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 07/27/2021

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 Correction Date 8/25/21 The following deficiencies relate to investigation of complaints 96556-C, 96950-C, 96991-C, 96209-C, and 97233-C and facility reported incident 97255-I, conducted May 3 - July 27, 2021. (See code of Federal Regulations (45 CFR) Part 483, Subpart B-C).	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and family member interviews, the facility failed to ensure that an allegation of missing resident property was investigated and reported to the State Survey Agency within 24 hours of the report as required. The facility reported a census of 50 residents. Findings include: The 2/26/21 Minimum Data Set (MDS) Assessment tool revealed Resident #8 admitted to the facility on 2/19/21 with diagnoses that included diabetes, non-Alzheimer's dementia, Parkinson's disease and depression. The MDS documented the resident scored 8 of 15 points possible on the Brief Interview for Mental Status (BIMS) test that the resident displayed indicated moderate cognitive impairment, had adequate hearing without use of hearing aide and clear speech. The MDS also documented the resident could sometimes makes themselves understood and sometimes others, and required extensive assist of 1 staff for repositioning, transfers, dressing, bathing, personal hygiene and toilet use and could not ambulate (walk). A risk for impaired psychosocial wellbeing due to limited visits and outings due to COVID-19 precautions problem on the nursing care plan directed staff to offer and assist with use of telephone, tablet or computer to maintain contact with family and friends.	F 609		

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F 609	Continued From page 2 A nursing progress note dated 2/23/21 at 9:25 p.m. by Staff M, registered nurse (RN) revealed the resident's family member called the facility and asked staff to ensure they kept the resident's cell phone was kept charged with volume turned up and placed near the resident. A progress note dated 3/3/21 at 10:31 a.m. by Staff N, social worker (SW), revealed she received a call from the resident's family member - the resident needed water because he was choking on a pill. The social worker went to the room and found a certified nursing assistant (CNA) in the room giving him a drink and helping him to reposition. The resident reported they had a pill stuck in their throat. She went to the nurse, Staff B, licensed practical nurse (LPN) and repeated what the family member said. Staff B said she was in the room and gave him a drink when his phone rang, she handed it to him, he told the family member he had a "pill stuck", the family was aware the nurse was in the room because the resident said that on the phone. An Inventory of Personal Effects document that listed items the resident brought to the facility did not list the resident's cell phone. The document was signed by the resident's family member on admission. Another area on the document for the resident or family signature upon discharge was blank. The resident was discharged on 3/24/21 at 1:00 p.m. with his family member. The facility's Abuse Prevention policy, dated as last reviewed 3/20/19 directed staff: a. Dependent adult abuse included misappropriation of resident property by an employee or employees with or without the	F 609		

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F 609	Continued From page 3 consent of the resident. b. The facility will initiate an investigation at the time of any finding of potential abuse, to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation. c. The administrator, or designee, shall report any allegation of misappropriation of resident property as well as report any reasonable suspicion of crime as required, not later than 24 hours after the allegation is made, to the State Survey Agency, and local law enforcement when required. The resident's family member and responsible party was interviewed on 5/11/21 at 7:07 p.m. and stated the resident had his cell phone with him at the facility, they called and spoke to the resident on the phone at least daily, and with the COVID-19 visitor restrictions, it was important that they maintained contact with the resident via the cell phone. The family member stated after the resident had been at the facility for approximately 2 weeks, his cell phone was missing and they reported it to the facility administration. The family member stated initially when they called the phone, it rang several times then went to voicemail, and several family members had called the phone number to help locate the phone but it was never found. The family member had to cancel the phone service/contract for the phone to avoid charges if the phone had been stolen. After the phone was gone, they called the facility and asked to speak to the resident, but was never able to connect with the resident, either because there wasn't a portable phone, or because staff wasn't available to take the resident the phone.	F 609		

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F 609	Continued From page 4 On 5/12/21 at approximately 8:40 a.m., a written list of items needed for the investigation that included the facility's investigation of the resident's missing cell phone was given to Staff O, RN, the facility's agency interim director of nursing (DON). On 5/12/21 at 11:43 a.m., Staff I, LPN, whose last day of employment at the facility was 4/10/21, stated the resident had a cell phone and the family reported it missing. Staff I said the SW was involved and there should have been documentation in the resident's record about it. On 5/12/21 as of 1:40 p.m., the facility had not provided any documentation related to the resident's cell phone. At that time, the administrator stated she thought the SW had discussed the matter. On 5/12/21 at 1:46 p.m., both the administrator and SW appeared and the administrator stated family had reported they thought the resident's cell phone was missing but they found it in his room. The SW stated the phone was dead and they charged it for the resident. The SW added she was there when the resident was discharged and certain the cell phone and charger were with the resident's belongings and taken with him when he was discharged. The SW stated there was no documentation about the cell phone because it was "never missing." During an interview on 5/12/21 at 2:04 p.m., the resident's family member stated they were very certain the resident's cell phone was not included with the belongings he was discharged with, they had gone through them at the time and told the staff they needed to continue to look for his phone. The family member stated after they	F 609		

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F 609	Continued From page 5 reported the phone was missing, they were never able to reach the resident on the cell phone and when they called it went straight to voice mail and the mailbox was full. The facility could not provide any documentation that indicated family reported the cell phone missing and/or any documentation of their actions their actions were after the report.	F 609		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676		

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F 676	Continued From page 6 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide a restorative nursing program as required. The facility reported a census of 50 residents. Findings include: The 4/13/21 MDS Assessment tool revealed Resident #3 had diagnoses that included hemiplegia (paralysis on 1 side of the body), pneumonia, diabetes, hypertension (high blood pressure) and a cerebrovascular accident (a stroke). The MDS documented the resident scored 11 out of 15 points on the BIMS cognitive assessment (moderate cognitive impairment) and required extensive assistance of at least 1 staff for bed mobility, transfers, dressing, toilet use, and bathing and personal hygiene could not walk. A restorative program related to mobility and range of motion deficit problem initiated on the nursing care plan on 3/5/19 directed staff: a. Assist to therapy room as needed. b. Inform restorative aide (RA) and resident/power of attorney of any changes to the	F 676		

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F 676	Continued From page 7	F 676		

program.
c. Follow therapy recommendations for the restorative program.
d. Remind and encourage resident to participate with assigned goals.

An ADL deficit problem on the nursing care plan directed staff:

a. Transfer resident with mechanical lift and 2 staff members.
b. Assistance of 1 staff for resident participation with personal hygiene.
c. Assistance of 1 staff for resident participation with dressing.

Staff interviews revealed:

5/12/21 at 11:10 a.m., Staff K, occupational therapist (OT), stated when therapy discharges a resident from service, there always recommended a restorative plan. Staff K reported the facility had a restorative aide Staff L, but the facility hasn't had the restorative program for a couple of months.

5/6/21 at 10:08 a.m., Staff H, registered nurse (RN) stated the facility was short staffed and as a result, there hadn't been a restorative program for 2 or 3 months.

5/11/21 at 12:05 p.m., Staff D, RN and former interim director of nursing stated there had not been a restorative program during the time she was employed (4/5/21 - 5/3/21) due to staffing shortages.

5/11/21 at 3:49 p.m., when asked for a list of residents with a restorative program and also a

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F 676	Continued From page 8 copy of the the facility's restorative policy, Staff G, RN, the facility's corporate nurse stated there had not been a restorative program at the facility since she started employment with the company in February, 2021. Staff G did not provide a list of residents with a prescribed restorative program or the facility's policy.	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide bathing assistance at appropriate intervals for residents that required it for 5 of 9 resident records reviewed (Resident's #1, #2, #3, #4 and #7). The facility reported a census of 50 residents. Findings include: 1. The 4/12/21 Minimum Data Set (MDS) Assessment tool revealed Resident #1 had diagnoses that included renal insufficiency, diabetes, asthma and depression. The MDS documented the resident scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment, which meant the resident demonstrated intact cognitive abilities. The MDS also documented the resident required extensive assist of 1 staff for bathing. An activity of daily living (ADL) problem on the	F 677		

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F 677	Continued From page 9 nursing care plan directed staff: a. 1 staff assistance required for baths. b. Skin inspections required weekly, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Bath/Shower records from 3/1/21 through 5/6/21 revealed the resident's scheduled shower days were Tuesday and Friday, twice a week, and the resident received showers on 3/5/21, 3/9/21, 3/23/21, 3/26/21, 4/10/21 and 5/4/21. During an interview on 5/5/21 at 11:01 a.m., the resident stated he was supposed to have showers twice a week on Tuesday and Friday, he received a shower the day before, that was the first shower that he'd had in a week in a half, and hadn't received his showers regularly for the last few months since the previous administrator left. When interviewed on 5/12/21 at 9:50 a.m., the resident stated he had received his showers as scheduled since the last time we spoke. 2. The 3/18/21 MDS assessment tool revealed Resident #2 admitted to the facility on 3/11/21 with diagnoses that included diabetes, seizure disorder, thyroid disorder and asthma. The MDS documented the resident demonstrated moderately impaired cognitive abilities and required extensive staff assist for bathing. An ADL deficit problem on the nursing care plan directed staff: a. One staff assist for showering 2 times a week and as needed. b. Check nail length and trim and clean on bath	F 677		

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F 677	Continued From page 10 day and as necessary. Bath/Shower records from 3/11/21 through 5/6/21 revealed the resident received showers on 3/16/21 and 3/19/21. During an interview on 5/5/21 at 11:14 a.m., the resident provided detailed information that included she was supposed to have showers on Wednesdays and Saturdays, but she has never received a bath or shower on Saturdays. She reported she has asked staff why but does not get any answers. During an interview on 5/12/21 at 9:58 a.m., the resident stated she still hadn't received a shower on Saturday, it was only 1 time a week if she was lucky. 3. The 4/13/21 MDS revealed Resident #3 had diagnoses that included hemiplegia (paralysis on 1 side of the body), pneumonia, diabetes, hypertension (high blood pressure) and a cerebrovascular accident (a stroke). The MDS documented the resident demonstrated moderately impaired cognitive abilities and required extensive assist of at least 1 staff for bathing. An ADL deficit problem on the nursing care plan directed staff: a. Resident is totally dependent on staff to provide a bath twice a week and as needed. b. Check nail length and trim and clean on bath day and as necessary. Facility records revealed the resident was hospitalized and out of the facility from 3/1/021 to 3/17/21, 3/30/21 to 4/5/21 and from 4/26/21 to	F 677		

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F 677	Continued From page 11 4/30/21. Bath/Shower records from 3/1/21 through 5/6/21 revealed the resident's scheduled shower days were Wednesday and Saturday on the 2:00 p.m. to 10:00 p.m. shift, twice a week, and the resident received showers on 3/6/21, 4/7/21 and 4/9/21. 4. The 3/9/21 MDS revealed Resident #4 had diagnoses that included seizure disorder, thyroid disorder and renal insufficiency. The MDS documented the resident demonstrated moderately impaired cognitive abilities and needed extensive assist of 1 staff for bathing. An ADL deficit problem on the nursing care plan directed staff: a. Assist the resident with one staff for a shower bath twice a week and as needed. b. Check nail length and trim and clean on bath day and as necessary. Bath/Shower records from 3/1/21 through 5/6/21 revealed: A record labeled as March 2021 Bath/Showers with the resident's name on it revealed shower days were on the 6:00 a.m. to 2:00 p.m. shift on Tuesday (although it showed the Tuesday crossed out with Monday written above it) and Thursday. The form showed resident received showers on Tuesday 3/2/21, Monday 3/8/21 and Thursday 3/11/21. Further record review identified the identical record from above copied and with the word "March" crossed out and "April" written above it.	F 677		

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F 677	Continued From page 12 The form revealed identical dates recorded that indicated the resident had showers completed on Tuesday 4/2/21, Monday 4/8/21 and Thursday 4/11/21. The May 2021 Bath/Showers record with the resident's name on it revealed shower days were Tuesday and Friday on the 2:00 p.m. to 10:00 p.m. shift. As of 5/13/21, the resident had received 1 shower in May on 5/8/21. 5. The 3/30/21 MDS Assessment tool revealed Resident #7 admitted to the facility on 3/23/21 with diagnoses that included hemiplegia, aphasia, a cerebrovascular accident and respiratory failure, had moderate cognitive impairment and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, toileting, bathing and personal hygiene, fed via gastrostomy tube, always incontinent of bowel, frequently incontinent of urine and unable to ambulate. A risk for skin breakdown problem on the nursing care plan directed staff to provide incontinence care after each incontinent episode, and report changes in skin integrity to the nurse. Shower records revealed the resident was showered on 4/8/21, 4/16/21, 4/19/21 and 4/26/21. The resident was discharged on 4/30/21. Staff interviews revealed: 5/11/21 at 12:05 p.m., Staff D, registered nurse (RN) and former interim director of nursing,	F 677		

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F 677	Continued From page 13 (employed 4/5/21 - 5/3/21) stated residents had complained they didn't get their showers, the administrator asked her to develop a tracking sheet for completion of resident showers but she hadn't had time to implement that as she often had to work as a nurse to cover open shifts. 5/6/21 at 9:43 a.m., Staff F, CNA stated CNA's are assigned resident baths/showers and have to complete a skin/shower sheet for each resident for every bath/shower they complete and the form is given to the nurse. 5/12/21 at 10:25 a.m., Staff E, CNA, stated the aides are expected to do showers/baths as part of their duties, know what showers are assigned to them because it is in the ADL book, sometimes they can't get to their showers due to staffing levels and they are to report to the nurse if they can't complete their assigned showers/baths. 5/6/21 at 11:21 a.m., Staff G, RN, facility corporate nurse stated the facility changed the way the CNA's were to document showers in April, 2021, but someone wrote on the ADL sheets for April "see bath/shower sheets" and didn't have the authority to do that. On 5/13/21 at 10:40 a.m., Staff G stated the facility didn't have a policy on resident baths/showers, and the facility could not provide any additional bath/shower records for the listed residents. 5/6/21 at 10:43 a.m., the administrator stated she was aware that showers weren't completed, the residents discussed the matter at a resident council meeting, she had educated staff the week before that all staff were expected to do cares assigned to them that included baths, she directed Staff D was to educate staff and start an	F 677		

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F 677	Continued From page 14 audit of cares completed, and not certain if she had done that before she quit.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident family member and physician interviews, the facility failed to provide adequate supervision and assistance to prevent hazards for 2 of 9 residents reviewed (Residents #7 and #9). On 4/30/21, a nurse left Resident #7 unsupervised on the commode in his room in order to enter the resident's adjoining bathroom to obtain his wheelchair. When the nurse returned with the wheelchair, she found Resident #7 on the floor; he had fallen and sustained a laceration to the head due to striking his head on the floor when he fell. The facility sent the resident to the hospital Emergency Room (ER) and computed tomography (CT) scans showed bilateral (both sides of brain) subarachnoid hemorrhage (bleeding on the brain) and a subdural hematoma (bruising with concussion) of the left frontal lobe. Resident #7 died on 5/2/21 as a result of injuries sustained in the fall on 4/30/21. The facility reported a census of 50 residents. Findings include:	F 689		

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F 689	Continued From page 15 1. The 3/30/21 Minimum Data Set (MDS) Assessment tool revealed Resident #7 admitted to the facility 3/23/21 with diagnoses that included hemiplegia (paralysis on 1 side of the body), cerebrovascular accident (a stroke), aphasia (speech inability or difficulty) and atrial fibrillation (irregular heart beat). The MDS documented the resident displayed moderate cognitive impairment without symptoms of delirium, moderate difficultly hearing without hearing aid used, had unclear speech, usually understood others and could sometimes make themselves understood. The MDS also documented Resident #7 required extensive assist of 2 staff for surface-to-surface transfers, bed mobility, dressing, eating, toilet use, bathing and personal hygiene, was always incontinent of bowel and frequently incontinent of bladder. The MDS revealed the resident could not stand or ambulate (walk), and the assessment revealed he had fallen within 1 month prior to the admission and also since the admission without a sustained injury. A risk for falls related to history of falls care plan initiated 3/24/21 directed staff to: 3/23/21 - Anticipate resident needs and educate/remind him to call for assistance as needed. 3/23/21 - Educate, provide supervision, and remind the resident to wear appropriate footwear. 3/24/21 - Scoop mattress to bed. Review of the incident reports revealed the following falls: On 3/24/21 at 8:10 a.m., staff observed the resident transferring themselves from their	F 689		

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F 689	Continued From page 16 wheel-chair to the bed in room and during the attempt to stand, the resident slid onto floor with his legs extending outward, and landed on his buttocks. The resident sustained a 3.5 centimeter (cm) "U" shaped skin tear on the upper right elbow that required a dressing. Staff then applied a scoop mattress to the bed. On 4/15/21 at 3:15 a.m., a certified nursing assistant (CNA) answered the resident's bathroom call light and noted the resident sat on the floor in front of the toilet. The resident stated he took himself to the restroom, lost his balance, and slid to the floor. Staff identified no injuries and did not implement any new interventions. The record showed post fall vital signs and neurological assessments were initiated by Staff H, registered nurse (RN) and former assistant director of nursing (ADON) on 4/15/21 at 7:15 a.m. On 4/16/21 at 4:45 p.m., Staff H, RN and former ADON described the resident found lying on floor on right side with wheel chair tipped over him, the fall was unwitnessed. Noted blood on floor by resident's right arm. There was no documentation of post fall vital signs or neurological assessments in the resident's record. On 4/30/21 at 8:30 a.m., Staff I, licensed practical nurse (LPN), went into the room to check on Resident #7, assisted the resident to the commode, went to grab the wheel-chair from the bathroom, and when the nurse returned the resident lay on the floor bleeding from a laceration on the right side of the head. Staff then sent the resident to the hospital Emergency Room (ER) and called 911 for ambulance	F 689		

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F 689	Continued From page 17 transport. Physical therapy notes transcribed between 4/16/21 and 4/29/21 revealed the resident had a static sitting balance (position held in a position for up to 45 seconds) that ranged from "did not tolerate" to fair, and a dynamic sitting balance (controlled repetitive movements of muscles and ligaments) that ranged from "did not tolerate" to fair. The notes revealed the resident had a fair static and dynamic sitting balance on 4/29/21, and a poor static and dynamic sitting balance on 4/28/21. The hospital records revealed staff evaluated the resident in the ER after a fall at the nursing home that resulted in head trauma with a laceration to right temple and below the right eye. Computed tomography (CT) scans revealed acute bilateral (both sides of brain) subarachnoid hemorrhage (bleeding on the brain) and a subacute subdural hematoma (bruising with concussion) of the left frontal lobe. The facility's self-assessment submitted with their self-reported incident related to the resident's 4/30/21 fall revealed the following: On 4/30/21 at 8:00 a.m., Staff found the resident on his left side near his bed. The resident stated he attempted to transfer himself from the bed, lost his balance, and hit his head on the bed frame. The facility noted a laceration to the left side of the head and applied and maintained pressure until transport arrived. The facility concluded the resident's injury was caused by a fall and documented the resident passed away on 5/2/21.	F 689		

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F 689	Continued From page 18 A progress note transcribed 4/30/21 at 3:17 p.m. by Staff N, facility social worker documented the hospital called and reported the resident admitted to the hospital and had orders for a neurological physician consult and palliative care. Staff interviews revealed: 5/12/21 at 10:40 a.m., Staff I, LPN, stated she was currently employed by a sister-facility, no longer worked at the facility, the last day she worked at the facility was on 4/10/21. Staff I reported on the morning of 4/30/21, she received phone calls from Staff A, RN, and the facility's corporate nurse Staff G, RN, with requests for her to work at the facility that day due to staff call-ins. Staff I stated she arrived to the Side 2 unit of the facility at approximately 8:15 a.m., staff B, LPN was there, she didn't receive report on any of the residents and none of the morning medications had been administered to the residents she was responsible for. Shortly after she arrived, she was notified that the resident was scheduled for a family visit at 9:00 a.m. so she went to the resident's room to get him up and ready for the visit. When she entered his room the resident was awake and tried to climb out of the bed, she called for assistance, Staff B helped her transfer him from the bed to the commode, she got the resident's wheel-chair, called out for Staff B to assist with the transfer and when she turned around the resident was on the floor. It appeared he had fallen forward out of the commode and struck his head on the floor, she didn't think he had attempted to self-transfer. The resident bled from a laceration on his head, she notified the medical provider immediately for orders to transfer to the hospital and called 911 for an ambulance.	F 689		

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F 689	Continued From page 19 On 5/11/21 at 10:15 a.m., Staff B, LPN, stated on the morning of 4/30/21, she helped Staff I, LPN transfer the resident to the commode because he required assist of 2 staff for transfers. Staff I remained in the room, and Staff B left the room and walked approximately 30 feet toward the nurse's station. Staff B stated in less than a minute, Staff I called for help because the resident was on the floor. On 5/11/21 at 1:20 p.m., Staff A, registered nurse (RN) stated the resident behaved impulsively, attempted to transfer independently, would self-transfer and was a high fall risk. Due to the resident's impulsiveness, he should not have been left alone unless he was in bed or safely positioned in a chair. 5/11/21 at 12:09 p.m., Staff D, RN and former interim director of nursing (DON), stated the resident was a high fall risk, he was always incontinent of bowel and bladder and did not use the commode, she didn't know why staff would have transferred the resident to the commode but should not have left him alone when he was positioned on the commode due to his balance problems and impulsiveness. During another interview on 7/13/21 at 9:25 a.m., Staff D stated after a resident falls, the nurse should always initiate the protocol for post fall vital signs and neurological assessments if the fall was unwitnessed or the resident hit their head when they fell. 5/11/21 at 10:47 a.m., Staff F, CNA, stated on 4/30/21, the resident was assigned to her and she saw the resident in bed between 6:30 a.m. and 7:00 a.m. when she checked on him. Staff F	F 689		

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F 689	Continued From page 20 stated the resident had a tendency to lean forward when he sat up so staff had to put his feet up in the recliner when he was seated in his room. 7/1/21 at 10:42 a.m., Staff W, hospitalist physician stated she examined the resident in the ER on 4/30/21 for his head injury associated with a fall at the facility, he was extremely thin and dehydrated, appeared cachectic, his mouth was very dry and he had not received adequate oral hygiene care. In addition to emergent care for the resident's head injury, the resident also required emergent intravenous therapy to treat his dehydration. 7/1/21 at 12:45 p.m., Staff X, radiologist physician stated the small acute bilateral subarachnoid hemorrhage was consistent with the injury on 4/30/21, and the subacute left frontal lobe subdural hematoma did not occur from the fall on 4/30/21, but it possibly could be consistent with the unwitnessed falls that occurred 2 weeks prior. The left frontal lobe subdural hematoma was not present on a head CT scan completed in February, 2021 at the hospital, and likely developed from a fall after February as it was consistent with 1 or more weeks old. During an interview on 5/18/21 at 4:10 p.m., the resident's family member and responsible party (RP) stated the resident had a stroke that led to right side paralysis and problems with sitting balance. She stated they had seen him lean forward or to his right in the wheelchair sometimes when they saw him at scheduled facility visits. The RP stated the facility did not notify her of the 3/24/21 fall and on 4/15/21 the facility notified them the resident's wheel-chair	F 689		

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F 689	Continued From page 21 had fallen over on top of him when he transferred himself in the bathroom. On 4/30/21, they had just left their home at approximately 8:40 a.m. en route to the scheduled facility visit when they received a call from the nurse who said the resident had an X-ray and the doctor had ordered a medication due to the results. Before they hung up they told her the resident had leaned forward when he reached for his oxygen tubing, fell out of his chair, and cut his head when it hit the floor so they were sending him to the ER. The RP stated they met the resident at the hospital and stayed with him, the nurses at the hospital and the ER doctor were very concerned about his injuries from the fall. The RP stated since the resident's death on 5/2/21, they had contacted the facility 3 different times to request copies of his records, and as of the time of the interview they still had not received them. The RP reported family elected for hospice care because the physician's explained he probably wouldn't have survived the surgery to relieve the bleeding on his brain, and so that meant the resident died as a result of the injuries from the fall. 2. Facility records revealed Resident #9 had diagnoses that included dementia with behavioral disturbance, anxiety, encephalopathy and pneumonia due to inhalation of food/vomit, the resident admitted at 4:00 p.m. on 3/19/21, discharged to family at 4:16 p.m. on 3/20/21, admitted for short-term Respite care at 12:36 p.m. on 4/29/21, and discharged to family care at 6:00 p.m. on 4/30/21. Progress note entries revealed: 3/19/21 at 6:26 p.m., resident confused, spoke only Italian language, non-compliant with	F 689		

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F 689	Continued From page 22 remaining in bed and undressed self frequently. 3/20/21 at 6:26 a.m., resident removed clothing and attempted self-transfers from bed, Staff P, CNA, assigned to the resident for 1 to 1 supervision/care for resident safety. 3/20/21 at 12:00 p.m., Oxycodone (strong narcotic analgesic) 5 milligrams given per order for pain and restlessness, 1 to 1 staff assignment continued. 3/20/21 at 1:32 p.m., resident encouraged to nap until family arrived to take the resident home, Oxycodone effective to reduce pain symptoms and restlessness, 1 to 1 staff assignment for resident safety continued. 4/29/21 at 12:36 p.m., arrived by personal vehicle accompanied by spouse, admitted for short Respite stay, resident believed he was at the facility for a doctor appointment. 4/29/21 at 3:40 p.m., Wandergard transponder bracelet (an electronic device that alerts facility when resident near an exit door) placed on resident's ankle due to wandering. 4/30/21 at 12:00 p.m., nurse practitioner (NP) at facility and authorized Ativan (an anti-anxiety medication) 0.5 milligrams administered oral 3 times a day for anxiousness. Resident does not want to remain in his room, ambulating with cane outside of the transitional hallway (restricted due to COVID-19 infection control precautions in place at that time at the facility) and ambulated towards the front door. Has been redirected away from the front door several times by staff, hitting staff with his cane, punched at staff and	F 689		

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F 689	Continued From page 23 pulled the activity director's hair because he wanted to leave the facility and go home with his spouse. 4/30/21 at 12:30 p.m., Ativan 0.5 mg administered for anxiety and aggressive behavior. 4/30/21 at 5:00 p.m., resident fell in facility foyer as he attempted to leave, sustained a 2.0 centimeter (cm) abrasion on his right cheek and a 0.2 cm abrasion on the bridge of his nose. Ambulated resident back to his room and assisted into bed. Vital signs and neurological assessment completed (per fall assessment protocol). 4/30/21 at 5:03 p.m., resident got out of bed and fell again, 3 cm by 3 cm hematoma (bruise) with scant bleeding noted at mid-occipital area (back of the head). 4/30/21 at 6:00 p.m., discharged home with family per their request. An incident report related to the 4/30/21 falls revealed: 4/30/21 at 5:00 p.m., completed by Staff A, registered nurse (RN), stated resident was found on floor in foyer with abrasion to right cheek and across bridge of nose, the resident fell when he tried to leave the facility. He had been wearing glasses, appeared he hit the door frame. At 5:03 p.m. resident fell immediately following the 5:00 p.m. fall, found in doorway of room with a 3 cm by 3 cm mid-occipital abrasion. The staffing schedule for Side 1, where the resident was located, on 4/30/21 revealed:	F 689		

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F 689	Continued From page 24	F 689		

Staff A, RN, scheduled from 6:00 a.m. to 6:00 p.m., 2 CNA's were scheduled for the 6:00 a.m. to 2:00 p.m. shift (usually 3 CNA's), 2 CNA's were scheduled for the 2:00 p.m. to 10:00 p.m. shift (usually 3 CNA's).

The staffing schedule for Side 2 on 4/30/21 revealed the nurse assigned from 6:00 a.m. to 6:00 p.m. had not reported to work. Per staff interviews, the facility had a nurse from another facility come in at 8:15 a.m. and work until relieved by an agency nurse that arrived at 11:30 a.m., 3 CNA's were scheduled from 6:00 a.m. to 2:00 p.m., and 1 CNA scheduled from 2:00 p.m. to 4:30 p.m. was relieved by another CNA scheduled at 4:00 p.m. (leaving 1 CNA for the area when there were usually 3).

Staff interviews revealed:

5/6/21 at 9:50 a.m., Staff A, RN, stated the resident had advanced dementia and didn't speak English. Even before his family left when he was admitted he was restless and tried to get up without assistance. He continued to try to get up on his own, he was disrobing, and they didn't have the staff to make him a 1 to 1 which is what he needed. The resident was looking for his family, tried to go out exit doors, he hit staff when they tried to redirect him away from the doors. Staff A was on the phone to notify the physician of the fall at 5:00 p.m. when the resident had another unwitnessed fall in his room, again looking for his family. His family came and picked him up after that.

6/1/21 at 9:00 a.m., the facility administrator stated decisions about resident's accepted for

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F 689	Continued From page 25 admission were made by their management team that included herself, the director of nursing, social worker, activity director, dietary manager and maintenance supervisor (their inter-disciplinary team). During an interview on 5/11/21 at 2:11 p.m., the resident's family member stated they had contacted different staff at the facility at different times after the 4/30/21 discharge in attempts to get more information about the resident's falls and injuries, but the facility would not provide the information. They noticed bruising on the right side of his face, both knees, his right hand and left forearm, and a lump on his head when he was discharged on 4/30/21. The family member stated the resident had dementia which had impacted his memory and judgement, but he had not had physical behaviors when at home and had a calm demeanor prior to his admission to the facility. The family member expressed serious concern for the resident's injuries and the facility's refusal to explain how they had occurred.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was	F 693		

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	165175	A. BUILDING _____ B. WING _____	C 07/27/2021

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 693	Continued From page 26 clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, registered and licensed dietician, nurse practitioner and physician interviews, the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding such as weight loss, diarrhea, vomiting, and dehydration for 1 of 2 residents reviewed (Resident #7) with an enteral feeding tube (tube inserted into the stomach that provides 100 percent of the resident's nutrition). The facility reported a census of 50 residents. Findings include: The 3/30/21 Minimum Data Set (MDS) assessment tool revealed Resident #7 admitted to the facility on 3/23/21 with diagnoses that included hemiplegia (paralysis on 1 side of the body), cerebrovascular accident (a stroke), dysphagia (swallowing difficulty) and aphasia (speech inability or difficulty). The MDS documented the resident displayed moderate cognitive impairment without symptoms of delirium and required extensive assist of 2 staff for bed mobility, dressing, toilet use, bathing and personal hygiene. The MDS also documented the resident received 51 percent or greater calories	F 693		

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F 693	Continued From page 27 and 501 milliliters or more of water via enteral feeding tube and was 5 feet 5 inches tall and weighed 115 pounds. A tube feeding problem on the nursing care plan identified a goal that included resident would maintain adequate nutritional and hydration status, without symptoms of malnutrition or dehydration, and the insertion site would be free of symptoms of infection. The care plan directed the following interventions: 1. Observe, document, and report any symptoms of abdominal pain, distension, tenderness, diarrhea, nausea, vomiting or dehydration. 2. Obtain and monitor lab work as ordered. Report results to physician and follow up as indicated. 3. Provide local care to feeding tube site as ordered and observe for symptoms of infection, as ordered. Physician orders dated 3/23/21 included the following: 1. Administer Osmolite 1.5 per feeding tube (enteral feeding formula that provides 1.5 calories per milliliter) via mechanical pump at 80 milliliters (ml) per hour for 16 hours a day, start at 2:00 p.m. and end at 6:00 a.m. 2. Flush feeding tube with 60 ml water every hour via mechanical pump. 3. Cleanse feeding tube insertion site with wound cleanser, pat dry, place split 4 inch by 4 inch gauze and secure daily at bedtime. 4. Weekly weights for 4 weeks. A physician order dated 3/30/21 directed staff to apply Dermaseptin (a topical cream that acts as a	F 693		

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F 693	Continued From page 28 moisture barrier on the skin) to the feeding tube insertion site twice daily until healed for reddened skin with yellow/green drainage. The April, 2021 treatment administration records (TARS) revealed: Care of the feeding tube insertion site was not signed as provided on 4/2/21, 4/5/21, 4/11/21, 4/12/21, 4/13/21, 4/15/21, 4/17/21, 4/18/21, 4/21/21, 4/26/21, 4/27/21, 4/28/21, and 4/29/21. Weights of 115.5 pounds recorded on 3/23/21, 107.0 pounds on 3/28/21 and 110.0 pounds on 4/3/21. Nursing Progress Note entries revealed: 3/28/21 at 12:48 a.m. - 3 large water loss stools in less than 30 minutes, stopped tube feeding for the night. 3/28/21 at 11:11 a.m. - nurse practitioner notified feeding stopped due to large watery stools, ordered enteral feeding resumed at that time. 3/29/21 at 6:22 p.m. - no stools since 6 a.m., gastrostomy tube site slightly reddened with yellow/green drainage, culture of drainage obtained and sent to the laboratory. 4/21/21 at 6:08 p.m. - small yellow emesis, resident stated his stomach hurt, notified NP, ordered tube feeding held until tomorrow at 6 o'clock. There were no serum laboratory studies ordered or completed between 3/23/21 and 4/30/21 while he resided at the facility. A hospital Emergency Room (ER) history and physical dated 4/30/21 revealed the resident	F 693		

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F 693	Continued From page 29 appeared cachectic (physical wasting with loss of weight and muscle mass due to disease), oral mucosa very dry with greenish dried exudate on palate, serum sodium 158 (normal value 135 - 145 milliequivalents per liter) BUN 75 (blood Urea Nitrogen normal value 7 - 20 milligrams per deciliter), creatinine 2.24 (normal level 0.6 - 1.2 milligrams per deciliter), elevated sodium, BUN and creatinine levels are indicative of dehydration. The document described the resident required treatment for an acute kidney injury related to the dehydration and severe protein-calorie malnutrition. Staff interviews revealed: 7/9/21 at 2:16 p.m., Staff Y, advanced registered nurse practitioner, stated staff did not notify her of the resident's weight loss. She said she would have expected staff to notify her of that or any enteral feeding associated problem as she would have ordered appropriate lab work and consulted with the facility dietician and physician if needed. Staff Y stated she did not know how the resident could have been dehydrated when he was hospitalized on 4/30/21. 7/13/21 at 5:51 p.m., Staff Z, the facility's registered and licensed dietician (RDLD), stated facility staff did not notify her of the resident's weight loss or enteral feeding related complications. She said she would have expected staff to notify her of those findings and she would have consulted with the ARNP or physician for recommendations for lab work and modification of feeding orders as appropriate. Staff Z stated the resident should have sustained a gradual weight gain from the enteral feeding at the ordered rate and could not understand how the	F 693		

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F 693	Continued From page 30 resident could have been dehydrated. 7/1/21 at 10:42 a.m., Staff W, hospitalist physician stated a patient with a feeding tube was supposed to receive adequate nutrition from enteral feedings and water flushes to support their needs, so they should not be dehydrated. She reported when she examined the resident in the ER on 4/30/21, he was extremely thin and dehydrated with sodium of 158 and BUN of 75. She added he appeared cachectic, his mouth was very dry, it appeared as if he had not received adequate oral hygiene car and he subsequently required emergent intravenous therapy to treat his dehydration.	F 693		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, nurse practitioner, and pharmacist interviews, the facility failed to maintain an inventory of medication ordered by the physician and failed to administer medications as ordered. This resulted in a resident having uncontrolled seizures that required hospitalization, for 1 of 9 residents reviewed (Resident #4). The facility reported a census of 50 residents. Findings include: The 3/9/21 Minimum Data Set (MDS) Assessment tool revealed Resident #4 had diagnoses that included seizure disorder, thyroid	F 760		

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F 760	Continued From page 31 disorder and renal insufficiency, scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, without symptoms of delirium, and required extensive assistance of at least 1 staff to reposition in bed, transfer to and from bed and chair, dressing, ambulation, bathing, personal hygiene and eating. A seizure disorder related to disease process problem on the nursing care plan directed staff: a. Give seizure medication as ordered by the doctor. b. Seizure Precautions: Do not leave resident alone during a seizure. Protect from injury, if resident is out of bed, help to the floor to prevent injury. Remove or loosen tight clothing. c. Post Seizure Treatment: Turn on side with head/back hyper-extended to prevent aspiration, keep airway open. After seizure take vital signs and neuro check. Monitor for aphasia (inability to speak), headache, altered level of consciousness, paralysis, weakness or pupillary changes. Physician orders directed staff to administer medications that included: a. Clonazepam (a medication that decreased abnormal electrical activity in the brain) 0.5 milligrams (mg) administered oral every 12 hours for seizures, ordered 3/1/21. b. Divalproex Sodium (an anti-epileptic medication) delayed release tablet 500 mg administered oral every 8 hours for seizures, ordered 3/1/21. c. Diastat AcuDial Diazepam Gel (a strong benzodiazepine medication used to treat anxiety	F 760		

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F 760	Continued From page 32 and seizures), insert 12.5 mg rectally as needed for seizures greater than 3 minutes, ordered 3/25/21. The April, 2021 Medication Administration Record (MAR) revealed: Clonazepam, scheduled at 7:00 a.m., and bed time (HS), twice daily, not administered on 4/25/21 at HS from 4/26/21 through 4/29/21. The record revealed Staff B, licensed practical nurse (LPN), the full-time day shift nurse worked the 6:00 a.m. to 6:00 p.m. shift on 4/26/21, 4/27/21, 4/28/21 and 4/29/21. The Clonazepam narcotic inventory control sheet records revealed the last dose of Clonazepam signed as administered at 8:00 a.m. on 4/25/21. A Nurse's progress note, transcribed on 4/30/21 at 4:10 a.m. by Staff D, registered nurse (RN) and interim director of nursing (DON) at that time revealed: At approximately 10:30 p.m. (4/29/21), the certified nursing assistant (CNA) and evening nurse reported the resident had a seizure that lasted longer than 3 minutes and administered emergency Diastat gel, increased oxygen from 2 to 4 liters per minute following the seizure, and the evening nurse notified the nurse practitioner (NP) who ordered the resident's transport to the hospital. Staff D wrote after review of the chart, it appeared the last 8 doses of scheduled Clonazepam had not been administered and this was reported to the NP, who stated the resident had a history of rebound seizures. The NP stated the last time this happened and the Diastat administered, the seizures reoccurred the same	F 760		

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F 760	Continued From page 33	F 760		

night and the resident required transfer to a higher level of care, and also treatment with intravenous anti-anxiolytics medication,n and EEG (electroencephalogram monitors brain waves) monitoring (at the hospital) to treat the condition.

A hospital emergency room (ER) progress note transcribed by the physician on 4/30/21 at 12:38 a.m. revealed the resident presented to the emergency department with seizure-like activity, jerking movements noted in the arms and head. Although intravenous (IV) Lorazepam (an anti-anxiolytic medication given for seizure activity) was administered, the resident continued to seize when assessed at 12:43 a.m. At 12:55 a.m., the physician noted the resident recently missed 8 doses of Clonazepam and administered 1000 mg of Keppra an anti-convulsant medication) through an IV solution. At 12:56 a.m. the resident continued to seize and an additional 0.5 mg Lorazepam was administered via IV. At 1:05 a.m., the seizure had resolved. At 1:54 a.m., the resident remained postictal (the time period after a seizure and before the return to baseline) and required admission to the hospital for cardiac monitoring.

An internal medicine physician progress note dated 4/30/21 at 2:52 a.m. revealed the resident remained postictal with seizure most likely caused by Clonazepam withdrawal.

The resident remained at the hospital until 5/1/21.

Staff interviews revealed:

5/11/21 at 12:05 p.m., Staff D, RN, former interim DON, stated the administrator contacted her on

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F 760	Continued From page 34 4/29/21 as she filled in as the day shift nurse at a sister-facility and informed her the nurse scheduled to work from 6:00 p.m. to 6:00 a.m. that day had called in, and Staff D would have to cover the shift. When Staff D arrived on 4/29/21 between 8:15 p.m. and 8:30 p.m., Staff B, licensed practical nurse (LPN) had stayed over from the previous shift and informed her they ran out of the resident's Clonazepam on 4/25/21. Staff D stated she called the pharmacy and someone there said the Clonazepam had not been refilled because the resident needed a laboratory test. 5/13/21 at 11:03 a.m., Staff B, LPN, stated she called the pharmacy to request a refill on the resident's Clonazepam after they ran out on 4/25/21, but there was a language barrier with the person at the pharmacy and she didn't think they understood her. 5/12/21 at 12:43 p.m., Staff C, pharmacist at the facility's pharmacy, stated the pharmacy reviewed all telephone and fax (facsimile) records back to 4/19/21, and the first call or notice the pharmacy received for a refill on the resident's Clonazepam was on 4/29/21 at 10:26 p.m. by Staff D, interim DON. Staff C stated there were refills available on the prescription, and they would have authorized staff to withdraw the medication from the automated medication dispenser at the facility if they had called or requested a refill, the resident wouldn't have had to go without the medication. 7/9/21 at 2:16 p.m., Staff Y, advanced registered nurse practitioner (ARNP), stated staff notified her on 4/29/21 that Diastat was administered due to seizure activity, the resident continued to have seizure activity more than 30 minutes after the	F 760		

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F 760	Continued From page 35 medication was administered and she ordered the resident's transfer to the hospital ER due to the resident's problematic seizure history.	F 760		

PLAN OF CORRECTION

Provider/Supplier Name:	Genesis Senior Living
Street Address, City, Zip:	5608 SW 9th Street Des Moines, Iowa
Date of Survey:	5/3/2021 thru 7/27/2021

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	
F609	Genesis Senior Living ensures that allegations of missing property are investigated & reported to the State Survey Agency within 24 hours of the report as required.	
	Resident #8 no longer resides in the facility	
	All residents with potential to be affected are protected thru education	
	Department Heads received education on completion of grievance forms promptly on 5/27/2021	
	Staff received education on Grievance Forms and policy on 6/8/2021	
	Grievance Log is reviewed weekly in IDT for proper completion & Completion to ensure compliance	
	QAPI Team will review IDT documentation of review each quarter for the next 3 quarters to ensure correction is permanent	
		POC DATE 8/25/2021
F676	Genesis Senior Living provides Restorative Programs to those residents that a Restorative Program is indicated.	
	Resident #3 is deceased	
	Residents with the potential to be affected are protected thru assessments and therapy interventions.	
	Restorative Assessments were completed on all existing/non therapy residents thru 8/25/2021.	
	Therapy completed screening on all residents indicated with contracture/impaired functional ROM 8/18/21 thru 8/25/21.	
	D.O.N or designee will audit therapy recommendations and Restorative Assessments to ensure compliance	
	QAPI Team will review audits each quarter for the next 4 quarters to ensure solutions are permanent	

		POC DATE 8/25/2021
F677	Genesis Senior Living provides bathing assistance at appropriate intervals for residents.	
	Residents #1 & #2 receive bathing assistance as required	
	Resident #3,4, &7 no longer resident in the facility	
	All residents with potential to be affected protected thru changes in scheduling, auditing & education	
	Direct Care Staff received education on Bathing Expectations on 5/4/21,5/11,6/8.	
	D.O.N or designee is responsible for updating bathing schedule based upon preference routinely. Bath schedule updated 6/4,7/16, and 8/21/2021	
	QAPI Team will review bath documentation and audits quarterly x 4 quarters to ensure that solutions are permanent	
		POC DATE 8/25/2021
F689	Genesis Senior Living ensures that adequate nursing supervision is provided to prevent accidents and hazards	
	Residents # 7& #9 no longer reside in facility	
	All residents with potential to be affected are protected thru assessment, auditing, and changes in notification system for amount of assist	
	Kardex's have been updated and placed at each nurse's station for ease of staff review 8/11/2021	
	Staff received education related to fall prevention and interventions on 5/16/21,6/8/21.	
	D.O.N or designee will complete routine audits to ensure that interventions are in place	
	QAPI Team will review audits quarterly for 4 quarters to ensure solutions are permanent	
		POC Date 8/25/2021
F693	Genesis Senior Living ensures that residents that are fed via enteral feedings receive the appropriate treatment and services to prevent complications	
	Professional staff had an add on to MAR documentation to include recording intake of enteral food and free water daily on 8/1/2021	
	D.O.N or designee will complete routine audits to ensure that interventions are in place	
	QAPI Team will review audits quarterly for 4 quarters to ensure solutions are permanent	
		POC Date 8/25/2021

F760	Genesis Senior Living ensures that resident is free from significant medication errors	
	Resident # 4 no longer resides in the facility	
	All residents with potential to be affected are protected thru staff education & auditing	
	Professional staff were provided with policy and procedure changes on 4/28,5/16,7/26 & 8/1/2021	
	D.O.N or designee will complete routine auditing to ensure that medication errors or missed medication to ensure ongoing compliance	
	QAPI Team will review audits quarterly x4 quarters to ensure that solutions are permanent	
		POC DATE 8/25/2021

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.