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 _____	C 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING	5608 SW 9TH STREET DES MOINES, IA 50315

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
√ KC 12/21/18	Correction date 12/19/18			
	The following deficiencies relate to the investigation of complaint #78784 & #79690. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).			
	Complaint #79085 & #79531 was not substantiated.			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550	See Attached	12/19/18
	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			
	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.			
	§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.			
	§483.10(b) Exercise of Rights. The resident has the right to exercise his or her			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		12/19/2018

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility failed to ensure three of five residents reviewed were treated in a manner that enhanced their quality of life. (Resident #3, #4 & #5) The facility census was 59 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 10/25/18, indicated Resident #3 had diagnosis that included non-Alzheimer's dementia, Stage 5 chronic kidney disease and abnormal gait and mobility and had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognitive status. The MDS assessment documented the resident required extensive staff assistance with dressing. During observation 11/21/18 at 9:50 a.m., the resident was positioned in bed under the covers with his eyes closed. Staff aroused the resident in preparation for dialysis and pulled back the bed	F 550		

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F 550	Continued From page 2 covers revealing the resident fully dressed in sweat pants, sweat shirt, socks and shoes. During interview at the time, the Assistant Director of Nursing (ADON) confirmed the resident was fully dressed. When asked the resident stated he preferred to sleep with his shoes off. 2. A MDS assessment dated 10/21/18, indicated Resident #4 had diagnosis that included Schizophrenia, encephalopathy and an altered mental status and had a BIMS score of 2, indicating severely impaired cognition. During observation 11/20/18 at 2:20 p.m., two staff transferred the resident from wheel chair to bed. Staff A, Registered Nurse, RN knocked on the door and walked right into the resident's room without waiting for an invitation to enter. 3. The MDS assessment dated 8/22/18, indicated Resident #5 had diagnosis that included cerebrovascular accident (CVA), osteoarthritis and obesity and had a BIMS score of 14, indicating intact cognition and was dependent on staff for toilet use, personal hygiene and bed mobility. The MDS assessment documented the resident was at risk for pressure ulcers with no pressure ulcers present and was not on a turning and repositioning program. Observation on 11/28/18 at 11:22 a.m., revealed the resident was positioned on her left side with her buttocks exposed as the Assistant Director of Nursing (ADON) and Staff B, Licensed Practical Nurse (LPN) performed a treatment to the resident's pressure ulcer on her right buttock.	F 550		

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F 550	Continued From page 3 After completion of the treatment a new open area was pointed out to staff. The ADON left the resident's room and gathered more treatment supplies while Staff B stayed at the resident's bedside, but failed to cover the resident. The ADON returned to the room and completed the treatment at 11:40 a.m. The resident was uncovered and exposed for 18 minutes. During interview on 11/28/18 at 11:47 a.m., the resident confirmed she was exposed during the treatment which bothered her because everyone was looking at her bottom and it made her feel vulnerable.	F 550		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff, resident and physician interview, the facility failed to ensure a resident did not develop a pressure sore unless their clinical condition demonstrates it was unavoidable for one of four	F 686		

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F 686	Continued From page 4 residents reviewed. (Resident #5) Resident #5 was left on the bed pan causing a Stage III pressure sore. The facility census was 59 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 8/22/18, indicated Resident #5 had diagnoses that included cerebrovascular accident (CVA), manic depression, osteoarthritis and obesity and had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS assessment documented the resident was dependent on staff for toilet use, personal hygiene needs, bed mobility, transfers and dressing and was non-ambulatory and occasionally incontinent of bowel and bladder. The assessment documented the resident was at risk for pressure ulcers, but had no pressure ulcers present and was not on a turning and repositioning program. Current weight was 217 pounds. A Care Plan with a focus area initiated on 3/15/18 and updated 6/13/18 and 10/29/18 indicated the resident had skin impairment related to mobility and range of motion (ROM) deficits and a focus area revised 8/3/17 which indicated the resident had an activities of daily living (ADL's) self care performance deficit related to ROM and mobility deficits and was noncompliant with working with therapy. Interventions include: a. Staff to educate the resident on not taking out the bed pan on own and to ask for assistance. (dated 3/15/18) b. Bariatric bed pan. (revised 8/9/18) c. After the certified nurse aides (CNA's) get the	F 686		

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F 686	Continued From page 5	F 686		

resident off the bed pan the resident liked to wipe themselves and the resident liked to take the bed pan out themselves as at times it rubbed on the residents coccyx and caused more irritation. (dated 7/10/18).
d. Bed from home with a mattress protector cover. (dated 7/28/17)
e. Required assistance from one (1) staff member with the bed pan. (dated 7/28/17)
f. Required assistance from 1 staff member with personal hygiene. (dated 6/16/17)

During an interview on 11/20/18 at 3:13 p.m., the resident stated she was left on the bed pan for an extended period of time which caused her current pressure ulcer.

During an interview on 11/28/18 at 11:47 a.m., the resident stated the area on her buttock was caused because staff left her positioned on a bed pan for a long time. The resident stated she felt the bed pan was positioned under her perineal area and she used the call light for assistance, however staff only answered the light when they wanted.

The Progress Notes dated 10/29/18 through 12/22/18, failed to have an assessment of an open area on the resident's right buttock.

During an interview on 11/21/18 at 1:32 p.m., the Assistant Director of Nursing (ADON) stated on 10/25/18 one of the 2:00 p.m. to 10:00 p.m., certified nurse aides, (CNA) placed the resident on the bed pan sometime during the shift and the bed pan was not found until after 4:00 a.m., when the night CNA noticed the bed pan was not hanging up per usual. When the bed pan was found and removed staff identified shearing and a

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F 686	Continued From page 6	F 686		

perfect ring of bruising from the bed pan. The ADON confirmed staff failed to perform an initial nursing assessment, wound assessment and/or incident report. The ADON indicated the issue as not brought to her attention until 10/30/18 when she performed the first assessment to the area.

During an interview on 11/28/18 at 12:07 p.m., Staff C, CNA confirmed she worked on 10/25/18 on the 2 p.m. to 10:00 p.m. shift, however she could not recall having positioned the resident on the bed pan because it was a long time ago.

During an interview on 11/28/18 at 1:21 p.m., Staff E, CNA indicated she could not recall if she assisted Staff C with placing the resident on the bed pan as the incident occurred a long time ago.

During an interview on 11/28/18 at 2:32 p.m., Staff D, Certified Medication Aide (CMA) confirmed she worked 10/25/18 from 6:00 p.m. until 5:00 a.m. and somewhere between 7:00 p.m. and 8:00 p.m. she administered medications and applied creams as prescribed by the physician. Staff D stated somewhere before midnight she answered the resident's call light but all she wanted was Doritos and a type of butter. Staff D confirmed she observed Staff F, CNA as she performed resident rounds however she was not in the resident's room as she had been unable to assist due to a broken foot and elbow at the time and she had already left the building when the bed pan was found under the resident.

During an interview on 11/28/18 at 3:15 p.m., Staff F, CNA indicated when she arrived to work on 10/25/18 for the 10:00 p.m. until 6:00 a.m., shift all of the 2:00 p.m. until 10:00 p.m., staff just left so there was no indication of any resident

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F 686	Continued From page 7	F 686		

changes. Staff F indicated at 12:00 a.m. she refilled the resident's water pitcher. At 2:00 a.m. she checked on the resident, however she was sleeping so she did not disturb her. Staff F stated somewhere between 4:00 a.m. and 6:00 a.m., when she performed her last rounds for the residents she noted the resident's bed pan was missing because it had not been hanging it the normal place. As the resident rolled over, Staff F found the bed pan around the resident's left hip area, not where the pressure ulcer had been noted and in an area that gave Staff F the impression the resident attempted removal of the bed pan herself which she had been known to do. Staff F indicated she applied Calmoseptine to the affected area to enable protection to the resident's skin.

During an interview on 12/6/18 at 9:28 a.m., the ADON confirmed the area was actually one and the same and located on the resident's right buttock/gluteal region.

A Progress Note entry dated 12/7/18 at 8:19 a.m., indicated a correction was made to the wound progress notes with the clarification the wound involved the resident's right buttock.

A Physician Progress note dated 10/26/18, documented the resident received an abrasion on her right posterior thigh from a bed pan that measured 2.5 centimeters (cm's) by 7 cm with a scant amount of blood and no induration.

Review of the Weekly Wound Observation forms revealed:

On 10/30/18 at 10:25 a.m., first observation of an abrasion on the resident's left buttock measured

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F 686	Continued From page 8	F 686		

10 cm by 2 cm with no depth, beefy red granulation tissue present with a scant amount of serosangineous drainage and no odor.

On 11/6/18 at 7:40 a.m., the abrasion measured 18 cm by 4 cm with no depth, beefy red granulation tissue present with a scant amount of serosangineous drainage and no odor.

On 11/14/18 at 3:47 p.m., the abrasion measured 16 cm by 4.5 cm with 0.2 cm in depth, beefy red granulation tissue with a scant amount of serosangineous drainage and no odor.

On 11/20/18 at 12:07 p.m., the area now changed to a Stage III pressure ulcer measuring 13.4 cm by 4.8 cm with 0.2 cm in depth, beefy red granulation tissue present with a scant amount of serosangineous drainage and no odor.

A Progress Note from the Wound Treatment Center dated 11/20/18 at 4:18 p.m., documented the area was linear/angular in shape, wound under the resident's right buttock suggested a pressure injury from an object such as a bed pan.

On 11/27/18 at 10:48 a.m., the Stage III pressure ulcer measured 17 cm by 3.5 cm with 1.0 cm in depth, beefy red granulation tissue present with a scant amount of sanguineous drainage and no odor.

Observation on 11/28/18 at 11:22 a.m., revealed the resident repositioned on the left side while the ADON and Staff B, Licensed Practical Nurse (LPN) performed a treatment to the resident's Stage III pressure ulcer. The Stage III pressure ulcer was packed and covered when it was pointed out the resident had another area. The

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F 686	Continued From page 9 ADON stated the new area was not present on 11/27/18. The new area measured 2 cm by 1 cm and 0.4 cm deep. During an interview on 12/5/18 at 3:50 p.m. , the Physician confirmed the pressure ulcer was avoidable and he felt the area could have increased in size after the initial observation.	F 686		

December 20, 2018

F000

This response and plan of correction constitutes the facility's credible allegation of compliance effective date of December 19, 2018. Submission of the plan of correction is not a legal admission by the facility that a deficiency exists or that any conclusions or allegations set forth by the survey agency are correct. Accordingly, the facility is executing the Plan of Correction solely because it is required by the state and federal laws as a condition of participation in the Medicaid programs.

F550

The residents do have a right to a dignified existence, treated with respect and dignity and care for each resident that enhances their quality of life. This includes residents #3, 4, and 5 and all others that reside in the facility.

1. Staff education has been completed to all staff related to Residents Rights and Dignity. DON/designee responsible for assuring audits completed.
2. Random Daily staff audits x5 weekly for 1 week of cares in progress, to ensure dignity/privacy to residents, then random audits twice weekly x1 week, then random monthly audits for continued compliance. All department heads responsible for compliance. The DON/designee will monitor.
3. Random daily resident interviews x5 weekly for 1 week, then 2x weekly for 1 week, then random monthly for dignity/privacy provided with all cares. All department heads responsible for assuring compliance. The DON/Designee will monitor.

This will be reviewed monthly during QAPI meetings to assure compliance with dignity and privacy.