition. This resident required extensive assist of 1 for transfers and personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #20 received pain medication both routine and prn in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a 4 out of 10 and documented that she had pain frequently. A Medication Administration Record for the month of June 2023, directed staff to administer a Fentanyl Patch 25 mcg/hr transdermal application at bedtime every 72 hours for chronic pain syndrome to Resident #20. The start date was 5/1/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/3/23. The last patch prior to this was applied on 5/30/23 and 3 days from that was 6/2/23. This resident went 4 days without the absorption of the patch from 6/2/23 when it should have been applied to 6/6/23. She had the patch applied again on 6/9/23, it wasn't applied on 6/12/23 then it was applied again on 6/15/23. The 2023 June MAR/TAR also revealed this resident did not receive the following medications/treatments as ordered: Omeprazole, Trazadone (for anxiety and depression), Carafate (GERD), levetiracetam (for seizure activity/convulsions), Miralax (for constipation), Xanax (for anxiety), hydrocodone/acetaminophen (for pain), reglan (for nausea), bacitracin (wound care), house barrier cream (for skin excoriation), muscle rub extra strength cream (for pain), and Bioten (for dry mouth). This resident was to receive Biotin 4 times a day. She did not receive Biotin from 6/1/23 to 6/23/23. The start date was 12/9/21. On 6/21/23 at 4:55 p.m., Resident #20 stated she was in pain and rated her pain at an 8 out of 10. She stated it hurt in her tailbone and back. Resident appeared to be in pain. On 6/22/23 at 10:35 a.m., noted Resident #20's had a patch on her right chest. It was not labeled. Resident #20 stated her tailbone pain is at an 8 which is constant, and her stomach pain was at a 5. She stated they were supposed to give her a suppository 2 nights ago and they never did. She stated she was constipated. When asked if they have missed giving her some pain medications, she said yes. She stated the reason she didn't receive her medication was they didn't have the medication to give. When asked if she was given anything to help with her pain she said no, they told me they didn't have anything else to give. 5. A MDS dated [DATE], documented that Resident #21's diagnoses included malignant neoplasm of the larynx (cancer of the voice box) and chronic pain. The BIMS score for Resident #21 was 12 out of 15 which indicated moderate cognitive impairment. This resident required extensive assist of 2 for transfers and extensive assist of 1 for personal hygiene. The Pain Management section revealed that Resident #21 received routine pain medication in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated his pain at a 6 out of 10 and documented that he had pain frequently. A 2023 MAR for the month of June, directed staff to administer Percocet 5-325mg three times a day at 8:00 a.m., 2:00 p.m., and at 8:00 p.m. to Resident #21. The MAR revealed that Resident did not receive his scheduled Percocet from 6/13/23 at 2:00 p.m. through 6/20/23. The MAR documented that he received a dose at 8:00 a.m. on 6/21/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 2023 June MAR/TAR also revealed this resident did not receive the following medications/treatments as ordered: Atorvastatin (for hyperlipidemia), duloxetine (for depression), Gemtosa (for overactive bladder), tamsulosin (overactive bladder), Zenpep (pancreatic enzyme), naproxen (for pain), baclofen (muscle relaxer), and gabapentin (pain). On 6/27/23 at 10:31 p.m., Resident #21 lying in bed. He nodded his head in affirmation that he did know they didn't have the pain meds to give him. When asked if he was in pain during that time, his eyes widened and he nodded a definite yes. When asked if he remembers what level his pain was at during that time and if he could rate it he shook his head no. He affirmed by nodding that he had went about a week without the pain medication and this happened a couple of weeks back. 6. A MDS dated [DATE] , documented that Resident #23's diagnoses included heart failure. This resident had a BIMS score of 8 out of 15, which indicated moderately impaired cognition. This resident required total dependence of 2 for transfers and total dependence of 1 for personal hygiene. A MAR for the month of June 2023, directed staff to administer Digoxin daily for cardiomyopathy (disease that makes it harder for the heart to pump), chronic congestive heart failure (disease that effects the pumping action of the heart), and persistent atrial fibrillation (irregular and often fast heartbeat). From 6/1/23 to 6/27/23, this resident did not receive her digoxin 7 times. Tobramycin eye gtts 4 times a day for pain was ordered on 6/14/23 and was discontinued on 6/19/23. The resident only received 4 doses. The 2023 June MAR/TAR also revealed this resident did not receive the following medications/treatments as ordered: insulin, Supplement 2.0 (for wound healing), and Midodrine (for low blood pressure). 7. A MDS dated [DATE], documented that Resident #30's diagnoses included heart failure. This resident had a BIMS score of 15 out of 15, indicating intact cognition. This resident required a limited assist of 1 for transfers and personal hygiene. A MAR for the month of June 2023, directed staff to administer Digoxin every other day. The MAR did not direct the staff to take a pulse prior to giving this medication. From 6/1/23 to 6/27/23, 5 doses were not given. The MAR directed staff to administer Levothyroxin daily for hypothryroidism. From 6/1/23 to 6/27/23, 11 doses were not given. The 2023 June MAR/TAR also revealed this resident did not receive the following medications/treatments as ordered: Rivoraxiban (for atrial fibrillation, congestive heart failure, and hypertension) and bumetanide (for heart failure). On 6/21/23 at 10:26 a.m., Staff C, Certified Nurse Aide/Certified Medication Aide (CNA/CMA), when asked what the circled initials meant on the MAR/TAR she stated it meant that they didn't have the medication. She stated it happened more than she would like to admit. She said the DON said to just pass the medications that you can. When asked why some residents had Fentanyl patches and another did not, she stated she did not know. She said maybe it had something to do with pharmacy. She said the facility does not want to report these things. Staff C stated she is told not to get so upset about things. On 6/21/23 at 2:45 p.m., the DON stated she was looking into the Fentanyl patches not being given. When asked what she knew about it, she just shook her head no. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/21/23 at 3:00 p.m., Staff C, when asked again about the numerous Fentanyl patches that weren't applied, she stated that the night shift which is mainly agency nurses put the patches on. She acknowledged all of the holes with the Fentanyl patches. She stated it meant they did not get the patches put on. She did not think there was drug diversion. She thought it was more laziness. On 6/21/23 at 4:07 p.m., Staff D, Register Nurse (RN) traveler with the facility corporation and the Nurse Consultant stated they were aware of this too and looking into it, when they were told there was a concern with the Fentanyl patches and narcotics not being given. On 6/22/23 at 10:30 a.m., Staff A, CMA stated that medications are getting missed and sometimes it's because staff don't understand the different names of Vitamins ie ascorbic acid vs Vitamin C and sometimes they just don't look for the medications. Staff A stated that Resident #4 was without Percocet. Staff A stated she had sent the information that he was out of his Percocet and needed more several times but she was not sure if they had gotten it. She stated that Staff E, RN had told her they were getting a script (prescription for a physician) for the Percocet. Staff A said she had sent the tag in about 5 days before he was out of them. Staff A said it was ample time, more than 3 days to get it ordered. Staff A stated they (nurses) had tried to get it out of the e-kit but he needed a new script. She said that he went 8 days without the percocet. Staff A did not think there was any drug diversion just laziness. She stated that Resident #4 was going through withdrawal symptoms. Stated he was really tired. Staff B, RN, was part of the above conversation. He stated that there normally are medications up front. Staff B stated they can go up and get them. Staff B stated he did not think there was any drug diversion, just sloppy nursing. On 6/22/23 at 4:06 p.m., Staff F, Nurse Practitioner (NP), stated the facility let her know that the 3 ladies did not receive their patches. She stated she took a look at them and discontinued 2 of the 3 ladies patches as she did not feel they needed it. She said the 3rd lady was a different story. She stated she did know about another resident not getting his Percocet. She found out through faxes. She will look for the faxes of the facility notifying her of the pain medication not being given. Staff F stated it was okay to call her back with any further questions. stated it was recently brought up to her about the Fentanyl patches not being administered, but she had been notified of this before and was notified by fax. No faxes were provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/22/23 at 2:30 p.m., Staff G, NP stated that no one had notified her of medications not being given. She had not heard about Fentanyl patches not being available. She had not heard about Resident #4 not getting his Percocet. She said there would be no reason for this. If not contacting her they could contact other providers to get a script or to get these medications ordered. She said in Resident #4's case she saw him after a fall and had abdominal x-ray/test done related to pain. She said at that time she reviewed his medications and did not feel he needed anything more for pain as he was on several medications that helped with pain. Staff G looked at Resident #4's MAR. She stated now that she knows he went without Percocet for that many days she will need to go back to Resident #4 and ask him about pain control. She said she came in to see 5 residents on this day and she was still at the facility because she finds things out when she talks with residents and feels she needs to take care of it. She stated a lot of the stuff she ends up doing are things the nurse should be doing but for some reason it is not getting done. Staff G gave an example of a request she received to discontinue Biotin. She said she looked at the MAR and the person had not been receiving Biotin. So, she did not discontinue the Biotin, instead she told the staff it needed to be given. She repeated that there is no reason the residents should not be receiving their medication. She stated a provider and pharmacy can be called. On 6/22/23 at 3:05 p.m., Staff E, RN stated that it was reported to her that Resident #4 did not have Percocet. She stated the CMA did not tell her until the last day that she worked. Staff E stated that sometimes she worked 2-3 days in a row. She stated that afternoon she called the pharmacy for it and the pharmacy said they were waiting on a script for it. Staff E stated that the pharmacy calls the care provider to get the script. She stated that the pharmacy was located out of state, so the pharmacy didn't always call the provider for the nurses. Staff E stated that on weekends it depends on who is on call, the provider might not write a script. Staff E didn't think she had called the on-call provider the day she found out about needing a Percocet refill. Staff E stated she reported it on to the next shift but did not remember who. Staff E stated she did think it was important for the residents to have their meds. Staff E stated the facility was running bubble packs as well as cards with medications (meds) in them. Staff E stated that she was running meds all the time. Staff E said she did not want to put the facility under the bus or anything, but the nurses are continually getting meds out of this system because the meds are not filled. Staff E stated it was like all day long they were pulling meds from the ekit (emergency kit storage). Staff E stated it was very time consuming. Staff E stated the fax machine was down for a long time. She said she had been there for 6 months and the facility finally got a fax machine this week. She stated they were unable to fax the pharmacy because of it. Staff E stated they had to call the pharmacy or Staff F, LPN and another nurse had been emailing the pharmacy. Staff E stated that she always called the pharmacy and they would get upset when you have a huge list, the pharmacy wanted the list sent instead. She stated the pharmacy also sometimes did not send the meds. Staff E said that every day she pulled medications out of the ekit, even though the meds had been requested from the pharmacy. Staff E stated that the CMAs don't let the nurse know if there is a med missing, they will just circle it. Staff E said that she and another nurse have reported to the DON that the med aides (CMA's) aren't reporting that there are not meds in the carts. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/27/23 at 9:45 a.m., Staff E stated she did not know where the pharmacy book was in the back (2nd floor). She stated she wasn't sure what they did when the nurses and CMAs filled out the sheets with the meds that are needed. Staff E said she didn't see the book and she thought the sheets might just get thrown away. She pulled a couple of sheets out of the box with things that needed to be shredded. On 6/27/23 at 10:25 a.m., Staff E pulled 2 more pharmacy sheets out of the box when asked if there were any more sheets in the box. On 6/27/23 at 9:50 a.m., Staff H, Licensed Practical Nurse (LPN), stated the facility got a new machine and it copies and prints but it doesn't fax. Staff H stated she had developed a process with the pharmacy where you have an encryption code so the emails between Staff H and the pharmacy can go between us without HIPPA violations. Staff H stated that she had been doing this for 2 months. Staff H stated she receives sheets from the CMAs and on Mondays, Tuesdays, and Wednesdays Staff H forwards the sheets on to the pharmacy and then writes emailed to pharmacy and the date and time. Staff H stated she then puts the sheets into the pharmacy book. Staff H stated that she only worked on the 1st floor. Staff H state the process to get medication was the doctor writes out the order for her on a script. and then she would take a picture and email to the pharmacy, after that she document in the electronic health record to make it an active order. Staff H stated she would usually then call the pharmacy and let them know that she had put in an active order and she would pull a couple of doses of the medication so that they could cover the first couple of doses that needed to be given. Staff H stated that not all nurses have access to their medication system. She stated that sometimes they have agency nurses and the agency nurses cannot get into the facility's medication system. Discussed Resident #19's medication and Staff H stated that it was so sad. Staff H stated that Resident #19 had been in pain since she has been here. Staff H stated that Resident #19 should not go without her pain medication. Staff H said that Resident #19 was so frail and pale and always looked like she was in pain. When told the pain level had been signed often as no pain for this resident, Staff H stated that was not right. Staff H stated what she thought staff were doing was seeing if Resident #19 was sleeping and marking it 0, they should be asking her. Staff H said that Resident #19 needed her pain medication. Staff H stated that hospice staff could call the pharmacy too and Staff H stated she did not know why agency nurses wouldn't just call the pharmacy. Staff H stated if they are writing down on the sheet that there was not a med available then it should be in the pharmacy book down there. They should be putting those sheets in to the pharmacy book and those papers should not be shredded. Staff H stated that usually on Mondays there are a lot of meds to order. Staff H stated that she just called the pharmacy and asked them how could she get the meds without a fax and they said she could use her own email but she would need to use their encryption. Staff H stated that's what she did. Staff H stated she did not want to put down the company but they had people running to another facility to fax orders because their facility couldn't get the meds. On 6/27/23 at 11:32 a.m., Staff K, CMA/CNA, stated that it did happen when meds were not available. Staff K stated she circled her initials on the MARs when meds were not available. Staff K stated that she actually [TRUNCATED]

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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. 46873 Based on resident interviews, staff interview, and record review, the facility failed to provide showers twice weekly per the resident Care Plans for 2 of 3 residents reviewed (Resident #7, Resident #8). The facility reported a census of 69 residents. Findings include: 1. The Minimum Data Set (MDS) for Resident #7, dated 3/17/23, identified a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented the resident was completely dependant for bathing and needed the assistance of 2 staff members for bathing. The current Comprehensive Care Plan for Resident #7 directs staff to assist Resident #7 two times a week and as necessary for bathing/showering, dated 8/12/18. The shower sheets provided by the facility for 2/15/23 through 4/5/23 revealed Resident #7 received a shower on: 2/15/23 2/22/23 (7 days after the previous shower) 3/1/23 (7 days after the previous shower) 3/8/23 (7 days after the previous shower) 3/15/23 (7 days after the previous shower) 3/23/23 (8 days after the previous shower) 3/29/23(6 days after the previous shower) 4/5/23 (7 days after the previous shower) 2. The MDS for Resident #8, dated 3/31/23, identified a BIMS score of 15 which indicated intact cognition. The MDS documented the resident needed the assistance of 1 staff member for part of her bathing activity. The current Comprehensive Care Plan for Resident #8 directs staff to assist Resident #8 two times a week and as necessary for bathing/showering, dated 5/18/21. The shower sheets provided by the facility for 2/15/23 through 4/5/23 revealed Resident #8 received a shower on: 2/15/23 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/1/23 (14 days after the previous shower) 3/8/23 (7 days after the previous shower) 3/15/23 (7 days after the previous shower) 3/23/23 (8 days after the previous shower) 3/29/23 (6 days after the previous shower) 3/31/23(2 days after the previous shower) 4/5/23 (5 days after the previous shower) On 4/11/23 at 11:07 am, Resident #8 stated she normally only receives showers once a week. She further stated this is not her choice, and her preference would be to get showers daily. In an interview on 4/25/23 at 11:40 AM, the Director of Nursing (DON) she stated it was the expectation that baths/showers be offered twice a week or at the residents preference. The Care Plan should reflect what the resident should be getting for scheduled baths/showers. The facility provided policy titled ADL(Activities of Daily Living) Bathing Policy last revised on 7/21/22, did not address the expected frequency residents were to receive baths/showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** 44972 Based on clinical record review, staff interviews and policy review, the facility failed to assess and document a fall and neurological assessments with a head strike for 2 of 3 residents reviewed for falls (Resident #1 and #4). The facility reported a census of 69 residents. Finding include: 1. The Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS revealed the resident required the total assistance of 1 person for bed mobility, transfers and toilet use. The resident was always incontinent of bowel and bladder, had 2 or more falls with no injury, and 2 or more falls with injury since the prior assessment and took an antipsychotic, antianxiety, and antidepressant medication daily. The MDS included diagnoses of non-Alzheimer's dementia, anxiety disorder, schizophrenia, hyperglycemia, cognitive communication deficit, and history of falling. The Comprehensive Care Plan dated 4/2/21 with a revision date of 12/26/22 for Resident #1 revealed a focus area for being at risk for falls related to the residents cognition and being unaware of safety needs, gait and balance problems, chronic knee pain bilaterally, and resident climbing out of bed independently into praying position on the mat next to the bed. Interventions instructed staff to anticipate and meet the resident's needs, provide education and reminders to call for assistance as needed, educate and provide supervision and reminders to the resident to wear appropriate, non-slip footwear, follow therapy recommendations for transfers and mobility, hipsters to prevent injury in the event of a fall, nonskid strips in place, place call light within reach while in the room, ensure gripper socks are on, physical therapy consult, and review information on past falls and attempt to determine cause of falls. An Incident Report dated 2/27/23 at 5:31 PM was completed related to resident's fall and stated vital signs and neurological assessment were at resident's baseline An Incident Report dated 3/7/23 at 10:39 AM was completed related to resident's fall and stated the resident's neurological assessment and range of motion were within normal limits. An Incident Report dated 3/20/23 at 12:36 PM was completed related to resident's fall and stated the resident's neurological assessment and vital signs were within normal limits. A progress note dated 2/27/23 at 3:36 PM documented Resident #1 was lying on her back with a pillow under her head with blood soaked gauze noted to the back of her head. The nurse held pressure to area until the Emergency Medical Technician's (EMT's) arrived and transferred the resident to the emergency room (ER). Family was contacted and will join the resident at the ER. A progress note dated 2/28/23 at 5:27 AM documented the hospital was called for an update on the resident's condition. The nurses reported the resident was being admitted for a diagnosis of left frontal hematoma with hemorrhage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 3/7/23 at 11:22 AM documented the resident was readmitted back to the facility from the hospital earlier that morning. At 11:00 AM the resident was found lying on the floor in her room next to her bed on her right side. The right side of her head had contact with the floor and a small new bump to the right side of the forehead. Neurological assessment and range of motion were within normal range. Resident reported pain but was unable to tell staff how she got on the floor related to her cognitive level. Daughter and primary care provider was notified. Received an order to send resident out via ambulance to the ER for evaluation and a computerized tomography (CT) scan. A progress note dated 3/7/23 at 4:37 PM documented the resident returned to the facility via ambulance. A progress note on 3/9/23 at 4:05 AM documented the resident voiced no complaints of pain or discomfort. No bump or bruising noted from fall. Neurological check was within normal limits and per resident's baseline. A progress note on 3/20/23 at 12:24 PM documented the resident fell next to the nurse's station. An assessment revealed a large hematoma to the left forehead and resident reporting neck and back pain. The resident was noted to have a skin tear to the left forearm. Staff placed a pillow under the residents head and covered her with a blanket. Vital signs and neurological assessment were within normal limits. Call placed to 911 and resident sent to the ER for evaluation and treatment. Family and primary care provider notified. The facility failed to provide the documentation of the neurological assessments being completed as documented in the progress notes and per protocol. 2. Resident #4's MDS assessment dated [DATE] identified a BIMS score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae. The Care Plan for Resident #4 initiated 5/13/16 and a revision date of 2/16/23, had a fall risk focus area, with a goal for the resident to not sustain any preventable serious injury if a fall should occur. Interventions directed staff to be sure the call light was within reach, half side rail in place for ease in bed mobility and safety, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that the resident was wearing appropriate footwear when ambulating or in the wheelchair, follow facility fall protocols, and provide resident a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light. Provide the resident with activities that minimize the potential for falls while providing diversion and distraction and have physical therapy (PT) evaluate and treat as ordered and as needed. An Incident Report dated 2/12/23 at 8:34 PM was completed related to resident's fall from the Hoyer and stated the resident's vital signs were stable and neurological assessment intact with pupils equal and reactive to light. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 2/12/23 at 8:56 PM, documented the resident was found lying on her back with her feet facing the bed on the floor with a pillow under her head. Blood noted to be coming from the back of the residents head. Per the Certified Nursing Assistant (CNA) the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff and fell sideways out of lift after the Hoyer sling caught on the wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. Vital signs were stable and neurological assessment intact. Laceration observed to back of head. The Emergency Medical Technician's (EMT's) were notified of need for transfer of the resident due to a head injury. A progress note dated 2/13/23 at 1:28 AM, documented the resident returned to the facility at 1:10 AM via ambulance from the emergency room . Documents received stated the resident was treated for injuries sustained from a fall earlier. Diagnosis of laceration of scalp. The resident received 5 staples to the laceration on the back of her head. The CT scans of the cervical spine and head without contrast were both negative. Resident resting in bed with no complaints of pain, call light in reach, and vital signs stable. On 4/18/23, the Administrator provided a written statement from Staff M, CNA stating that he worked in the facility on 2/12/23 and he was walking past a room with a resident slid down in her chair on the opposite hall he was working. He reported it to Staff L, CNA and they both entered the resident's room and helped guide Resident #4 to the floor in a lying position. Staff L, CNA then left to get a Hoyer and brought it into the room and they adjusted the sling behind the residents back as the resident was on the floor. They hooked the resident up to the Hoyer lift. As Staff L, CNA was raising the Hoyer, the resident shifted herself to the right. Staff M, CNA told Staff L, CNA to stop but the resident shifted herself so fast Staff L, CNA did not have time to react causing the resident to fall out of the sling onto the floor hitting her head on the back right of the Hoyer lift. Staff L, CNA immediately went and got the nurse and the nurse called 911 because the fall caused injury to the resident's head. The ambulance arrived and took the resident to the hospital. In a phone interview on 4/19/23 at 9:23 AM, Staff O, Registered Nurse (RN) stated Staff L, CNA came and got her to report resident #4 fell and was on the floor and had a head laceration. Staff reported to her they were Hoyer transferring the resident from the chair and she fell out the right side of the sling. The resident was on the floor when she entered the room and a pillow was under her head. Staff O, RN reported she completed an assessment, vital signs were taken, and a neurological assessment was completed and were intact. Staff O, RN left the room to get the resident's chart and items for the laceration to the back of her head. Upon return she completed another assessment and vital signs, pulse oximeter, and neurological assessment were done. Staff O, RN stated neither staff involved mention to her at all that resident had been lowered to the floor and that they were completing a Hoyer transfer off the floor. They stated it was from the wheelchair and the Hoyer sling had caught on the arm of the wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 4/19/23 at 9:55 AM, Staff L, CNA reported she was involved with the fall from the Hoyer for Resident #4. At around 7:40 PM, another CNA notified her that the resident was attempting to get out of her wheelchair or was sliding out of the wheelchair. She entered the room to assist him. She noted the resident was sliding out of the chair and the staff were not able to lift her back up into the chair. They made the decision to lower her to the floor. She was laid on the floor on her back. She then went to find a Hoyer to lift the resident back into her chair. She was unsure if a nurse was notified of the resident being on the floor. She stated she did not notify the nurse. They used the sling that had been under her in the wheelchair and tucked it under her so they could hook her up to the Hoyer. Hooked her up to the machine using the black loops on the top and the green loops on the bottom. She reports she was running the controls and the other male CNA was located behind the wheelchair with the residents feet pointed towards him. She stated she got the resident about half way up and the male CNA stated Her arm! She stated she immediately stopped the machine but the resident then slid out the right side of the sling. She reported the residents head, arm, shoulder and chest area came out the side of the sling and she hit her head on the base of the lift. Staff L, CNA then lowered the lift back down and went and found the nurse. The nurse came to the resident's room and assessed her. Per an email sent on 4/25/23 at 4:40 PM, Staff P, Regional Director of Operations reported he had interviewed Staff M, CNA and he had reported he had worked one shift at the facility on 2/13/23 and remembered the incident with Resident #4. He reported the resident was sliding from her chair and so she was lowered by staff to the floor. Staff got the mechanical lift to get her up off of the floor. While the resident was in the lift on the floor she began moving around and hit her head on the tan cover at the base of the lift that covers the leg separation bar. There was no malicious intent by the other staff he was with, the resident just hit her own head. In a phone interview 4/26/23 at 9:22 AM, Staff M, CNA reported that he did speak with Staff P, Regional Director of Operations yesterday while he was at work. The email statement that was sent by Staff P, Regional Director of Operations from their interview yesterday was reviewed with him. Staff M, CNA's original write up regarding the incident was then reviewed with him. He reported he was not actually working in the hall that the resident was in but noted her to be sliding out of her chair when he walked by. He immediately got a hold of Staff L, CNA and they went into the room to assist her. The resident was slid all the way down in the chair. So they lowered her to the floor and placed her sling under her. At that point Staff L, CNA went to get a Hoyer to lift her up. He stated once she was back with the lift they hooked the resident up to the Hoyer and Staff L, CNA was running the controls and he was located at the residents feet. He said Staff L, CNA began to lift the resident using the controller. He said that the resident was maybe a foot or so off the ground and he thought maybe she got scared and jolted herself to the right a bit and her right arm came out and then she jolted to the right one more time before Staff L, CNA could stop the lift and her right arm, then her head and upper body came out of the right side of the sling and fell to the floor and resident struck her head on the base of the Hoyer. He stated her bottom half remained in the sling but her top half came out the side. He stated Staff L, CNA immediately lowered the Hoyer back to the floor. Staff L, CNA then went and got the nurse and he stayed with the resident until the nurse arrived. The facility failed to provide the documentation of the neurological assessments being completed as documented in the progress notes and per protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility CNA's involved in the fall incident with the resident failed to notify a nurse of lowering the resident to the floor so the resident could be assessed prior to being Hoyer lifted off the floor. In an interview on 4/25/23 at 11:44 AM, the Director of Nursing (DON) stated it was the expectation that after every fall a nurse completed an assessment, made sure the resident was safe, complete vital signs and neurological checks if the fall was unwitnessed or there was a head strike. They were expected to call the family or representative, notify the physician, notify Administration if there is a serious injury, complete an incident report and document the incident in the progress notes. In an interview on 4/25/23 at 3:36 PM, the Administrator reported they were unable to locate neurological check documentation that were to be completed on resident after her falls. A facility provide policy titled Fall Management Guidelines Overview dated 2/16 with a revision date of 7/14/17 defined falls as unintentionally coming to rest on the ground, floor, or other lower level but not as a result of an overwhelming external force (i.e., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. A facility provided policy titled Neurological Evaluation dated 3/28/23 and stated The Licensed Nurse shall perform a Neurological Evaluation as followed for a 72 Hour Timeframe, unless otherwise ordered by the Physician. The results will be recorded on the Neurological Evaluation Form. Every 15 Minutes X 1 Hour Every 30 Minutes X 1 Hour Every 1 Hour X 2 Hours Every 2 Hours X 8 Hours Every 4 Hours X 12 Hours Every Shift X 48 Hours

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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, family, physician, and staff interviews, and policy review, the facility failed to ensure a resident's pressure ulcer did not worsen through following physician orders and accurately assessing the need for further medical intervention for 1 of 1 residents reviewed (Resident #3). This resulted in harm to the resident due to a boggy heel worsening to a Stage 4 pressure ulcer with bone infection and a prolonged hospitalization . Findings include: The Minimum Data Set (MDS) assessment dated [DATE] of Resident #3 identified a Brief Interview of Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The MDS revealed the resident was independent with no setup help needed for bed mobility. The MDS revealed the resident required limited assistance with help of 1 staff member for transfers. The MDS documented diagnoses that included diabetes, heart failure, non Alzheimer's dementia, and malnutrition. The current Comprehensive Care Plan of Resident #3 with a Target Date of 5/18/2023 failed to reveal any documentation of the resident being at risk of skin impairment or having any wounds. The Care Plan failed to document any interventions for skin integrity or treatment of any skin wounds. Determining the Stage of Pressure Injury MDS Skin Assessment Tool: Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. 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. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. On 11/30/22 at 4:59 PM, the MDS Coordinator documented an open area to Resident #3's right heel which was draining. Orders were received on 12/1/22 for daily wound care with dressing changes to the wound. On 12/9/22 at 1:11 AM, Staff E, Registered Nurse, documented in a Skin Observation Tool note she removed a dressing from the resident's wound dated 12/1/22. The note documented the wound had purulent, foul smelling drainage and the resident's skin going up the back of her calf was red and warm (signs of infection). This was the only Skin Assessment documented on the resident during her time at the facility. On 12/9/22 at 12:24 PM Staff A, ARNP, documented Resident #3 was seen for assessment of a right heel wound which was reported to have odor and pus discharge. On 12/9/22 at 5:41 PM the Assistant Director of Nursing (ADON) documented new orders had been received for an antibiotic related to the foot wound for Resident #3. On 1/23/23 at 9:53 PM the Director of Nursing (DON) documented she called Resident #3's daughter and informed her the resident had tested positive for COVID. She also discussed the resident's wound with her at this time, need for antibiotic and a wound culture. On 1/24/23 at 5:19 PM, Staff C documented she informed Resident #3's daughter, the Resident was now on two antibiotics, was weak and shaking. On 1/24/23 at 5:24 PM, Staff C documented Resident #3's daughter requested the Resident be sent to the hospital. (continued on next page)

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	165175	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	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 0686 Level of Harm - Actual harm Residents Affected - Few	On 1/25/23 at 4:50 PM, Staff C documented Resident #3 was admitted to the hospital, had one surgery on her right heel and was scheduled for a second surgery the next morning. The facility wound care physician had an initial visit with the resident on 12/14/22. She noted the size of the wound to be 8 cm 8 x cm by a non measurable depth. At that time, the wound was 30% necrotic (non viable, dead tissue) and 70% eschar (dried necrotic tissue). The wound care physician assessed the wound weekly and gave orders for daily wound care treatments to be completed by the facility staff. Each week the wound notes reflected the wound to be a non measurable depth. Recommendations were made to float her heel when in bed, to wear a prevalon boot, and reposition per facility protocol. On the weekly visit on 1/20/23, the wound was noted to have deteriorated. On 4/10/23 at 12:45 PM, a family member of Resident #3 stated the resident was still hospitalized from being sent to the hospital on 1/24/23 from the facility and the wound on her heel was the reason for the prolonged hospitalization . On 4/12/23 at 2:14 PM a family member of Resident #3 stated the resident had 4 surgeries so far during the prolonged hospitalization including bone grafts. She stated more surgeries were likely going to be needed in the future and the resident currently had a wound vac on the wound. She also stated the facility had never contacted her regarding this wound until a few days prior to the hospitalization . On 4/13/23 at 8:05 AM the Director of Nursing (DON) stated her expectation if a wound is found on a resident is to report that to the Assistant Director of Nursing (ADON) who also acts as the facility skin/wound nurse. Further her expectation is to notify the nurse practitioner or physician and get orders and interventions in place. At the time of a new wound being found, she stated her expectation to be the wound to be measured and documented using a Skin Assessment and documented weekly. On 4:13/23 at 9:45 AM the ADON stated the nurse who was first aware of a wound is expected to measure and document the wound and to notify the physician and obtain orders and to initiate for the wound physician to begin weekly visits. On 4/13/23 at 10:30 AM the MDS Coordinator stated she was working the floor on 11/30/22 when one of the Certified Nurse Aides told her about the heel wound on Resident #3. She stated she remembered looking at the wound and telling the ADON about it. She also said the normal procedure if a new wound was found is to note the location and measurements of the wound and give that information to the ADON. The ADON would then notify the facility medical director or wound doctor and get orders and notify the family. On 4/13/23 at 2:50 PM, Staff A, ARNP stated she recalled one of the staff nurses informing her initially the heel was boggy. She ordered a wound culture and initiated antibiotics. She stated she initiated the wound doctor to begin seeing the Resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/13/23 at 4:05 PM Staff E, Registered Nurse (former employee) stated she worked the overnight shift at the facility. She stated she was unaware of the resident's wound until 12/9/22 and had never been told about it in report. She said one of the CNA's mentioned it to her and asked her to assess it. She stated she could smell it when she entered the room and it smelled like gangrene. She removed a the dressing which was dated 12/1/22. It had a horrid odor and slough was present. She stated she sent faxes to the wound physician and the primary care physician and reported to the day shift the Resident needed to be seen immediately and notified the DON. Staff E said the lack of care the residents in the facility get is why she is no longer an employee. She described the care as horrific. She said when she would arrive to work the night shift, multiple day shift medications were often not given. She noted the resident was a night owl and often would not go to bed until the middle of the night and normally had a sock and a shoe on her foot. Her other leg was amputated and she used that foot to self propel in her wheelchair. She stated she did not have any heel protectors or any preventatives in place for the wound until she initiated them the early morning hours of 12/9/22. On 4/14/23 at 2:11 PM Staff C, LPN stated the first time she saw the heel wound on the Resident it was just boggy and had treatments for betadine. She said for the next several weeks she was scheduled on the other side of the building and did not care for the resident during that time period. When she was next scheduled on the hall the Resident resided on, the wound had significantly worsened and the smell from the wound was present in the hallway. This was on 1/24/23 and she then sent the resident to the hospital. She stated the normal protocol for a new wound is to get orders for a dressing and treatment and place and note in the box for the physician to assess on next rounds to the facility. A skin assessment should be placed in the Electronic Health Record. On 4/14/23 at 3:08 PM, Staff F, ARNP stated she was aware of the resident but did not know her well. She stated the resident had comorbidities of diabetes and poor nutrition and heart failure and often refused cares. She stated she felt the development of the wound was not avoidable due to comorbidities and behaviors. On 4/14/23 at 3:52 PM the Wound Care Physician state the wound was very advanced upon her initial assessment of the Resident. She stated during her visits she provided education to the resident to elevate the heel. She was aware the resident did refuse treatments at times. She stated with the resident's diabetes and history of a similar wound leading to amputation on her other leg that complications were likely for the Resident. On 4/18/23 at 9:10 AM, a hospital physician who has cared for the resident throughout the hospitalization stated upon admission to the hospital the wound was a Stage IV pressure ulcer with bone being visible. She stated it may have started out as a diabetic foot ulcer and progressed to a Stage IV pressure wound. She stated she would consider Resident #3 to be a high risk for development of wounds due to her history of this type of wound, her diabetes, and her behaviors. She stated in her medical opinion, Resident #3 should have been hospitalized earlier than she was and surgical intervention was needed earlier. She felt the initial development of the wound was likely not avoidable but a higher level of treatment should have been sought earlier than it was. On 4/18/23 at 10:50 AM, the DON stated the facility has weekly Risk meetings and skin issues are discussed. She stated the facility has no policy regarding doing regular foot checks on diabetic patients. She stated her expectation if a resident refuses cares is to re-approach the resident later in the shift. If the resident continues to refuse cares the Nurse Practitioner should be notified and follow up with the resident. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/18/23 at 11:10 AM, the Registered Dietitian stated she was only aware the resident had a wound on her foot which required antibiotics. She stated she was not aware it was a pressure wound or that it was severe. She stated during the time frame Resident #3 admitted to the facility weekly skin assessments were not being done which is against corporate policy. She stated this is something the DON has been working on but while it's improving it's still a work in progress. She stated wounds are discussed in weekly meetings but she normally attends via telephone and the discussion is normally very brief and not detailed. On 4/18/23 at 12:45 PM, the Therapy Coordinator stated Resident #3 was very non compliant. She frequently refused therapy due to the pain from the wound. He stated he has seen dressings on residents dated several days old and seen residents not wearing pressure relieving boots as they are supposed to. He further stated he has had conversations with multiple staff regarding these issues. The policy Skin Evaluation dated 12/28/22 included the following points: Residents will have a head to toe skin evaluation performed and documented on a routine basis. Any skin abnormalities identified through this evaluation may be documented in Interdisciplinary Notes. The Unit Manager/Wound Nurse will review and sign the Skin Observation Tool if documented manually. The signature indicated follow up, documentation and care plan interventions have been implemented. 46873

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 44972 Based on observations, resident, staff and family interviews, record review, and policy review, the facility failed to provide safe mechanical lift transfers for 5 of 7 residents reviewed (Residents #4, #7, #14, #16, and #18). The facility failed to transfer residents safely by not following the Hoyer lift recommendations and locking the lift while raising the resident, not having a clear process in place to ensure staff were using the appropriate sling for transfers, and allowing a non-certified staff to assist in the Hoyer transfer. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 9, 2023 on April 25, 2023 at 1:44 P.M. The Facility Staff removed the Immediate Jeopardy on April 26, 2023 through the following actions: a. Education of nursing staff on proper use of Hoyer lift and ensuring the brakes are not locked when raising the resident. b. Removing the Invacare Hoyer lift from service until compatible slings can be obtained. c. A new process was implemented to put the size of sling the resident was to use on the Kardex and placed copies at each nurse's station. d. Nursing staff return demonstrations of a Hoyer lift transfer completed by the Director of Nursing (DON) and Nurse Manager. e. Education of nursing staff that all mechanical lift transfers are to be completed with two certified nursing staff. The scope lowered from a K to an E at the time of the survey after ensuring the facility implemented education and made appropriate changes to their processes and procedures. The facility identified a census of 69 residents. Findings include: 1. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure, and osteomyelitis of the vertebrae. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Care Plan initiated 5/13/16 and a revision date of 2/16/23, had a fall risk focus area, with a goal for the resident to not sustain any preventable serious injury if a fall should occur. Interventions directed staff to be sure the call light was within reach, half side rail in place for ease in bed mobility and safety, encourage participation in activities that promote exercise, physical activity for strengthening and improved mobility, ensure that resident was wearing appropriate footwear when ambulating or in the wheelchair, follow facility fall protocols, and provide the resident a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light. Provide resident with activities that minimize the potential for falls while providing diversion and distraction and have physical therapy (PT) evaluate and treat as ordered and as needed. The Care Plan initiated 3/13/16 also had an activities of daily living (ADL) self-care performance deficit focus area related to activity intolerance, muscle weakness, obesity, and fatigue with a goal that the resident would maintain their current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions directed staff to encourage the resident to utilize half side rails for increased bed mobility, encourage resident to be up in the wheelchair for meals, assistance of one staff person for bed mobility and dressing and the resident required mechanical aid (Hoyer) and assistance of two staff for transfers. A fall Incident Report dated 2/12/23 at 8:34 PM documented the resident was found lying on the floor with her feet facing the bed and a pillow under her head. Blood noted to be coming from the back of the residents head. Per staff the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff when she fell sideways out of the lift after the Hoyer sling caught on the wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. The resident was assessed and a laceration viewed to the back of the scalp after flushing the area. The ambulance was called to transport to the emergency room for further assessment. Vital signs were stable at (T),Temperature 97.4, (HR) Heart Rate 96, (R) Respirations per minute 20, (BP) Blood Pressure 127/54, and (PO2) pulse oximeter of 94% on room air. Neurological assessment intact and pupils were equal and reactive to light. Resident was oriented to person, place, and situation. Predisposing environmental factors included clutter, poor lighting, food on the floor, and crowding. Predisposing physiological factors included impaired memory. The Physician was notified of the fall at 8:57 PM. A progress note dated 2/12/23 at 8:56 PM, documented the resident was found lying on her back with her feet facing the bed on the floor with a pillow under her head. Blood noted to be coming from the back of the residents head. Per the Certified Nursing Assistant (CNA) the resident was being transferred from the wheelchair to bed by full mechanical lift (Hoyer) and assistance of two staff and fell sideways out of the lift after the Hoyer sling caught on wheelchair arm. The Hoyer sling was still on the lift and the bottom straps observed to not be crossed. Vital signs were stable and neurological assessment intact. Laceration observed to back of the head. The Emergency Medical Technician's (EMT's) were notified of need for transfer of the resident due to a head injury. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note dated 2/13/23 at 1:28 AM, documented the resident returned to the facility at 1:10 AM via ambulance from the emergency room . Documents received stated the resident was treated for injuries sustained from a fall earlier. Diagnosis of laceration of the scalp. The resident received 5 staples to the laceration on the back of her head. The computerized tomography (CT) scans of the cervical spine and head without contrast were both negative. Hospice was notified of residents return to the facility and will come to the facility to assess and readmit to hospice. Resident resting in bed with no complaints of pain, call light in reach and vital signs stable. A physician progress note dated 2/13/23 at 11:58 PM, documented the resident was seen to follow up with an injury to resident's posterior head and post hospital visit. Resident returned to the facility with staples in her posterior head laceration. Surrounding skin was red with no drainage. The resident complained of pain rating at 5 out of 10 and her pain was managed by Tylenol. Resident was awake and alert. Lungs were clear to auscultation, respirations were even and unlabored. Pulse oximeter 97%. Posterior head laceration noted to have some swelling, erythema, and staples. Resident was alert, awake, and oriented to self. Plan was to monitor laceration to posterior head for bleeding, use Tylenol for pain, monitor for signs and symptoms of infection, and notify the provider of metal status changes. In an observation on 4/13/23 at 1:50 PM, Staff G, Certified Nursing Assistant (CNA) and Staff H, CNA transferred Resident #4 from her wheelchair into her bed. Staff G, CNA removed resident's oxygen and the liberator (portable oxygen tank) was turned off. They hooked the sling up to the locked Hoyer using the green loops on the top and the purple loops on the bottom. The resident was instructed to cross her arms and hug herself and she complied. Staff H, CNA used the remote to raise the resident out of the chair. Staff H, CNA unlocked the Hoyer and steered the Hoyer so the resident was positioned in the center of the bed and lowered her down. The sling was removed from the Hoyer. Oxygen was applied once laid down in bed. In an observation on 4/18/23 at 9:40 AM, Staff I, CNA and Staff J, CNA completed a Hoyer transfer for Resident #4 from her wheelchair to bed. Oxygen was removed prior to the transfer. Staff J, CNA placed the Hoyer from the side of the chair with legs apart and it was locked. The sling was a bariatric sling and did not have straps that crisscross under the legs. The staff reported this was the same sling that is always used for this resident. The staff hooked the sling up to the Hoyer using the purple loops on the bottom and the green loops on the top. She was raised up out of the chair, the Hoyer was unlocked and the staff guided to the center of the bed and gently lowered onto the center of the bed. She was rolled side to side and the sling was removed from under her. Staff reapplied resident oxygen and covered her up. The call light was given to resident. In an interview on 4/12/23 at 12:21 PM with Resident #4's Power of Attorney (POA), he stated that the facility was not always the best at updating him on changes in Resident'#4's condition. He stated he recalled an incident in February when the resident fell from a Hoyer and was sent to the hospital and the facility never notified him. He stated he was notified by the hospital when she was admitted for the night but not by the facility. He stated he had a long conversation with the Administrator about this and it has been better since. In an interview on 4/18/23 at 12:22 PM, the Assistant Director of Nursing (ADON) stated it is the expectation that all Hoyer and EZ Stand transfers be completed with two staff without exception. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/18/23 at 1:05 PM, the Administrator acknowledged Staff L, CNA was involved in the fall from the Hoyer with Resident #4. Staff L, CNA terminated her position on the night of the fall (2/12/23). The administrator reported per punch detail, Staff L, CNA punched out at 10:19 PM and wrote a note stating that was her last day. He stated she was very upset over the fall and she was not transferring Resident #4 with the Hoyer by herself, she had another staff person with her (Staff M, CNA). The Administrator did report that she had been involved in a fall from a Hoyer a few weeks prior in which she was transferring using the Hoyer by herself. He stated they had done a lot of education with Staff L, CNA on this and she was not doing Hoyer transfers by herself any longer. On 4/18/23, the Administrator provided a written statement from Staff M, CNA stating that he worked in the facility on 2/12/23 and he was walking past a room with a resident slid down in her chair on the opposite hall he was working. He reported it to Staff L, CNA and they both entered the resident's room and helped guide Resident #4 to the floor in a lying position. Staff L, CNA then left to get a Hoyer and brought it into the room and they adjusted the sling behind the residents back as the resident was on the floor. They hooked the resident up to the Hoyer lift. As Staff L, CNA was raising the Hoyer, the resident shifted herself to the right. Staff M, CNA told Staff L, CNA to stop but the resident shifted herself so fast Staff L, CNA did not have time to react causing the resident to fall out of the sling onto the floor hitting her head on the back right of the Hoyer lift. Staff L, CNA immediately went and got the nurse and the nurse called 911 because the fall caused injury to the resident's head. The ambulance arrived and took the resident to the hospital. In a phone interview on 4/19/23 at 9:23 AM, Staff O, Registered Nurse (RN) stated Staff L, CNA came and got her to report resident #4 fell and was on the floor and had a head laceration. Staff O, RN was agency and she did not know the resident so was unsure of her baseline. Staff reported to her they were Hoyer transferring the resident from the chair and she fell out the right side of the sling. The resident was on the floor when she entered the room and a pillow was under her head. Resident #4 was covered with a blanket as she reported feeling cold. Staff O, RN reported she completed an assessment, vital signs were taken and a neurological assessment was completed and were intact. Staff O, RN left the room to get the resident's chart and items for the laceration to the back of her head. Upon return she completed another assessment and vital signs, pulse oximeter, and neurological assessment were done. Resident remained on the floor in the same position until the ambulance arrived as she didn't want to move her. Staff O, RN stated neither staff involved mention to her at all that resident had been lowered to the floor and that they were completing a Hoyer transfer off the floor. They stated it was from the wheelchair and the Hoyer sling had caught on the arm of the wheelchair. She questioned if the sling was to be crisscrossed under the resident's leg and she was informed the resident didn't use that type of sling and that the sling was correctly put under the resident and she was correctly hooked up to the lift. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview on 4/19/23 at 9:55 AM, Staff L, CNA reported she did work on 2/12/23 and was involved with the fall from the Hoyer for Resident #4. She reported she was working with another CNA who was agency and a male (Staff M, CNA). At around 7:40 PM, he notified her that the resident was attempting to get out of her wheelchair or was sliding out of the wheelchair. She entered the room to assist him. She noted the resident was sliding out of the chair and the staff were not able to lift her back up into the chair. They made the decision to lower her to the floor. She was laid on the floor on her back. She then went to find a Hoyer to lift the resident back into her chair but it took her about 5 minutes to locate and get the Hoyer back to the room. She was unsure if a nurse was notified of the resident being on the floor. She stated she did not notify the nurse. They used the sling that had been under her in the wheelchair and tucked it under her so they could hook her up to the Hoyer. Hooked her up to the machine using the black loops on the top and the green loops on the bottom. She was positive the sling was correctly hooked to the lift and they left the sling attached to the machine after the incident. She reported she was running the controls and the other male CNA was located behind the wheelchair with the residents feet pointed towards him. She stated the resident's head was pointed toward her and no one was touching her as they couldn't reach her. The wheelchair was in the way for him and she couldn't reach around Hoyer to touch her while running the control. She stated she got the resident about half way up and the male CNA stated Her arm! She stated she immediately stopped the machine but the resident then slid out the right side of the sling. She reported the residents head, arm, shoulder, and chest area came out the side of the sling and she hit her head on the base of the lift. Staff L, CNA then lowered the lift back down and went and found the nurse on the 100 hall. The nurse came to the resident's room and assessed her. Staff L, CNA reported she did raise the residents head enough to put a pillow under it for comfort. She reported she left the room to go answer a light and assist another resident. She stated they used the sling that had been under her in the wheelchair and she was not aware of a chart for sizing of Hoyer slings. She stated she was not aware of any other residents falling out of a Hoyer and never anyone under her care. In an interview on 4/19/23 at 11:51 AM, the DON stated that Staff M, CNA (agency) was involved in the fall from the Hoyer for Resident #4, and returned to the facility the next morning and talked to them about the incident. He took the DON and Staff N, OTA/Therapy Coordinator to the room and showed them with the Hoyer what had happened. Per an email sent on 4/25/23 at 4:40 PM, Staff P, Regional Director of Operations reported he had interviewed Staff M, CNA and he had reported he had worked one shift at the facility on 2/13/23 and remembered the incident with Resident #4. He reported the resident was sliding from her chair and so she was lowered by staff to the floor. Staff got the mechanical lift to get her up off of the floor. While the resident was in the lift on the floor she began moving around and hit her head on the tan cover at the base of the lift that covers the leg separation bar. There was no malicious intent by the other staff he was with, the resident just hit her own head. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a phone interview 4/26/23 at 9:22 AM, Staff M, CNA reported that he did speak with Staff P, Regional Director of Operations yesterday while he was at work. The email statement that was sent by Staff P, Regional Director of Operations from their interview yesterday and was reviewed with him. Staff M, CNA's original write up regarding the incident was then reviewed with him. He stated he remembers the night as it was Super Bowl Sunday. He stated he felt the place was very short staffed. He reported he was not actually working in the hall that the resident was in but noted her to be sliding out of her chair when he walked by. He immediately got a hold of Staff L, CNA and they went into the room to assist her. The resident was slid all the way down in the chair. So they lowered her to the floor and placed her sling under her. At that point Staff L, CNA went to get a Hoyer to lift her up. He stated once she was back with the lift they hooked the resident up to the Hoyer and Staff L, CNA was running the controls and he was located at the residents feet. He stated he felt that Staff L, CNA may not have been paying the closest attention to what she was doing as she was arguing with the roommate at the same time she was running the lift. He stated he did not feel that she had any malicious intentions but maybe wasn't paying the closest attention to what she was doing. He said Staff L, CNA began to lift the resident using the controller. He said that the resident was maybe a foot or so off the ground and he thought maybe she got scared and jolted herself to the right a bit and her right arm came out and then she jolted to the right one more time before Staff L, CNA could stop the lift and her right arm, then her head and upper body came out of the right side of the sling and fell to the floor and resident struck her head on the base of the Hoyer. He stated her bottom half remained in the sling but her top half came out the side. He stated Staff L, CNA immediately lowered the Hoyer back to the floor. Staff L, CNA then went and got the nurse and he stayed with the resident until the nurse arrived. He could see the back of her head was bleeding. He also reported he asked both Staff L, CNA and the nurse what kind of action needed to be taken with an incident like this and they both said nothing different than any other fall. 2. Resident #7's MDS assessment dated [DATE] identified a BIMS score of 14, indicating intact cognition. The MDS indicated Resident #7 required extensive assistance of one person for bed mobility, total dependence of two people for transfers, and total dependence of one person for toilet use. Resident #7 was wheelchair dependent and always incontinent of bowel and bladder. The MDS included diagnoses of diabetes mellitus, thyroid disorder, Alzheimer's dementia, cerebral palsy, non-Alzheimer's dementia, seizure disorder, depression, schizophrenia and suicidal ideation. The Care Plan initiated on 7/27/18 with a revision date of 4/7/23, revealed a fall risk focus area related to cognition and being unaware of safety needs and cerebral palsy and a goal that the resident will have no unaddressed falls. Interventions directed staff to anticipate and meet resident needs, encourage resident to wear gripper socks, follow therapy recommendations for transfers and mobility - assist of two people for Hoyer lift transfers, place call light in reach, and skid strips next to bed. The Care Plan initiated on 7/27/18 with a revision date of 4/7/23, also had an ADL self-care performance deficit focus area related to cerebral palsy with a goal the resident maintain their current level of function. Interventions directed staff to encourage the resident to utilize half side rails for increased bed mobility, one person assistance with bed mobility and assistance of two staff with transfers - Hoyer lift only. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation on 4/12/23 at 2:00 PM, Staff Q, CNA and Staff R, CNA completed a Hoyer transfer for Resident #7. The resident was sitting in her wheelchair and had the Hoyer sling in place under her. They brought the Hoyer in and hooked her up to it using the blue loops on the top and the purple loops on the bottom. The Hoyer legs were spread and the Hoyer machine was locked. Staff Q, CNA then used the remote to raise the resident into the air and then the machine was unlocked and steered around with Staff R, CNA assisting to guide the resident until she was centered over the bed. She was encouraged to give herself a hug during the transfer. Once she was centered over the bed she was lowered onto the bed and unhooked from the machine. The resident tolerated the process well. The sling was removed from under her by rolling her side to side. 3. Resident #14's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #14 required total dependence of one person for bed mobility and toilet use and total dependence of two people for transfers. Resident was always incontinent of bowel and bladder and was wheelchair dependent. The MDS included diagnoses of atrial fibrillation, diabetes mellitus, thyroid disorder, arthritis, anxiety disorder, depression, respiratory failure, and morbid obesity. The Care Plan initiated on 2/28/22 with a revision date of 4/7/23, revealed an ADL self-care performance deficit activity intolerance focus area related to impaired balance and limited mobility and a goal to maintain current level of function with ADL. Interventions directed staff to assist with bed mobility using two people, encourage to discuss feelings about self-care deficit, praise all efforts at self-care, and Hoyer transfers with assistance of two people. In an interview on 4/19/23 at 2:35 PM, Resident #14 stated she had been a Hoyer lift transfer since admitting to the facility. Staff used the same style and size sling for all transfers. They normally use two staff for her transfers but Staff L, CNA had transferred her alone a couple of times but nothing recent. Felt secure most of the time with her transfers except when the transfer was being completed with one staff person. 4. Resident #16's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS indicated Resident #16 required extensive assistance of one person for bed mobility, total dependence of two people for transfers, and total dependence of one person for toilet use. She was wheelchair dependent, used oxygen, and always incontinent of bowel and bladder. The MDS included diagnoses of heart failure, renal insufficiency, cerebrovascular accident, hemiplegia, anxiety disorder, depression, bipolar disorder, schizophrenia, and chronic obstructive pulmonary disease. The Care Plan initiated on 2/10/22 with a revision date of 4/20/22, revealed an ADL self-performance deficit with a goal to maintain current level of function with ADL's. Interventions directed staff to assist resident to turn and reposition in bed, encourage use of enabling bars/side rails to maximize independence with turning and repositioning in bed, allow sufficient time for dressing and undressing, and requires the assistance of two people for Hoyer transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A fall Incident Report dated 1/9/23 at 3:04 PM, documented the nurse was alerted to Resident #16's room by a loud noise and yelling coming from the resident's room. The nurse arrived and observed the resident resting with her head and torso supported in the lift sling and her legs in the wheelchair under the armrest. The Hoyer sling was attached to the lift and the Hoyer lift was tipped sideways with the lift portion between the resident's legs and on her groin. The resident was assisted to the floor with the sling and the assistance of six staff. Resident was assess for injury and it was noted the resident had bruising and raised and abraded areas on her inner thigh. Resident had functional range of motion per her baseline but complained of left hip pain. While being assessed, the resident's eyes rolled back and her body began to shake. Her eyes were fixed open and she was not responsive to verbal or physical stimuli. The nurse directed staff to call 911 and the resident was having suspected seizure activity. Paramedics arrived and transported the resident to the hospital for evaluation. Immediate action: Resident was assisted to the floor, assessed for injury and sent to hospital via ambulance. Resident noted to have an abrasion to front of left thigh. Resident oriented to person. Predisposing environmental factors included clutter, furniture, crowding, and equipment malfunction. Physician was notified of incident. A progress note date 1/9/23 at 3:41 PM, documented the nurse was alerted to Resident #16's room by a loud noise and yelling coming from the room. The nurse arrived and observed the resident resting with her head and torso supported in the lift sling and her legs in the wheelchair under the armrest. The Hoyer sling was attached to the lift and the Hoyer lift was tipped sideways with the lift portion between the resident's legs and on her groin. Resident was assisted to the floor with the lift sling and the assistance of six staff. Resident was assessed for injury and it was noted that she had bruising and pinched areas on her inner thigh. Resident had functional range of motion per her baseline but complained of pain. While being assessed, the resident's eyes rolled back and her body began to shake. Her eyes were fixed open and she was not responsive to verbal or physical stimuli. The nurse directed staff to call 911 as the resident was having suspected seizure activity. Paramedics arrived and transported the resident to the emergency room for evaluation. A progress note dated 1/9/23 at 11:24 PM, documented Resident #16 returned to the facility at approximately 10:00 PM via ambulance. Resident was found to have a clear CT scan and x-rays showed no broken bones or fractures. The resident reported her tailbone and bottom were sore. Resident was given her bedtime medications which included pain medication. Vital signs were stable upon arrival back to the facility (T - 97.8, HR - 74, R - 20, BP - 122/86, and oxygen level was 96% on room air). Resident voiced no other concerns at that time. A physician progress note dated 1/11/23 at 6:29 PM, documented resident had a fall on 1/9/23 from a malfunction of the Hoyer and landed on her back. She was transported to the emergency room . A head CT, back and hip x-ray was done. Hip x-ray was negative for fracture but it did show a contusion of the hip. The head CT was unremarkable. Today she complained of occipital headache, onset was after the fall on 1/9/23, describes it as intermittent throbbing and rates the pain at a 5. She was seen for post emergency room visit. No acute distress and oriented x 4. Plan: Celebrex 100 milligrams (mg) by mouth twice daily as needed for headache as previously ordered, utilize Tylenol as previously ordered and notify the provider with any changes. In an interview on 4/19/23 at 11:51 AM, the DON acknowledged the fall from a Hoyer involving Resident #16 had occurred when Staff L, CNA was operating the Hoyer without a second person at the time. She stated she was not aware of other staff operating mechanical lifts independently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/25/23 at 8:10 AM, Staff N, OTA/Therapy Coordinator reported he held several in-services throughout the week following the incident with the Hoyer tipping and a staff person using the mechanical lift independently. He stated the in-service consisted of them watching a YouTube video and then they worked in groups of two and practiced Hoyer transfers of a person from the bed to the wheelchair and then back to bed. He stated he observed and let them do the transfers unless he saw a concern, then he would educate and correct at the time. He stated Staff L, CNA did attend the in-service and completed the transfer perfectly. He stated that he feels she knew exactly how to complete the transfers but it was a behavior thing that she chose to take short cuts. 5. Resident #18's MDS assessment dated [DATE] identified a BIMS score of 3, indicating severely impaired cognition. The MDS indicated Resident #18 required total dependence of one person for bed mobility and toilet use and total dependence of two people for transfers. Resident was wheelchair dependent and had a feeding tube. Resident was always incontinent of bowel and bladder. The MDS included diagnoses of anemia, cerebrovascular accident, altered mental status, and dysphagia. The Care Plan initiated on 9/9/13 with a revision date of 12/9/21, revealed a fall risk focus area related to dementia, inability to recognize safety issues, poor gait/balance, and need for assistance with transfers with a goal to not sustain any preventable serious injury. Interventions directed staff to ensure proper footwear with transfers or in wheelchair, anticipate and meet resident needs, ensure call light is available and encourage to use for assistance, encourage participation in activities that promote exercise, physical activity for strengthening and improve mobility, non-skid strips in place next to bed, and half side rail on bed to help roll herself from side to side. The Care Plan initiated on 9/9/13 with a revision date of 12/9/21, revealed an ADL self-care performance deficit focus area related to a history of transient ischemic attack, muscle weakness, contractures/hemiparesis, and cognitive deficits related to dementia with a goal to not have any preventable decline in the resident's current level of function in ADL's. Interventions directed staff to utilize one person to check and change resident, anti-slip one way slide in wheelchair at all times due to repeated falls, use her wheelchair for locomotion, use two people for all Hoyer transfers, and encourage the resident to participate to the fullest extent possible with each interaction. In an observation on 4/20/23 3:50 PM, Staff S, CNA and Staff T, Hospitality Aide performed a Hoyer transfer for Resident #18. The resident was sitting in her wheelchair with the Hoyer sling in place. The resident's daughter present for transfer. Staff T, Hospitality Aide was running the Hoyer. Staff S, CNA was placing the sling on the boom of the Hoyer. Top loops were on the green and the bottom loops were on purple. The Hoyer was not locked. Staff T, Hospitality Aide raised the boom of the lift and the resident's daughter assisted as the resident's left foot had foot drop and started to get stuck under the lift. The daughter assist in guiding the resident's legs. The wheelchair was pushed back towards the other side of the room and the resident was lowered to the bed. Staff T, Hospitality Aide has been employed at the facility since 11/23/22 and worked as a dietary aide and moved into the hospitality aide position on 2/26/23. In an interview on 4/20/23 at 4:23 PM, The Administrator stated Staff T, Hospitality Aide would be sent to CNA class. She hadn't started things yet so they hadn't enrolled her yet. The facility provide Hospitality Aide policy identified that no hands on care is allowed in this position. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 4/19/23 at 11:51 AM, the DON stated she wasn't sure but thought staff measured the resident to decide what kind and size of sling a resident should use with the Hoyer lift. She stated there is normally one sling in the room unless it gets dirty and then it is replaced with the same type and size sling that was in there previously. In an interview on 4/19/23 at 1:00 PM, the Administrator reported the Maintenance Superv [TRUNCATED]

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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** 44972 Based on clinical record review, observation, staff interview, and policy review the facility failed to provide incontinence care to minimize the occurrence of urinary tract infections and to ensure the perineal area was kept clean and dry for 2 of 4 residents reviewed (Resident #2 and #4). The facility reported a census of 69 residents. Finding include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #2 identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toilet use. The resident was dependent on a wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder and spinal stenosis. A Care Plan dated 1/5/20 with a revision date of 7/15/22 for Resident #2 revealed a focus area for bowel and bladder incontinence and being at risk for urinary tract infections (UTI) and/or skin breakdown with a goal the resident would be kept clean, dry, and comfortable daily with the use of incontinence products. Interventions directed staff to check the resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, provide incontinence care after each incontinent episode, and use barrier cream to perineal area. Review of progress notes revealed the resident had been treated for UTI's the following dates since 2/1/23: 2/18/23 Resident was sent to the emergency room and admitted with diagnosis of UTI and encephalopathy. 2/27/23 Resident returned from the hospital 3/38/23 Resident started on Cipro 250 milligrams (MG) (antibiotic) by mouth twice daily for 10 days for diagnosis of UTI. 3/29/23 Order was received to discontinue the Cipro related to resistance to the organism causing the UTI and to start Rocephin 1 Gram (G) (antibiotic) intramuscularly (IM) every day for 5 days. 4/11/23 Resident was started on Keflex 500 MG (antibiotic) by mouth four times a day for 10 days for a diagnosis of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/12/23 at 7:52 AM, Staff I, CNA and Staff CC, CNA completed cares on resident before breakfast. The two staff members knocked and entered the room. They did not wash their hands but applied gloves and asked the resident if she was ready to get dressed. She stated she was ready and needed to be boosted up in bed and her brief needed changed as she was soaking wet. The staff immediately removed her blanket and began to undo her wet brief. Both staff assisted with undoing the wet brief and Staff I, CNA used wet wipes to cleanse the perineal area. She used the one wipe - one swipe method to cleanse from front to back but did not wash the mons pubis area. The wet brief remained under her at that time. Staff CC, CNA requested and assisted resident to turn onto her left side and the wet brief was removed from under her at that time. The comply underpad was noted to be wet but left under her at this point. Staff I, CNA cleansed the buttock area and right hip using the one wipe - one swipe method. The left hip was never cleansed. Once done, a new brief was put under her and she was assisted to her back and the clean brief was pulled through on the left side and then pulled up between her legs and attached with the pull tabs. Staff I, CNA changed her gloves at this time but no hand hygiene was completed. Staff CC, CNA assisted the resident to roll to the side again and the wet comply underpad was tucked under her and she was assisted to her back and the comply underpad was removed from the left side. It was noted that the residents brief, comply pad, sheet and gown were all wet with urine. Staff CC, CNA went to the closet and picked out clothes for the resident. Staff I, CNA was putting dirty clothes and soiled items in a garbage bag. Staff CC, CNA handed a pair of pants to Staff I, CNA who assisted the resident in putting them on. Staff CC, CNA found a shirt for the resident and removed the dirty urine soaked hospital gown from the resident. She assisted the resident to put on her shirt. Staff CC, CNA had not changed her gloves at all. The two staff assisted the resident to sit on the side of the bed in preparation for the transfer into the resident's wheelchair. 2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae. A Care Plan dated 7/21/19 with a revision date of 11/25/22 for Resident #4 revealed a focus area for bowel and bladder incontinence and is at risk for signs and symptoms of UTI and/or skin breakdown related to the incontinence and diuretic use. The interventions directed staff to check resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, administer medications as ordered, place the call light or other communication devices within reach at all times, provide incontinence/perineal care after each incontinent episode, and use barrier cream to the perineal area. Review of progress notes does not indicate the resident had been diagnosed with a UTI since 2/1/23. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/13/23 at 1:50 PM, Staff G, CNA and Staff H, CNA complete incontinence care for resident #4. The staff transferred the resident from her wheelchair into her bed using the Hoyer lift. Hand hygiene was completed upon entering the room and they both applied gloves. Staff reported that the resident was laid down after every meal and checked and changed at that time. The Resident was rolled to the right and the resident's brief was undone and tucked as well as the Hoyer sling under her. It was noted the resident did not have a dressing on her coccyx area and it was bleeding. The brief was soaked and her pants and the sling were wet as well. Staff assisted the resident to roll to the left and the brief and sling were removed. Staff did not change their gloves or sanitize their hands. A new brief was tucked under the resident. Peri-fresh was sprayed onto the resident's buttocks and her buttocks was cleansed using the one wipe - one swipe method from front to back while on her side. Staff slightly spread her legs while on her side and wiped perineal area front to back using one wipe - one swipe. The resident was turned onto her back and the brief was pulled up between her legs. The brief was not fastened. The resident's groins, pubis and outer buttock cheeks were not cleansed. Gloves were removed by CNA's but no hand hygiene completed. Staff applied the resident's pants and pulled them up to her upper thighs as they were waiting for the nurse to come and apply a dressing to the open area on the coccyx. Staff H, CNA washed her hands and left the room to go get the nurse to apply the dressing. Staff DD, Licensed Practical Nurse (LPN) entered the room to complete the dressing change to her coccyx. Hand hygiene completed upon entering the room and supplies set up on a tray table with a towel for a barrier. No gloves were worn. She used 4 x 4's to wipe the bloody drainage away. She then got a Mepilex dressing and applied it to the area. The patch was dated and initialed after applied to the wound. The resident was positioned on her right side for the treatment. Staff H, CNA applied gloves but did not complete hand hygiene prior to applying her gloves and applied Periguard to the resident's inner thighs and buttocks area. She removed her gloves and positioned her onto her back. Pants were removed at resident's request. Covered with a sheet, the head of bed was elevated, and call light placed in reach. No hand hygiene completed by the CNA's when leaving the room. In an interview on 4/25/23 at 11:48 AM, the Director of Nursing (DON) she stated it was the expectation that staff complete rounds frequently and check and change residents. Staff should also be toileting residents and changing them at their request, and before and after meals. Staff know the residents that are heavy wetters and should check them more frequently. Staff should also watch for cues that a resident may need to use the toilet, like trying to get up out of the chair or bed. A facility provided policy titled Perineal/Incontinence Care dated 1/1/14 stated incontinence perineal/incontinence care was to be done to provide cleanliness and comfort to the resident, prevent infections and skin irritation, and observe the resident's skin condition.

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Greater Southside Health and Rehabilitation	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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40907 Based on observations, interviews, and record review the facility failed to administer pain medication as ordered by a physician leaving 4 out of 4 residents reviewed without adequate pain control (Resident #4, #19, #20, and #21). Four residents reviewed were not administered their Controlled II pain medication as ordered for prolonged periods of time. The nurses and CMAs stated the medication was not available to give, therefore they did not give it. Resident #21 went 8 days without receiving his three times a day routine order of Percocet (an oral opioid pain medication). The other 3 residents did not receive their Fentanyl patches (potent opioid pain patch) as ordered every 3 days. In a 22 day period, the 3 residents reviewed did not have their patch applied every 3 days as ordered resulting in Resident #4 going 11 days, Resident #19 going 12 days, and Resident #20 going 7 days without Fentanyl during the 22 day review period. This situation resulted in Immediate Jeopardy to residents health and safety for the facility. The facility was notified of the Immediate Jeopardy on 6/29/23. The facility abated the Immediate Jeopardy situation on 6/29/23 lowering the scope from a K to an E after staff education was complete and the facility ensured all scheduled/ordered pain medications were available for residents. The facility reported a census of 62 residents. Findings include: 1. A Minimum Data Set (MDS) dated [DATE], documented that Resident #4 diagnoses included Multiple Sclerosis (MS), osteomyelitis of the vertebra (infection of the bone), and non-Alzheimer's dementia. A Brief Interview for Mental Status (BIMS) documented a score of 8 out of 15, which indicated moderate cognitive impairment. Resident #4 required total dependence of 2 for transfers, and personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #4 received pain medication both routine and PRN (as needed) in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a moderate level and documented that she had pain occasionally. A Medication Administration Record (MAR) for the month of June 2023, directed staff to administer a Fentanyl Patch 12 mcg (microgram)/hr(hour) transdermal (absorbed through the skin) application at bedtime every 3 days for chronic pain to Resident #4. The start date was 2/20/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/2/23, it was applied the following day on 6/3/23. The resident had a patch applied on 5/5/23 and 5/8/23, then this resident did not have a patch applied again until 5/21/23. On 6/21/23 at 4:00 p.m., When asked if she had pain, this resident stated she did. When asked to rate the pain, she stated it was at a 5 on a scale of 0-10 and the pain was on her bottom. Resident lying in bed at the time. On 6/22/23 at 11:20 a.m., it was noted that Resident #4 had a patch on her right chest dated 6/21/23. Resident was asleep. This resident woke up but required some patting on the arm by staff. On all observations of Resident #4 during this survey Resident #4 had been awake, eyes opened, and responsive with exception of this observation. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. An MDS dated [DATE], documented that Resident #19's diagnoses included MS and chronic pain. The MDS revealed a BIMS score of 15 out of 15, which indicated intact cognition. This resident required total dependence of 2 staff for transfers. She required total dependence of 1 staff for personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #19 received pain medication both routine and PRN in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a 5 out of 10 (0 is no pain and 10 is the worse pain you can imagine) and documented that she had pain frequently. A Medication Administration Record for the month of June 2023, directed staff to administer a Fentanyl Patch 25 mcg/hr transdermal application at bedtime every 72 hours (3 days) for chronic pain to Resident #19. The start date was 3/4/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/2/23, it was applied on 6/5/23. It revealed that she was to get a patch placed on 6/8/23 and did not have a patch applied until 6/14/23. She was scheduled to have a patch applied on 6/17/23 and did not have it applied until 6/20/23. It was documented that it was not available on 6/23/23. The MAR also directed staff that Oxycodone (opioid) 5 mg tablet was to be administered orally 4 times a day to Resident #19. The order date was 6/8/23. From 6/8/23 at 5 p.m. when the first dose was to be given to 6/12/23 at 6:00 a.m. the doses were not given. The 6:00 a.m. dose on 6/13/23 and all 4 doses on 6/14/23 and 6/15/23 were not available. The 8:00 p.m. dose on 6/23/23 was also not available. On 6/21/23 at 4:54 p.m., Resident #19 stated she was in pain and rated it at a 9 out of 10. She stated that she needed to lie down. She stated she hurt everywhere. Resident appeared to be in pain. She was pale and did not move during the conversation. On 6/22/23 at 10:30, Resident #19 was observed to have a patch last placed on 6/20/23 on her left chest. Resident #19 rated her pain at a 9 and stated she hurt all over. She added that the medication person is going to give her pain meds now and they will help. She said she went without the patch a few days ago and she became very sick. She stated she was throwing up and everything. She stated once they were able to get a patch the sickness went away. 3. An MDS dated [DATE], documented that Resident #20's diagnoses included anxiety and chronic pain syndrome. The MDS revealed a BIMS score of 15 out of 15, which indicated intact cognition. This resident required extensive assist of 1 for transfers and personal hygiene. The MDS documented that this resident received opioid medication 7 out of the 7 observation period days. The Pain Management section revealed that Resident #20 received pain medication both routine and PRN in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated her pain at a 4 out of 10 and documented that she had pain frequently. A Medication Administration Record for the month of June 2023, directed staff to administer a Fentanyl Patch 25 mcg/hr transdermal application at bedtime every 72 hours for chronic pain syndrome to Resident #20. The start date was 5/1/23. Review of the record revealed that this resident did not receive the patch as scheduled on 6/3/23. The last patch prior to this was applied on 5/30/23 and 3 days from that was 6/2/23. This resident went 4 days without the absorption of the patch from 6/2/23 when it should have been applied to 6/6/23. She had the patch applied again on 6/9/23, it wasn't applied on 6/12/23 then it was applied again on 6/15/23. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/21/23 at 4:55 p.m., Resident #20 stated she was in pain and rated her pain at an 8 out of 10. She stated it hurt in her tailbone and back. The resident appeared to be in pain. The DON (Director of Nursing) was notified of where Resident #19 and Resident #20 were rating their pain. Both residents had been outside to smoke and were sitting beside their respective beds in their wheelchairs in their room. These two residents are roommates. Both residents had facial grimacing. Resident #19 had guarded movements and sat very still. Observation on 6/22/23 at 10:35 a.m., noted Resident #20 had a patch on her right chest. It was not labeled. Resident #20 stated her tailbone pain is at an 8 which is constant, and her stomach pain was at a 5. She stated they were supposed to give her a suppository 2 nights ago and they never did. She stated she was constipated. When asked if they have missed giving her some pain medications, she said yes. She stated the reason she didn't receive her medication was they didn't have the medication to give. When asked if she was given anything to help with her pain she said no, they told me they didn't have anything else to give. 4. A MDS dated [DATE], documented that Resident #21's diagnoses included malignant neoplasm of the larynx (cancer of the voice box) and chronic pain. The BIMS score for Resident #21 was 12 out of 15 which indicated moderate cognitive impairment. This resident required extensive assist of 2 for transfers and extensive assist of 1 for personal hygiene. The Pain Management section revealed that Resident #21 received routine pain medication in the 5 prior days. The Pain Assessment revealed that in the prior 5 days this resident rated his pain at a 6 out of 10 and documented that he had pain frequently. A MAR for the month of June, directed staff to administer Percocet 5-325mg three times a day at 8:00 a.m., 2:00 p.m., and at 8:00 p.m. to Resident #21. The MAR revealed that Resident did not receive his scheduled Percocet from 6/13/23 at 2:00 p.m. through 6/20/23. The MAR documented that he received a dose at 8:00 a. m. on 6/21/23. On 6/27/23 at 10:31 p.m. observed Resident #21 lying in bed. He nodded his head in affirmation that he did know they didn't have the pain meds to give him. When asked if he was in pain during that time, his eyes widened and he nodded a definite yes. When asked if he remembers what level his pain was at during that time and if he could rate it he shook his head no. He affirmed by nodding that he had went about a week without the pain medication and this happened a couple of weeks back. On 6/21/23 at 10:26 a.m., Staff C, Certified Nurse Aide/Certified Medication Aide (CNA/CMA), when asked what the circled initials meant on the MAR/TAR (/Treatment Administration Record) she stated it meant that they didn't have the medication. She stated it happened more than she would like to admit. She said the DON said to just pass the medications that you can. When asked why some residents had Fentanyl patches and another did not, she stated she did not know. She said maybe it had something to do with pharmacy. She said the facility does not want to report these things. Staff C stated she is told not to get so upset about things. On 6/21/23 at 2:45 p.m., the DON stated she was looking into the Fentanyl patches not being given. When asked what she knew about it, she just shook her head no. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/21/23 at 3:00 p.m., Staff C, when asked again about the numerous Fentanyl patches that weren't applied, she stated that the night shift which is mainly agency nurses put the patches on. She acknowledged all of the holes with the Fentanyl patches. She stated it meant they did not get the patches put on. She did not think there was drug diversion. She thought it was more laziness, destroyed. On 6/21/23 at 4:07 p.m., Staff D, Register Nurse (RN) traveler with the facility corporation and the Nurse Consultant stated they were aware of this too and looking into it, when they were told there was a concern with the Fentanyl patches and narcotics not being given. On 6/22/23 at 10:30 a.m., Staff A, CMA stated that medications are getting missed and sometimes it's because staff don't understand the different names of Vitamins i.e. ascorbic acid vs Vitamin C and sometimes they just don't look for the medications. Staff A stated that Resident #4 was without Percocet. Staff A stated she had sent the information that he was out of his Percocet and needed more several times but she was not sure if they had gotten it. She stated that Staff E, RN had told her they were getting a script (prescription for a physician) for the Percocet. Staff A said she had sent the tag in about 5 days before he was out of them. Staff A said it was ample time, more than 3 days to get it ordered. Staff A stated they (nurses) had tried to get it out of the e-kit (emergency medication kit) but he needed a new script. She said that he went 8 days without the Percocet. Staff A did not think there was any drug diversion just laziness. She stated that Resident #4 was going through withdrawal symptoms. Stated he was really tired. Staff B, RN, was part of the above conversation. He stated that there normally are medications up front. Staff B stated they can go up and get them. Staff B stated he did not think there was any drug diversion, just sloppy nursing. On 6/22/23 at 4:06 p.m., Staff F, Nurse Practitioner (NP), stated the facility let her know that the 3 ladies did not receive their patches. She stated she took a look at them and discontinued 2 of the 3 ladies patches as she did not feel they needed it. She said the 3rd lady was a different story. She stated she did know about another resident not getting his Percocet. She found out through faxes. She will look for the faxes of the facility notifying her of the pain medication not being given. Staff F stated it was okay to call her back with any further questions. Stated it was recently brought up to her about the Fentanyl patches not being administered, but she had been notified of this before and was notified by fax. No faxes were provided. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/22/23 at 2:30 p.m., Staff G, NP stated that no one had notified her of medications not being given. She had not heard about Fentanyl patches not being available. She had not heard about Resident #4 not getting his Percocet. She said there would be no reason for this. If not contacting her they could contact other providers to get a script or to get these medications ordered. She said in Resident #4's case she saw him after a fall and had abdominal x-ray/test done related to pain. She said at that time she reviewed his medications and did not feel he needed anything more for pain as he was on several medications that helped with pain. Staff G looked at Resident #4's MAR. She stated now that she knows he went without Percocet for that many days she will need to go back to Resident #4 and ask him about pain control. She said she came in to see 5 residents on this day and she was still at the facility because she finds things out when she talks with residents and feels she needs to take care of it. She stated a lot of the stuff she ends up doing are things the nurse should be doing but for some reason it is not getting done. She repeated that there is no reason the residents should not be receiving their medication. She stated a provider and pharmacy can be called. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/22/23 at 3:05 p.m., Staff E, RN stated that it was reported to her that Resident #4 did not have Percocet. She stated the CMA did not tell her until the last day that she worked. Staff E stated that sometimes she worked 2-3 days in a row. She stated that afternoon she called the pharmacy for it and the pharmacy said they were waiting on a script for it. Staff E stated that the pharmacy calls the care provider to get the script. She stated that the pharmacy was located out of state, so the pharmacy didn't always call the provider for the nurses. Staff E stated that on weekends it depends on who is on call, the provider might not write a script. Staff E didn't think she had called the on call provider the day she found out about needing a Percocet refill. Staff E stated she reported it on to the next shift but did not remember who. Staff E stated she did think it was important for the residents to have their meds. Staff E stated the facility was running bubble packs as well as cards with medications (meds) in them. Staff E stated that she was running meds all the time. Staff E said she did not want to put the facility under the bus or anything, but the nurses are continually getting meds out of this system because the meds are not filled. Staff E stated it was like all day long they were pulling meds from the ekit (emergency kit storage). Staff E stated it was very time consuming. Staff E stated the fax machine was down for a long time. She said she had been there for 6 months and the facility finally got a fax machine this week. She stated they were unable to fax the pharmacy because of it. Staff E stated they had to call the pharmacy or Staff F, LPN and another nurse had been emailing the pharmacy. Staff E stated that she always called the pharmacy and they would get upset when you have a huge list, the pharmacy wanted the list sent instead. She stated the pharmacy also sometimes did not send the meds. Staff E said that every day she pulled medications out of the ekit, even though the meds had been requested from the pharmacy. Staff E stated that the CMAs don't let the nurse know if there is a med missing, they will just circle it. Staff E said that she and another nurse have reported to the DON that the med aides (CMA's) aren't reporting that there are not meds in the carts. Staff E then went into the medication room. The system was hooked up to a computer. Staff E stated the nurses are able to type in the name of a resident and the medication needed and then you can get it out of the ekit. She stated that the nurses run meds for the residents and then deliver them. She said that it happened often that all of the meds are not there. Staff E said that often times with narcotics, the pharmacy will say a script was needed. Staff E stated that it could be difficult to get a script. Staff E said she honestly did not know if there was drug diversion at the facility, it's pretty scary. Staff E said that she had seen that people have signed things off and she had wondered how the CMAs have signed stuff off that the facility did not have. Staff E was unable to give any specific examples of this nor could she give a time frame. Staff E stated that Staff A and Staff C had told Staff E that night shift agency aides are not passing the meds. Staff C was really good about reporting to Staff E but Staff A didn't always report. Staff E said that Staff A would report to Staff B, but he was Staff A's son in law. Staff E stated she reported this to the DON and nothing really happened. Staff E stated that she did not want to be fired or anything but many things needed fixed. Staff E became tearful and said it's hard to work here because it's very busy and many things get missed. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/26/23 at 3:13 p.m., Staff I, RN Hospice stated she had brought up concerns regarding Resident #19 going through withdrawals. Staff I said the facility set her up on routine Oxycodone with the Fentanyl patch before related to Resident #19 requesting so much PRN (as needed) Oxycodone. Staff I said that with Resident #19 taking both of the meds she would still rate her pain at an 8 or 9. Staff I said that Resident #19 had a history of MS so it could be hard to tell with her because you don't know if she is masking pain. When asked who she goes through for medications, she stated they go through the facility doctor first. Staff I said that a lot of times they do things without communicating with her. Staff I stated she has to ask for an updated medication list for Resident #19. Staff I said she sees Resident #19 two times a week. When asked if she knew about Resident #19 not receiving her Fentanyl patch, Staff I stated that she would notice it would be dated for 5 days prior or not on her at all. Staff I said she had her hospice aide check the date on the patch and the hospice aide was to let Staff I know if the date was more than 3 days old or if there was no patch. Staff I stated that Resident #19 would ask Staff I if Staff I would go and see when she was due for her next dose of pain medication. Staff I stated that Resident #19 would ask more about the oxycodone and not the patch. Staff I said she had been Resident #19's case manager for almost 2 months now and that Resident #19 had went on hospice on 1/27/23 and there was a different hospice nurse case manager before Staff I. Staff I said that Resident #19 can make her own decisions and Resident #19 did have a son and a daughter that she wants us to update on her care. Staff I had a conversation with Resident #19 about missing Fentanyl patches. Staff I said that back in May she had went in and noticed that Resident #19 hadn't had one (Fentanyl patch) changed and Staff I brought it up to her and they were able to get a new one started. Staff I stated that since then Resident #19 had been able to let Staff I know if it was taken care of or not taken care of. Staff I stated that in June Resident #19 told Staff I that the Fentanyl patch wasn't being taken care. Staff I said that she spoke with the floor nurse and spoke with the ADON (Assistant Director of Nursing) and it seemed like every time Staff I would talk to somebody, they would tell Staff I they'd get the Fentanyl Patch shortly. Staff I stated she did not feel the issue got addressed. Staff I stated that the other hospice nurse spoke with the floor nurse on June 14th when the other hospice nurse noticed that the patch had not been changed and her roommate noticed the patch had not been changed. Staff I stated that she knew she was biased because them discontinuing the patch after the fact is doing her a disservice. On 6/26/23 at 4:20 p.m., Resident #19 stated that she was in pain and rated her pain at a 9 and 1/2. This resident was lying in bed. Stated she was feeling really bad and was going downhill fast. When asked what she meant by that she stated she just wasn't doing good. When asked about the Fentanyl patch, she said they took that off last week and told her that she didn't need it. When asked what she thought about that, she stated it really didn't help her much anyway. This resident had opened her eyes when the door was knocked on but did not open them very far. This resident did not move any extremities nor her head when she talked. When asked if staff check on her and ask her about her pain, she stated sometimes. When asked if they were checking twice a day, she stated no. When asked if she ever has no pain, she said no. When asked what the lowest her pain had been in the past few months, she stated a 6 or 7. The MAR for Resident #19 for the month of June 2023, directed staff to do a twice a day pain assessment with 0 as no pain, 1-3 as mild pain, 4-6 as moderate pain, and 7-10 as severe pain. The documentation of the pain revealed that from June 1st through June 26th this resident had pain rated four times at 7, two times at 8 and one time at a 6, the rest of the documentation revealed 0's or there were times when it wasn't filled out. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/26/23 at 4:30 p.m., Resident #4 was lying in bed smiling. Stated she really didn't have any pain. She was feeling pretty good. Resident #4 was wide awake and appeared happy. She asked about what time it was. The MAR for Resident #4 for the month of June 2023, directed staff to record pain on a 0-10 scale twice a day. The documentation of the pain revealed that from June 1st through the first part of June 26th this resident had 40 times the pain was not rated. On 6/27/23 at 9:15 a.m., Staff J, agency RN, stated he thought there was a Fentanyl patch on the 2nd floor downstairs for a day or so that was not put on. Staff J stated he did not put on but he did leave a note and passed it on. Staff J stated there was no way for him to get the patch. He stated he talked to day shift. He said that it was pretty complicated to talk to pharmacy on the weekend. He said he did assessments. When told about the patches that weren't placed and the time frame the residents went without a Fentanyl patch, he stated he did not know that they did not have patches for that long. Staff J stated he worked a lot on the 2nd floor (where all 4 residents resided). Staff J stated he would work a few days and then off but when he would come back he did not recall seeing any resident going a long time without a patch. Staff J stated that the CMAs do not apply Fentanyl. Staff J said that medications being not available happened quite often. Staff J stated that every time something happened when there wasn't a medication, he always left a note. Staff J stated that he would give a verbal report but he also would write the meds on the sheet and then hand it to the next shift. Staff J stated that the pharmacy says that he needs to fax when he did get a hold of the pharmacy. Staff J stated that the facility's fax was not working and on weekends the pharmacy was not available. Staff J stated that if you want to order more than one or two meds the pharmacy would say to fax the list of meds as the pharmacy preferred faxes. Staff J stated that he always made sure he put it on the sheet that they have so the day nurse would know what the situation was and then they could handle it during the day. When asked about the sheet, he stated he was not very sure where the sheet was kept. Staff J stated that they hand over a copy of it to the next nurse. Staff J stated that sometimes he would pass 8:00 p.m. meds but most of the time it's a CMA. Staff J stated he didn't know about Resident #21's Percocet. Staff J stated that he felt the residents received good care and he thought the communication with the pharmacy was the biggest concern. On 6/27/23 at 9:45 a.m., Staff E stated she did not know where the pharmacy book was in the back (2nd floor). She stated she wasn't sure what they did when the nurses and CMAs filled out the sheets with the meds that are needed. Staff E said she didn't see the book and she thought the sheets might just get thrown away. She pulled a couple of sheets out of the box with things that needed to be shredded. On 6/27/23 at 10:25 a.m., Staff E pulled 2 more pharmacy sheets out of the box when asked if there were any more sheets in the box. (continued on next page)

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Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/27/23 at 9:50 a.m., Staff H, Licensed Practical Nurse (LPN), stated the facility got a new machine and it copies and prints but it doesn't fax. Staff H stated she had developed a process with the pharmacy where you have an encryption code so the emails between Staff H and the pharmacy can go between us without HIPPA violations. Staff H stated that she had been doing this for 2 months. Staff H stated she receives sheets from the CMAs and on Mondays, Tuesdays, and Wednesdays Staff H forwards the sheets on to the pharmacy and then writes emailed to pharmacy and the date and time. Staff H stated she then puts the sheets into the pharmacy book. Staff H stated that she only worked on the 1st floor. Staff H state the process to get medication was the doctor writes out the order for her on a script, then she would take a picture and email to the pharmacy, after that she documented in the electronic health record to make it an active order. Staff H stated she would usually then call the pharmacy and let them know that she had put in an active order and she would pull a couple of doses of the medication so that they could cover the first couple of doses that needed to be given. Staff H stated that not all nurses have access to their medication system. She stated that sometimes they have agency nurses and the agency nurses cannot get into the facility's medication system. Discussed Resident #19's medication and Staff H stated that Resident #19 had been in pain since she has been here. Staff H stated that Resident #19 should not go without her pain medication. Staff H said that Resident #19 was so frail and pale and always looked like she was in pain. When told the pain level had been signed often as no pain for this resident, Staff H stated that was not right. Staff H stated what she thought staff were doing was seeing if Resident #19 was sleeping and marking it 0, they should be asking her. Staff H said that Resident #19 needed her pain medication. Staff H stated that hospice staff could call the pharmacy too and Staff H stated she did not know why agency nurses wouldn't just call the pharmacy. Staff H stated if they are writing down on the sheet that there was not a med available then it should be in the pharmacy book down there. They should be putting those sheets in to the pharmacy book and those papers should not be shredded. Staff H stated that usually on Mondays there are a lot of meds to order. Staff H stated that she just called the pharmacy and asked them how could she get the meds without a fax and they said she could use her own email but she would need to use their encryption. Staff H stated that's what she did. Staff H stated she did not want to put down the company but they had people running to another facility to fax orders because their facility couldn't get the meds. On 6/27/23 at 11:32 a.m., Staff K, CMA/CNA, stated that it did happen when meds were not available. Staff K stated she circled her initials on the MAR's when meds were not available. Staff K stated that she actually asks her nurse if the med is printable, meaning they can get it from the medication system, but if not to circle it and write a note on 24 hour report. When asked how often she thinks this happens, she stated daily. She stated it had gotten better because they had a new ADON who listens. Staff K stated that they tell the resident when we don't have a med for them and most of the time they are not surprised, unless it's a pain med, anti coagulant (blood thinner), anti anxiety, etc. Staff K stated they have one resident who gets upset if he did not get his oxycodone (pain medication), Lyrica (blocks pain signals in nervous system), or Clonazepam (anti-anxiety). Staff K sated that it took time but they were able to get it for him because they would call the pharmacy and the on call physician and get it pulled. Staff K stated that sometimes the on call doctor doesn't answer and sometimes the pharmacy doesn't answer. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/27/23 at 12:03 p.m., Staff L, RN stated she passes medications when they need someone. Staff L stated she would just get meds out of their medication system if she needed a med. She stated she has had trouble with the system jamming. Staff L stated she leaves at 10:30 p.m. and asks prior to leaving if anybody needs anything. Staff L stated she worked noon to 10:30 p.m. Staff L stated that they were checking every night now, they check the MARS and TARS they have to sign. Staff L, RN stated she knew that medications not being available was a problem and they had been working on it real hard. Staff L stated that the facility lost a couple of nurses about a month ago and then it wasn't brought to our attention. Staff L stated after that she went to check not too long ago for gaps and that's when she noticed it was a couple weeks ago. Staff L stated she had no clue that Resident #21 went without Percocet. Staff L stated that they could have called the on call providers. Staff L stated that they can get a hold of pharmacy 24 hours a day and they could get a hold of a physician 24 hours a day. Staff L stated that there was always 2 nurses in the facility so any of them can call and get medication. Staff L stated that they had trouble with faxing a while back. Staff L stated that it was routine orders that the facility had trouble with getting. Staff L stated she did not know who would tell Resident #21 they couldn't get the Percocet. Staff L stated they could always get Percocet. When told that Resident #21 said he was in pain during the time he did not receive the Percocet, Staff L nodded understanding and stated that she was somewhat related to Resident #4, and he will always tell you he has pain. Staff L stated that Staff E, Staff H, and Staff B, all know what to do (how to retrieve medications). Staff L stated that no one ever told her that the facility was out of narcotics for residents, until the facility caught it. Staff L stated that Resident #19 had been on narcotics about 7 months. Staff L stated that Resident #19 is in pain now and stated that Resident #19 was addicted. Staff L said that the meds are available. She stated that staff could also call the ADON, the DON, or Staff L and they would come in and get the meds for the staff. Staff L stated that pretty much every day that she works she takes meds out of the facility's medication system. On 6/28/23 at 9:02 a.m., Staff I called and wanted to give an update on Resident #19. She stated she wanted to give an update on Resident #19's pain. Staff I stated that Resident # [TRUNCATED]

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review and staff interview, the facility failed to maintain medical records which were readily accessible and systematically organized during the survey process for 1 resident (Resident #3). The facility reported a census of 69 residents. Findings include: During the investigation of a Stage 4 pressure ulcer acquired by Resident #3, requests were made of the facility multiple times to provide Medication Administration Records (MAR) and Treatment Administration Records (TAR) for Resident #3 for the month of December, 2022. On 4/12/23 at 1:39 PM the request was made for the MAR and TAR records for the hall of the 100 room numbers for December of 2022 via an email request to the Administrator. On 4/13/23 at 9:30 AM the Director of Nursing (DON) provided a stack of MARS and TARS. She stated they included every resident who resided on the 100 hall in the month of December 2022. The provided records failed to include the records for Resident #3. Per the census in the Electronic Health Record of Resident #3, she resided in room [ROOM NUMBER] 12/1/22-12/12/22 and moved to room [ROOM NUMBER] on 12/13/22. On the afternoon of 4/14/23, the Administrator stated they had gathered the records for Resident #3 for a prior survey in February of 2023 and they were in a separate area and they were in the process of looking for them. On 4/18/23 at 10:35 AM the DON stated she would look to see if she was able to locate the records. She stated she would also look for any skin assessments that were done on paper. On 4/20/23 at 3:00 PM the December of 2022 MARS and TARS were provided, 8 days following the initial request being made. No skin sheets were provided. The Skin Observation Tool dated 12/9/22 for Resident #3 included a note documenting the author had removed a dressing dated 12/1/22. Purulent, foul smelling drainage was noted. The Order Summary Report for Resident #3 documented the resident had orders for dressing changes to be done daily beginning on 12/2/22. The Report further documented the resident received orders on 12/9/22 for a 10 day course of antibiotics for a skin ulcer. On 1/24/23 Resident #3 was admitted to an acute care hospital for the care of a Stage 4 pressure ulcer which resulted in multiple surgeries. The policy Medical Records, Review date 4/25/19 included the following points: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Each resident will have a medical record. The record shall be kept current, complete, legible and available at all times. When a resident is admitted to the hospital on a bed hold status, the Medical Record is to be kept open until discharged to home, another level of care, or elsewhere. If the resident is discharged , the Medical Record is closed, and a new record is to be opened using the same Medical Record number upon return. The policy Skin Evaluation dated 12/28/22 included the following point: Manual Skin Observations Evaluations are to be kept with the Treatment Record and filed in the Medication/Treatment section of the Medical Record.

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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 review, observation, staff interview and policy review, the facility failed to maintain proper infection control practices to prevent cross contamination and potential infection when completing perineal care and wound care for 2 of 4 residents reviewed (Residents #2 and #4). The facility reported a census of 69 residents. Findings include: 1. The MDS assessment dated [DATE] for Resident #2 identified a BIMS score of 9, indicating moderately impaired cognition. The MDS revealed the resident required extensive assistance of 1 person with bed mobility and transfers and totally dependent on 1 person for toileting. The resident was dependent on wheelchair for mobility and always incontinent of bowel and bladder. The MDS included diagnoses of deep vein thrombosis, arthritis, anxiety disorder, depression, bipolar disorder, schizophrenia, conversion disorder, borderline personality disorder, and spinal stenosis. A Care Plan dated 1/5/20 with a revision date of 7/15/22 for Resident #2 revealed a focus area for bowel and bladder incontinence and being at risk for urinary tract infections (UTI) and/or skin breakdown with a goal the resident would be kept clean, dry, and comfortable daily with the use of incontinence products. Interventions directed staff to check resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, provide incontinence care after each incontinent episode, and use barrier cream to perineal area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/12/23 at 7:52 AM, Staff I, CNA and Staff CC, CNA completed cares on resident before breakfast. The two staff members knocked and entered the room. They did not wash their hands but applied gloves and asked the resident if she was ready to get dressed. She stated she was ready and needed to be boosted up in bed and her brief needed changed as she was soaking wet. The staff immediately removed her blanket and began to undo her wet brief. Both staff assisted with undoing the wet brief and Staff I, CNA used wet wipes to cleanse the perineal area. She used the one wipe - one swipe method to cleanse from front to back but did not wash the mons pubis area. The wet brief remained under her at that time. Staff CC, CNA requested and assisted resident to turn onto her left side and the wet brief was removed from under her at that time. The comply underpad was noted to be wet but left under her at this point. Staff I, CNA cleansed the buttock area and right hip using the one wipe - one swipe method. The left hip was never cleansed. Once done, a new brief was put under her and she was assisted to her back and the clean brief was pulled through on the left side and then pulled up between her legs and attached with the pull tabs. Staff I, CNA changed her gloves at this time but no hand hygiene was completed. Staff CC, CNA assisted the resident to roll to the side again and the wet comply underpad was tucked under her and she was assisted to her back and the comply underpad was removed from the left side. It was noted that the residents brief, comply pad, sheet, and gown were all wet with urine. Staff CC, CNA went to the closet and picked out clothes for the resident. Staff I, CNA was putting dirty clothes and soiled items in a garbage bag. Staff CC, CNA handed a pair of pants to Staff I, CNA who assisted the resident in putting them on. Staff CC, CNA found a shirt for the resident and removed the dirty urine soaked hospital gown from the resident. She assisted the resident to put on her shirt. Staff CC, CNA had not changed her gloves at all. The two staff assisted the resident to sit on the side of the bed in preparation for the transfer into the resident's wheelchair. 2. Resident #4's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The MDS indicated Resident #4 required extensive assistance of one person for bed mobility, total assistance of two persons for transferring, and total assistance of one person for toilet use. Resident #4 was always incontinent of bowel and bladder and used oxygen therapy. The MDS included diagnoses of diabetes mellitus, anemia, heart failure, multiple sclerosis, non-Alzheimer's dementia, depression, schizophrenia, respiratory failure and osteomyelitis of the vertebrae. A Care Plan dated 7/21/19 with a revision date of 11/25/22 for Resident #4 revealed a focus area for bowel and bladder incontinence and is at risk for signs and symptoms of UTI and/or skin breakdown related to the incontinence and diuretic use. The interventions directed staff to check the resident before and after meals and as needed for incontinent episodes, communicate changes in urine odor, color, bleeding, or pain with urination to the nurse, administer medications as ordered, place the call light or other communication devices within reach at all times, provide incontinence/perineal care after each incontinent episode, and use barrier cream to the perineal area. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 4/13/23 at 1:50 PM, Staff G, CNA and Staff H, CNA complete incontinence care for resident #4. The staff transferred the resident from her wheelchair into her bed using the Hoyer lift. Hand hygiene was completed upon entering the room and they both applied gloves. Staff reported that the resident was laid down after every meal and checked and changed at that time. The resident was rolled to the right and the resident's brief was undone and tucked as well as the Hoyer sling under her. It was noted the resident did not have a dressing on her coccyx area and it was bleeding. The brief was soaked and her pants and the sling were wet as well. Staff assisted the resident to roll to the left and the brief and sling were removed. Staff did not change their glove or sanitize their hands. A new brief was tucked under the resident. Peri-fresh was sprayed onto the resident's buttocks and her buttocks was cleansed using the one wipe - one swipe method from front to back while on her side. Staff slightly spread her legs while on her side and wiped perineal area front to back using one wipe - one swipe. The resident was turned onto her back and the brief was pulled up between her legs. The brief was not fastened. The resident's groins, pubis and outer buttock cheeks were not cleaned. Gloves were removed by CNA's but no hand hygiene completed. Staff applied the resident's pants and pulled them up to her upper thighs as they were waiting for the nurse to come and apply a dressing to the open area on the coccyx. Staff H, CNA washed her hands and left the room to get the nurse to apply the dressing. Staff DD, Licensed Practical Nurse (LPN) entered the room to complete the dressing change to her coccyx. Hand hygiene completed upon entering the room and supplies set up on a tray table with a towel for a barrier. No gloves were worn. She used 4 x 4's to wipe the bloody drainage away. She then got a Mepilex dressing and applied it to the area. The patch was dated and initialed after applied to the wound. The resident was positioned on her right side for the treatment. Staff H, CNA applied gloves but did not complete hand hygiene prior to applying her gloves and applied Periguard to the resident's inner thighs and buttocks area. She removed her gloves and positioned her onto her back. Pants were removed at resident's request. Covered with a sheet, the head of bed was elevated, and call light in reach. No hand hygiene completed by the CNA's when leaving the room. In an interview on 4/25/23 at 11:51 AM, the Director of Nursing (DON) stated it was the expectation that staff wash their hand or use hand sanitizer before touching a resident and every time they take off their gloves. Staff were to use gloves for all incontinence care and wound care. They were expected to change their gloves and complete hand hygiene when moving from dirty to clean with incontinence care and wound care and should complete hand hygiene prior to leaving the residents room. A facility provided policy titled Perineal/Incontinence Care dated 1/1/14 stated the following procedure for completing perineal/incontinence care: Place equipment on clean surface within easy reach Provide hand hygiene and apply gloves Remove soiled brief/underpad from resident by rolling the brief/underpad to contain as much fecal matter as possible Cleanse the resident's perineal area using an approved no-rinse incontinence cleansing product For female resident, separate labia and cleanse one side, the other, then the center of the labia toward the rectal area. Cleanse the perineal area from front to back. The rectal area and buttocks should be cleansed as well. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use a clean area of cloth for each area cleansed. Assure all areas affected by incontinence have been cleansed Remove gloves and perform hand hygiene Apply clean gloves Apply protective ointment as part of incontinence care Remove gloves and perform hand hygiene, Apply clean gloves Apply clean brief and reapply clothing Discard contaminated items in approved containers Remove gloves and perform hand hygiene Reposition resident into a safe and comfortable position and return the bed to the lowest position, unless contraindicated Place call light within reach

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 40907 Based on employee file review and interview, the facility failed to provide Dependent Adult Abuse (DAA) Training as required by Iowa Administrative Code to 1 of 6 staff reviewed (Staff S). The facility reported a census of 62 residents. Findings include: A review of employee records was done on 6/29/23. An email was sent on 6/29/23 at 4:43 p.m., requesting missing employee file information. A request for Staff S's Dependent Adult Abuse training was included in the email as it was not found in her folder. On 7/5/23 at 12:55 p.m., the Human Resource Specialist provided a graph which documented that a request had been made that Staff S receive the DAA training on 6/30/23 and again on 7/5/23. Staff S's hire date was 10/26/22, indicating that Staff S had gone over the 6 month period of time allotted for her to receive the training. The Human Resource Specialist acknowledged that Staff S should have had her DAA training. The Administrator was present for this interaction. An Abuse Prevention policy dated 10/2022, directed that the facility was committed to protecting the residents from abuse by anyone including, but not necessarily limited to: Facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. Steps to Prevent, Detect, and Report included training. It directed that all staff shall be in-serviced upon initial employment, and at least annually thereafter, regarding Resident's Rights, including freedom from abuse, neglect, mistreatment, misappropriation of property, exploitation, and the related reporting requirements and obligations.