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

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

(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 01/06/2022 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints. Investigation of complaints # 97638-C, # 98120-C, # 98604-C, # 98734-C, # 99316-C, # 99332-C, # 99523-C, # 99678-C, # 99696-C, # 99972-C, and # 100923-C were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on	F 567		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Admin.

(X6) DATE 12/20/2021

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.

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

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

(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 567	Continued From page 1	F 567		

resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.
(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interviews, and policy review, the facility failed to provide residents with access to their personal funds on the weekends for 8 of 10 residents reviewed for financial managment by facility staff (Residents #19, # 26, #29, 36, #43, #46, #49, and #50). The facility reported a census of 50 residents.

Findings:

The Trial Balance statement dated 10/27/21 by the facility's Resident Trust Management Service documented that 42 residents opted to have facility staff assist with management of their finances. Ten of the 42 were selected for review, which included the residents listed below.

1. The MDS (Minimum Data Set) assessment tool, dated 9/1/21, listed Resident #19's BIMS

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

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

(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 567	Continued From page 2	F 567		

(Brief Interview for Mental Status) score as 12 out of 15 possible points, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #19 stated she is not able to get her money on the weekend, only Monday - Friday.

2. The MDS assessment tool, dated 9/17/21, listed Resident #26's BIMS score as 15 out of 15, indicating intact memory and cognition.

During an interview on 10/27/21 at 10:45 a.m., Resident #26 stated it used to be that residents could get petty cash anytime at the nurse's station but can't anymore. If the resident wanted money, call and ask the BOM (Business Office Manager) to come down so you can ask her for the money.

3. The MDS assessment tool, dated 9/15/21, listed Resident #29's BIMS score as 14 out of 15, indicating intact memory and cognition.

During an interview on 10/27/21 at 10:45 a.m., Resident #29 stated it used to be that we could get our petty cash anytime at the nurse's station but they do not anymore. If the resident wanted money, you asked the BOM to come down and then you asked her for the money.

4. The MDS assessment tool, dated 9/22/21, listed Resident 36's BIMS score as 10 out of 15, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #36 stated residents have to ask for petty cash before the weekend and not ask for

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

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

(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 567	Continued From page 3 cash on the weekend. 5. The MDS assessment tool, dated 9/22/21, listed Resident 43's BIMS score as 10 out of 15, indicating moderate cognitive and memory impairment. During interview on 10/27/21 at 10:45 a.m., Resident #26 stated it used to be that residents could get petty cash anytime at the nurse's station but not anymore. To get money, the resident called and asked the BOM to come down and so you can ask her for money. 6. The MDS assessment tool, dated 10/8/21, listed Resident 46's BIMS score as 14 out of 15, indicating intact memory and cognition. During an interview on 11/2/21 at 11:00 a.m., Resident #46 stated residents are unable to get money on the weekend with the BOM not there. 7. The MDS assessment tool dated 10/6/21, listed Resident #49 BIMS score as 14 out of 15 During an interview on 10/27/21 at 10:45 a.m., Resident #49 stated it used to be that residents could get petty cash anytime at the nurse's station but not anymore. To get money, the resident called the BOM to come down and so you can ask for money. 8. The MDS assessment tool dated 10/6/21, listed Resident #50 BIMS score as 15 out of 15, indicating intact cognition. During an interview on 10/27/21 at 10:45 a.m., Resident #50 stated it used to be that residents could get our petty cash anytime at the nurse's	F 567		

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

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

(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 567 — F 567

Continued From page 4
station but not anymore. If you want money, you call and ask the BOM to come down and then ask for money.

An interview with BOM on 10/27/21 at 10:45 a.m. revealed the residents should have access to their money 24/7 but they have to come to her office if they need cash recently so she has not kept the black box (for money storage) in the medication cart for weeks. The BOM stated the residents have not been able to get money on the weekends, as she has not refilled the black box.

During an interview with Director of Nursing (DON) on 11/10/21 at 12:00 p.m. she stated the expectation that all residents have access to their funds at all times, even on the weekends. The facility has a black box with cash kept on the medication cart. The DON had never verified the black box is in the med cart.

The facility's undated policy titled Business Office-Resident Trust Fund Policy and Procedure, instructed:
a. Residents of a Skilled Nursing Center are to have their funds managed and personal spending money available to them.
b. When the Resident Trust Cash Box is replenished, funds should be used from the Resident Trust Bank account
c. Residents shall be able to make withdrawals from their account at any time.

F 568 SS=E — F 568

Accounting and Records of Personal Funds
CFR(s): 483.10(f)(10)(iii)

§483.10(f)(10)(iii) Accounting and Records.
(A) The facility must establish and maintain a system that assures a full and complete and

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

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

(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 568	Continued From page 5	F 568		

separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.
(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.
(C)The individual financial record must be available to the resident through quarterly statements and upon request.
This REQUIREMENT is not met as evidenced by:
Based on record review, resident, family member and staff , and policy reviews the facility failed to provide residents with quarterly financial statements for 7 of of 10 residents reviewed who entrusted funds with the facility (Residents #19, #22, #25, #36, #37, #49, and #50). The facility reported a census of 50 residents.

Findings:

The Trial Balance statement dated 10/27/21 by the facility's Resident Trust Management Service documented that 42 residents opted to have facility staff assist with management of their finances. Ten of the 42 were selected for review, which included the residents listed below.

1. The MDS (Minimum Data Set) assessment tool, dated 9/1/21, listed Resident #19's BIMS (Brief Interview for Mental Status) score as 12 out of 15, indicating moderate memory and cogntive impairment. The MDS documented an admission date of 6/19/15.

During an interview on 11/2/21 at 11:00 a.m., Resident #19 stated she ha received a quarterly statement regarding her financials one time.

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

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

(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 568	Continued From page 6	F 568		

2. The MDS assessment tool, dated 9/8/21, listed Resident #22's BIMS as 15 out of 15, indicating intact memory and cognition.

During an interview with Resident #22 on 11/9/21 at 2:40 p.m. the resident reported he had not received a quarterly statement regarding his trust balance in over 2 years.

3. The MDS assessment tool, dated 9/10/21 listed Resident #25's BIMS as 13 out of 15, indicating intact memory and cognition.

During an interview on 11/2/21 at 11 a.m., Resident #25 stated she has not received a quarterly statement regarding her trust account.

4. The MDS assessment tool, dated 9/22/21, listed Resident 36's BIMS score as 10 out of 15, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #36 stated she has not received a quarterly statement on her trust account.

5. The MDS assessment tool dated 10/15/21, listed Resident 37 BIMS score as 12 out of 15, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #37 stated she received quarterly statements for 1st and 2nd quarter of 2021, but no others.

6. The MDS assessment tool dated 10/6/21, listed Resident #49 BIMS score as 14 out of 15,

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

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

(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 568	Continued From page 7	F 568		

indicating intact cognition.

During an interview on 10/27/21 at 10:45 a.m., Resident #49 stated he does not receive quarterly statements regarding his trust account.

7. The MDS assessment tool dated 10/6/21, listed Resident #50 BIMS score as 15 out of 15, indicating intact cognition.

During an interview on 11/2/21 at 10:01 a.m., Resident #50's Power of Attorney (POA) stated she had not received a quarterly statement since Resident #50 admit date to the facility of 6/9/21.

During an interview 10/27/21 at 10:45 a.m., the Business Office Manager (BOM) stated she hands the quarterly financial statements out to the residents that handle their own affairs or sends them to the POA. The BOM had not provided residents with the 3rd quarter statements because she had been too busy. The BOM could not provide documentation that she provided quarterly statements to residents or copies of said quarterly statements.

During an interview on 11/10/21 at 12:00 p.m., the Director of Nursing (DON) stated the expectation that all residents participating in the Resident Trust Fund (RTF) will receive a quarterly statement.

The undated facility policy titled Business Office-Resident Trust Fund Policy and Procedure, directed:

a. The Center's Business Office will issue a statement, on a quarterly basis, of all transactions to each resident or legal guardian. Resident

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

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

(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 568	Continued From page 8 Funds Management Service (RFMS) will mail these reports to the center. A copy of the quarterly statements will be kept in the Business Office for 12 months from the statements date. The facility Admission Agreement, undated, recorded: The facility will open a personal account through RFMS, the facility would provide residents with an accounting of these funds upon request, and at least once every three months.	F 568		
F 569 SS=E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff	F 569		

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

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

(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 569		F 569		

Continued From page 9
interviews, and facility policy review, facility staff failed to notify residents/or legal representative when within or approaching the maximum a Medicaid recipient can have in cash assets for 8 of 10 residents (#11, #12, #19, #22, #25, #36, #37, and #49) and failed to convey the residents' personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate as provided by State law within 30 days of death for 2 of 2 residents reviewed (#152 and #153). The facility reported a census of 50 residents.

Findings:

The Trial Balance statement dated 10/27/21 by the facility's Resident Trust Management Service documented that 42 residents opted to have facility staff assist with management of their finances. Ten of the 42 were selected for review, which included the residents listed below.

1. The MDS (Minimum Data Set) assessment tool, dated 8/11/21, listed Resident #11's BIMS (Brief Interview for Mental Status) score as 10 out of 15, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #11 stated no one had notified her she needed to spend down money in her Resident Trust Fund (RTF) account or needed to spend down the balance. Resident #11 stated she asked to purchase a new television.

The Trial Balance statement of 10/27/21 recorded Resident #11's trust balance at $2,640.05.

The Payor Type list dated 10/26/21 documented

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

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

(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 569	Continued From page 10	F 569		

Medicaid as Resident #11's primary payer.

2. The MDS assessment tool, dated 8/11/21, listed Resident #12's BIMS as 8 out of 15, indicating severe cognitive impairment.

The Trial Balance statement of 10/27/21 recorded Resident #12's balance at $5,085.11

The Payor Type list dated 10/26/21 documented Medicaid as Resident #12's primary payor.

During an interview on 11/9/21 at 11:13 a.m., with the resident's Guardian she reported never having been notified by the BOM that spend down needed to occur with her ward. The Guardian had served as the resident's guardian for 5 years. She and had completed three spend downs this year with other residents in her ward, which totaled nine. The Guardian stated when contacted about a spend down, she would encourage a burial trust. She stated she would communicate with the funeral home and have to sign for her ward. If the ward had a burial trust, she would discuss with the facility social worker or staff to inquire what her ward may need such as a bed, chair, or T.V.

3. The MDS assessment tool, dated 9/1/21, listed Resident #19's BIMS as 12 out of 15, indicating moderate cognitive and memory impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #19 stated no one had notified her she needed to spend down money in her RTF account or needed to spend down the balance.

The Trial Balance statement of 10/27/21 recorded Resident #19's balance at $2,998.34.

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

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

(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 569	Continued From page 11 The Payor Type list dated 10/26/21 documented Medicaid as Resident #19's primary payor. 4. The MDS assessment tool, dated 9/8/21, listed Resident #22's BIMS as 15 out of 15, indicating intact cognition. During an interview on 11/9/21 at 2:40 p.m. the resident reported no one had notified him he needed to spend down money in his RTF account. The Trial Balance statement dated 10/27/21 recorded Resident #22's balance at $2,869.95. The Payor Type list dated 10/26/21 documented Medicaid as Resident #22's primary payor. 5. The MDS assessment tool, dated 9/10/21 listed Resident #25's BIMS as 13 out of 15, indicating mild cognitive impairment. During an interview on 11/2/21 at 11 a.m., Resident #25 stated no one has notified her she needed to spend down money in her RTF account or needed to spend down the balance. The Trial Balance statement dated 10/27/21 recorded Resident #25's balance at $5,472.52. The Payor Type list dated 10/26/21 documented Medicaid as Resident #25's primary payor. 6. The MDS assessment tool, dated 9/22/21, listed Resident 36's BIMS score as 10 out of 15, indicating cognitive impairment. During an interview on 11/2/21 at 11:00 a.m., Resident #36 stated no one had notified her she	F 569		

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

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

(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 569	Continued From page 12	F 569		

needed to spend down money in her RTF account or needed to spend down the balance.

The Trial Balance statement dated 10/27/21 documented Resident 36's balance at $4,736.72.

The Payor Type list dated 10/26/21 documented Medicaid as Resident #36's primary payor.

7. The MDS assessment tool dated 10/15/21 listed Resident #37's BIMS score as 12 out of 15, indicating mild cognitive impairment.

During an interview on 11/2/21 at 11:00 a.m., Resident #37 stated no one had notified her she needed to spend down money in her RTF account or needed to spend down the balance.

The Trial Balance statement of 10/27/21 recorded Resident 37's balance at $3,265.21.

The Payor Type list dated 10/26/21 documented Medicaid as Resident #37 primary payor.

8. The MDS assessment tool dated 10/6/21, listed Resident #49 BIMS's score as 14 out of 15, indicating intact cognition.

During an interview on 10/27/21 at 10:45 a.m., Resident #49 stated the Business Office Manager (BOM) shared with him in July 2021 that he needed to spend down his RTF account balance. Resident #49 stated he asked to buy a T.V. in July 2021. Resident #49 stated he had not received a new T.V. at the time of this survey.

The Trial Balance statement of 10/27/21 documented Resident 49's balance at $2,700.21.

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

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

(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 569	Continued From page 13 The Payor Type list dated 10/26/21 documented Medicaid as Resident #25's primary payor. 9. The MDS assessment tool dated 5/7/21, listed Resident #152's BIMS score as 00 out of 15, indicating severely impaired cognition. Facility documentation revealed Medicaid as Resident #152 primary payor and a resident expiration date of 5/29/21. The Trial Balance statement dated 10/27/21 recorded Resident 152's RTF balance of $6,408.35 The facility could not provide documentation of notice to convey the resident's personal funds and a final accounting to the individual or probate jurisdiction administering the individual's estate as provided by State law within 30 days of death. 10. The MDS assessment tool dated 7/20/21, listed Resident #153 BIMS score as 14 out of 15, indicating intact cognition. Facility documentation revealed Medicaid as Resident #153 primary payor and a resident expiration date of 7/19/21. The Trial Balance statement of 10/27/21 recorded Resident #153's RTF balance at $3,131.17. The facility could not provide documentation of notice to convey the resident's personal funds and a final accounting to the individual or probate jurisdiction who administered the resident's individual estate as provided by State law within 30 days of death.	F 569		

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

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

(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 569	Continued From page 14 The Trial Balance statement dated 10/27/21 provided by the BOM revealed 16 of 37 RTF account balances as over the State of Iowa Medicaid allowable balance of $2,000.00. The 16 of 37 RTF balances ranged from $2,000.00 to $6,351.00. During interview on 10/27/21 at 10:45 a.m. the BOM stated that Resident #49's RTF balance is over the allowable State limit due to the facility being short staffed and unable to make a T.V. purchase for him. The BOM reported she watched RTF balances and let the resident or Power of Attorney (POA) know when the resident had $1800 or more. The BOM stated she does not document conversations regarding spend downs nor document daily balances. An interview with Staff Y, Certified Nurse Assistant (CNA) on 10/28/21 at 1:40 p.m. revealed she would shop for residents once per month. Staff Y stated the BOM provided her with a list and money of items to buy. Staff Y stated Resident #49 had not been on the list provided to her. During an interview on 11/4/21 at 12:59 p.m. the BOM stated she notified the estates email of expired residents #152 and #153 within 30 days of their deaths and of a positive RTF balance. The BOM reported her head was fuzzy and she did not know if she received a response on where to forward their RTF balance. Upon request, the BOM could not provide documentation of monthly audits of RTF's, documentation of corporate internal audits of the RTF, that residents or their legal representatives were notified when account balances approached the maximum Medicaid recipient cash balance and documentation of	F 569		

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

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

(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 569	Continued From page 15	F 569		

notification that she communicated with Residents #152's and #153's individual or probate jurisdiction within 30 days of their deaths.

During an interview on 11/10/21 at 12:00 p.m. the Director of Nursing (DON) revealed her expectation is residents who participate in the RTF be notified by the BOM if they are close to exceeding the Medicaid maximum allowed balance amount. The DON stated she is aware of two residents that are close to the max allowed and the BOM is to notify the state recovery office immediately after a resident expired. The DON was not aware of any expired residents that have funds in the RTF.

The facility's undated Business Office-Resident Trust Fund Policy and Procedure instructed:
a. An internal audit of the resident trust will be completed on a quarterly basis by the corporate office. The resident/legal guardian reserves the right to be informed of Internal RTF audits and the results of those audits.
b. A resident's combined personal accounts cannot exceed the amount determined by current state regulations
c. The Center shall issue a notice to the resident/legal guardian when the resident is within $200.00 of approaching this limit in the RTF account. This report will be run monthly and all residents within the designated limit shall receive that their funds are close to exceeding the state mandated personal allowance maximum limit.
d. The Center's Business Office will issue a statement, on a quarterly basis, of all transactions to each resident or legal guardian. RFMS will mail these reports to the center. A copy of the quarterly statements will be kept in the Business Office for 12 months from the statement date.

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

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

(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 569	Continued From page 16	F 569		

e. Upon passing of the resident, funds will be disbursed as follows:
1. Medicaid residents-all personal funds must be reported to the State based on regulatory requirements involving estate recovery. These funds can only be released to the state or made payable directly to a mortuary to cover any unpaid funeral expense. A copy of an invoice reflecting the unpaid balance must be provided.

Per Iowa Medicaid Eligibility for Long-Term Care: Income & Assets Limits, https://www.medicaidplanningassistance.org/medicaid-eligibility-iowa/:
a. Institutional / Nursing Home Medicaid - This is an entitlement program, which means anyone who meets the eligibility requirements is offered assistance. It is provided only in nursing homes.
b. Income limit: $2,382/month. All of a resident's income, with the exception of a monthly personal needs allowance of $50 and a spousal income allowance (if applicable), must go towards the cost of nursing home care.
c. Asset limit: $2,000. Countable (non-exempt) assets include cash and most anything that can easily be converted to cash to be used to pay for long-term care.

Per National Center on Law and Elder Rights, https://ncler.acl.gov/getattachment/Resources/Nursing-Home-Residents-and-Stimulus-Checks-(1).pdf.aspx?lang=en-US:
a. Under Medicaid rules, a stimulus payment is not counted as income. Therefore, receiving a stimulus payment does not change a resident's monthly payment (often called a "patient pay amount" or "share of cost"). The resident pays the same monthly amount to the nursing facility and keeps the stimulus payment for their own

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

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

(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 569	Continued From page 17 use. In addition, the stimulus payment does not count as a Medicaid resource for 12 months. In other words, for the first year, the payment cannot cause you to have "too much" savings. Example: After receiving the stimulus payment, her savings will increase from $1,800 to $3,000. To retain Medicaid eligibility, she must spend down her savings to under $2,000 within a year-before May 2021.	F 569		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

(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 580	Continued From page 18	F 580		

resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, family interviews and staff interviews, and facility policy review, facility staff failed to notify family members in regards to a room change (Resident #102), when residents had a change in condition (Residents #23, #46, and #52), and failed to notify a physician with a significant weight loss (Resident #9) for 5 of 19 residents reviewed. The facility reported a census of 50 residents.

Findings include:

1. According to the Minimum Data Set (MDS) assessment dated 3/8/21, Resident #102 had diagnoses that included Non-Alzheimer's dementia, depression and cancer. The MDS

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

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

(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 580	Continued From page 19	F 580		

identified a BIMS (Brief Interview for Mental Status) score of 12 which indicated moderate cognitive and memory impairment.

The Care Plan with a target date 5/31/21 recorded Resident #102 had impaired cognitive function/dementia or impaired thought processes related to diagnosis of Alzheimer's disease. The Care Plan directed staff to communicate with responsible party regarding her needs and discuss concerns about confusion.

Review of Progress Notes dated 4/24/21 at 12:59 AM revealed Staff R, RN (Registered Nurse) documented at 10:15 AM that Resident #102 came down the hallway walking very fast with her walker. Staff R asked Resident #102 what she was doing and Resident #102 replied she had hit her roommate, told her to shut up, threatened to kill her, and called her a derogatory name because the roommate was always talking and as a result Resident #102 could not read or watch television. Staff R documented she completed a head to toe assessment on Resident #102 and there was no sign or symptoms of injury and relocated Resident #102 to a different room. Staff R documented she notified the ARNP (Advanced Registered Nurse Practitioner) and ADON (Assistant Director of Nursing) of the situation.

On 4/24/21 at 1:41 AM, Staff S, MDS Coordinator, documented she informed the Administrator of the incident and due to the lateness of the hour, planned to pass it on to the day nurse to contact the family regarding the incident.

On 4/25/21 at 12:50 AM, Staff R, prior ADON (Assistant Director of Nursing) documented

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 580	Continued From page 20	F 580		

Resident #102's family was called to notify them of the altercation between Resident #102 and her roommate, there was not an answer and she left a message to call back. The notes lacked documentation of timely family notification of the altercation and room change for Resident #102.

The facility policy titled Notification of Change in a Resident's Condition with a review dated of 11/1/18 instructed the resident representative will be notified of a change in a resident's condition per standards of practice and Federal and/or State regulations. The facility policy further revealed the resident representative would be notified regarding any incident per Federal and State regulations.

In an interview 11/3/21 at 2:35 PM, the DON stated that any time a resident has an altercation, the expectation is the resident representative would be notified just as staff would notify the physician.

2. The MDS assessment dated 8/4/21 indicated Resident #9 had diagnosis of anemia, Alzheimer's disease, progressive neurological conditions, malnutrition, muscle weakness, malaise, cachexia (weakness and wasting of the body due to severe chronic illness), osteoporosis, and dysphagia. The MDS indicated BIMS score of 3 out of 15 which indicated severely impaired cognition. The resident required the assistance of one for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The MDS documented the resident had incontinence. The MDS documented she measured 62 inches in height and a weight measurement of 86 pounds (lbs). The assessment documented a weight loss of 5% in one month or 10% or more in the last 6

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

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

(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 580	Continued From page 21	F 580		

months. The MDS indicated the resident on a mechanically altered diet. The MDS documented the resident took an antidepressant and an opioid during the look-back period.

The Care Plan problem dated 8/17/21 revealed Resident #9 had a nutritional problem related to low body mass index (BMI) and diagnoses of dementia and weakness, activities of daily living (ADL) self-performance deficits, adult failure to thrive and pocketing meds in her mouth. The goal was to maintain her current weight and consume 50% at meals. Interventions included: magic cup, supercereal at breakfast, ice cream and house shake (dated 1/25/20), monitor and record intake (dated 11/30/20), staff to encourage and assist resident as will allow (dated 11/15/17), utilize finger foods (dated 11/30/20) and to obtain weight values per facility protocol/as ordered and report significant variances to the provider (dated 5/2/17).

Resident #9's documented weights were as follows for the past 6 months:

Date/Time	Weight
4/3/2021 6:09 AM	98.5 lbs
4/11/2021 5:19 PM	99.5 lbs
4/19/2021 1:16 PM	95.0 lbs
4/25/2021 8:48 AM	97.0 lbs
5/1/2021 6:41 PM	97.5 lbs
6/2/2021 12:41 PM	95.5 lbs
6/29/2021 9:43 AM	96.5 lbs
7/8/2021 6:26 PM	89.0 lbs
7/20/2021 12:22 PM	89.5 lbs
7/27/2021 10:53 A	86.5 lbs
8/4/2021 9:52 AM	86.0 lbs
8/12/2021 10:17 AM	87.5 lbs
8/19/2021 10:06 AM	88.0 lbs
8/20/2021 1:59 PM	86.0 lbs
8/25/2021 10:23 AM	83.5 lbs

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

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

(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 580		F 580		

Continued From page 22

9/3/2021 3:33 PM 90.0 lbs
9/9/2021 4:34 PM 90.0 lbs
9/13/2021 4:34 PM 91.0 lbs
9/23/2021 3:00 PM 89.5 lbs
9/30/2021 1:19 PM 95.5 lbs
10/7/2021 1:23 PM 93.5 lbs
10/8/2021 9:13 AM 87.5 lbs

10/13/2021 9:53 AM 88.0 lbs

Resident #9 experienced an 11.56% weight loss from 4/11/21 to 10/13/21.

The Medication Administration Record of 11/1 - 11/20/21 documented Resident #9 received Remeron 7.5 mg tablet by mouth one time per day for adult failure to thrive and instructed to weigh him weekly, provide a frozen nutritious treat twice a day, and house supplement 120 milliliters four times daily.

The Progress Notes for Resident #9 documented the following:
a. On 4/8/21 at 3:25 PM, a Risk meeting was held. The resident had a weight gain and staff made the doctor aware of the desirable gain. The resident continued to have a poor appetite, no recent falls, interventions in place, no complaints of pain or discomfort, restorative program in place, no skin issues, and the plan was to continue with current plan of care. No issues noted at the time.
b. On 4/8/21 at 5:12 PM, staff entered a weight change note. The resident's weight on 4/3/21 at 6:09 AM measured 98.5 lbs. This was a 5.3% weight gain. The weight gain was desired, and staff made the dietitian and doctor aware. Staff documented the plan to continue to observe.
c. On 5/9/21 at 8:14 PM, staff entered a weight

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

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

(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 580	Continued From page 23	F 580		

change note. The resident's weight measured 97.5 lbs. on 5/1/21 at 8:41 AM, a +7.5% change [12.1%, 10.5] +10.0% change [12.1%, 10.5]. Resident #9 received 120 milliliters supplement 2.0 four times a day and frozen nutritious treat at meals which helped to increase her weight. Remeron started in January to stimulate her appetite. The resident's appetite remained fair. Continue to monitor weights.

The clinical record lacked any documentation of residents continued weight loss since 5/1/21 or notification of the provider since 4/8/21.

Per documentation Resident #9 saw a provider on 2/27/20, 4/21/20, 6/16/20, 8/18/20, 10/14/20, 12/9/20, 2/10/21, 4/13/21.

In an interview on 11/4/21 at 12:07 PM, Staff W, Registered Dietician, stated that the process used when a resident had a weight loss was to have staff first reweigh the resident. If they still showed a loss, she checked to see how they were eating, what supplements they were on and if they complete offered meals. Staff W then set them up on weekly weights to be monitored more closely. She may start 2 Cal, or a fortified juice or something along that line. She has the resident continued to be weighed weekly for 4 weeks after their weight has stabilized and would continue to try different things to help stabilize the weight. Staff W stated she tried to document monthly on residents with weight loss. She communicated with the providers on a regular basis but had not currently been writing it down. Staff W stated she was aware she should be documenting these interactions. She also stated it was her belief that nursing should be notifying the physician. She said it used to be communicated through their

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

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

(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 580	Continued From page 24	F 580		

Continued From page 24
Risk or Quality Assurance (QA) meetings but they haven't had those for several months.

In an interview on 11/4/21 at 2:35 PM, the Director of Nursing (DON), stated that Staff W sent out notification to the facility when she was in the facility of any significant resident weight changes. Staff W then put it in the provider's mail box to be evaluated when they were in house. Staff W filled out the weight variance when in house and the provider reviewed and wrote orders as needed. The DON concluded the facility no longer had Risk or QA meetings for this type of information to be discussed.

Per the Weight Variances Policy dated 3/31/21 all residents who experience significant, insidious and/or unintentional weight loss or gains shall be assessed for nutritional status by Registered Dietician. The Registered Dietician shall assess the resident and submit a request for monitoring and/or intervention. Once the order is obtained nutrition intervention is communicated to the Dietary Manager and/or designee through nursing and/or Nutrition Management. Residents assessed at risk may be weighed weekly. Residents shall be assessed for progress monthly or as needed by the Registered Dietician and adjustments to care made according to resident progress. Resident progress shall be reviewed with the Director of Nursing and Dietary Manager. All progress or any changes made shall be documented in the medical records and care plan updated accordingly.
3. The MDS assessment dated 9/8/21 recorded Resident #23 had diagnoses of dementia, anxiety disorder, unsteadiness on her feet, dysphagia, muscle weakness, and difficulty in walking. The resident had a BIMS of 11, indicating moderately

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

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

(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 580	Continued From page 25	F 580		

impaired cognition. The MDS revealed the resident had total dependence on one person for bed mobility and activities of daily living (ADL).

Observation on 11/1/21 at 9:45 AM revealed Resident #23's bottom appeared slightly excoriated and with a slightly open area on the coccyx, without odor noted.

Review on 11/3/21 at 2:26 PM revealed no follow up documentation noted in the electronic health record (EHR) of family notification in regards to the area on Resident #23's coccyx.

Review of Progress Notes in the EHR revealed Resident #23 had a review of her skin issues on 11/11/21. The EHR and facility records lacked notification to the family, POA, or guardian regarding the skin issue until 11/15/21.

On 11/3/21 at 2:36 PM, the DON stated any time staff called the doctor, she expected family to be notified.

4. Review of the MDS assessment dated 10/8/21 revealed Resident #46 had diagnoses of seizures, anxiety disorder, and difficulty walking. The resident had a BIMS of 14, indicating cognition intact. The MDS revealed the resident required supervision for bed mobility and limited assistance of one for ADL's.

The resident's Progress Note revealed documentation for Resident #46 regarding a new skin issue on 11/11/21. The notes and the EHR lacked documentation of notice to the family, POA, or guardian regarding the skin issue until 11/15/21

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

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

(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 580	Continued From page 26 5. The MDS assessment dated 10/26/21 documented Resident #52 had diagnoses of diabetes, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. The resident had a BIMS of 8, indicating moderately impaired cognition. The resident required the assistance of one with bed mobility and ADL's. The resident's progress notes and EHR revealed Resident #52 had a new skin issue on 11/10/21. The records lacked notification to the family, POA, or guardian regarding the skin issues until 11/15/21.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		

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

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

(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 584	Continued From page 27	F 584		

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff and resident interviews, and facility policy review, the facility failed to provide a clean, comfortable and homelike environment. The facility identified a census of 50 residents.

Findings include:

1. Observations revealed the following:

a. On 10/25/21 at 12:25 PM, a mechanical lift sat next to the wall in Resident # 32's room. The mechanical lift foot platform had brown, sticky debris, and what appeared to be Cheerios and other food particles.

b. On 10/27/21 at 12:30 PM, the mechanical lift foot platform continued to have a dark brown and sticky substance, and food particles.

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

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

(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 584	Continued From page 28	F 584		

In an interview on 10/28/21 at 10:20 AM, Staff M, Housekeeper, reported the housekeepers cleaned resident equipment such as the mechanical lifts. Staff M stated they had a list of items they cleaned daily and weekly.

In an interview 11/3/21 at 11:10 AM, the Housekeeping and Laundry Supervisor reported they had a schedule for disinfecting surfaces, and a daily and weekly cleaning list for staff to fill out and date when completed. The Supervisor stated the certified nurse assistants (CNA's) cleaned the mechanical lifts and resident care equipment.

In an interview 11/4/21 at 9:14 AM, Staff C, MDS (Minimum Data Set) nurse, reported the CNA's are assigned to clean equipment such as the mechanical lifts. Staff C stated she could provide no documentation of when the resident care equipment had been cleaned for the past 3 months.

The facility's Disinfecting Surface Schedule recorded surfaces are disinfected twice a day. The schedule had no signature, date or time listed next to "all lift equipment".

A Primecare Drive Sit to Stand Lift owner's manual instructed that all gross and solid contaminants should be removed from the sit to stand lift, then all components washed and sanitized, using isopropyl alcohol 70% solution or a cloth moistened with lanolin and water.

2. Observation on 10/27/21 at 1:15 PM revealed Staff H, CNA, wheeled Resident # 31 in a wheelchair to the 100 hall shower room. The shower room floor had missing and broken tile, and the floor tile and grout appeared dirty. The

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

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

(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 584	Continued From page 29	F 584		

wall and baseboard around the shower stall had a brown, black and yellow substance.

Observation on 11/2/21 at 1:15 PM with Staff N, Housekeeper, revealed missing and broken floor tile in the 100 hall shower room, and the shower room stall wall above the baseboard had a brown/black/yellow substance.

In an interview on 11/2/21 at 1:05 PM, Staff E, CNA, reported if something was broken, she let her charge nurse know, and then they notified Maintenance to fix the equipment.

In an interview on 11/2/21 at 1:15 PM Staff N, Housekeeper, reported she cleaned the shower room and other areas of facility daily. Staff N reported broken floor tile in the shower for at least a month. Staff N stated she did her best to clean the shower area but unsure what else she could do to clean the area better.

In an interview on 11/3/21 at 11:10 AM, the Housekeeping and Laundry Supervisor reported if something is broken or needed repaired or looked at, she let Maintenance know.

In an interview on 11/3/21 at 11:40 AM, the Administrator reported she was aware of the broken floor tile in the 100 shower room and floor tile in need of repair. The Administrator reported a plan for facility renovation.

In an interview on 11/4/21 at 10:20 AM, the Administrator reported the Maintenance person said staff needed to enter work requests in the TELS system. The Administrator reported when she asked staff about using the TELS, they told her they had never been trained or didn't have

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

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

(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 584	Continued From page 30 time to enter a work order into the TELS system. The Administrator confirmed she didn't know how to use the TELS system. 3. During an environmental tour of the facility on 10/25/21 from 1:02 to 3:54 PM, observation revealed: a. The upstairs dining room wall with patched white pain on tan walls. b. The upstairs dining room with bent blinds on window. c. The upstairs dining room with large hole exposing insulation and duct work. d. The upstairs dining room ceiling tiles with blackened tiles surrounding them. e. Room 217 had a stack of blankets under the sink which appeared saturated. f. Room 213 had scratched paint the length of the bed closest to the window. Follow up observation of room 217's sink on 10/28/21 at 10:48 AM revealed multiple saturated and discolored white blankets. Observation on 11/1/21 at 9:11 AM revealed Staff N, Housekeeper removing discolored and saturated blankets from under room 217 sink with floor tiles loose and border unglued and away from wall. During an interview with Staff O, Social Worker (SW) on 10/25/21 at 1:02 PM revealed that the large hole in the dining room that exposed duct work and insulation has been there for as long as she remembered. During an interview on 10/26/21 at 8:06 AM Resident #49 revealed the sink in his room had been leaking for over a week.	F 584		

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

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

(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 584	Continued From page 31	F 584		

During an interview with Staff P, Maintenance on 10/28/21 at 10:48 AM, he stated that they had the sink in room 217 serviced on 9/22/21 and it temporarily stopped leaking. Staff P stated he has not done anything else to fix the leak.

During an interview on 11/22/21 at 2:22 PM, Staff P stated the facility lacked maintenance policies and procedures. Staff P stated facility staff verbally notify him when something is broken as they do not know how to use the TELS system.

During an interview on 11/4/21 at 12:30 PM, Staff C, Licensed Practical Nurse (LPN) stated staff do not use the Maintenance book located at the nurse's station when something needs repaired. Staff C stated staff call or text maintenance.

On 11/4/21 at 1:00 PM, the Administration stated staff are in survival mode and Staff P will fix what needs to be fixed at the time.

4. The MDS assessment dated 10/15/21 recorded Resident #53 had diagnoses including hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The MDS documented a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment.

During interview and observation on 11/3/21 at 11:35 AM, Staff T, CNA, gave Resident #53 a shower. Resident #53 reported frequently throughout his shower that he was cold. Resident #53 stated the water felt warm enough but the air was cold. At the time, only one heat lamp on in the shower room area.

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

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

(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 584	Continued From page 32 Observations on 11/3/21 revealed the following: a. The first floor east shower room temperature right after the shower at 68 degrees Fahrenheit (F). b. Only one of the red heat lamp lights in working condition c. The lower level west shower temperature measured 80.2 degrees F at 11:40 AM. d. The first floor east shower room temperature measured 67.1 degrees F at 11:42 AM with the facility Administrator present. In an interview on 11/4/21 at 10:20 AM, the Director of Nursing (DON) stated it was the expectation that staff turn in any environmental concerns by utilizing the maintenance book. However, she stated many of the staff just stop the maintenance man in the hall or in passing and let him know of their concerns. In an interview on 11/4/21 10:25 AM, the Administrator acknowledged the shower room temperature needed to be warmer than 67 degrees. The Administrator stated there were plans to remodel and revamp the shower rooms but until then she planned to have maintenance put both heat lamps in and have them start the shower, turn on the heat lamps and let the room warm up prior to bringing a resident in to the area. She also planned to put a thermometer in the room so staff were aware of the temperature before bringing the resident in and to ensure that room is comfortable for the resident. Per the Genesis Care Center Air temperature test log, all buildings are required to maintain an ambient temperature throughout resident areas in a temperature range of 71 to 81 degrees F or at a more restrictive range required by state or local	F 584		

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

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

(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 584	Continued From page 33 requirements. The air temperatures were checked once according to the log on 10/29/21 and the temperatures at that time ranged from 71 to 74 degrees throughout the facility.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and family member interviews, and facility policy review, the facility failed to report to the State Department of Inspections and Appeals and thoroughly investigate missing personal property for 1 of 19 (#151) residents reviewed. The facility reported a census of 50 residents. Findings include: The MDS (Minimum Data Set) assessment tool, dated 8/16/21, listed Resident #151's BIMS (Brief Interview for Mental Status Score) as 12 out of 15, indicating moderate memory and cognitive impairment. The assessment documented the resident's diagnoses included anemia, high blood pressure, kidney disease, diabetes and chronic	F 607		

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

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

(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 607	Continued From page 34	F 607		

lung disease. The MDS of 9/1/21 documented Resident #151 died in the facility.

An interview with Staff C, Licensed Practical Nurse (LPN) on 11/4/21 at 9:09 a.m. revealed the facility did not use a Resident Inventory Log when new admissions arrive to the facility.

During an interview with the Power of Attorney (POA) of Resident #151 on 11/4/21 at 1:09 p.m., she reported Resident #151 arrived to the facility with a wallet, a $100 dollar bill, and a rosary. The POA stated facility staff did not complete an admission log. Resident #151 expired at the facility on 9/1/21. On 9/10/21, the POA called the facility and reported to the Social Worker (SW) of missing items and the SW informed the POA staff could not locate the missing items. The POA stated she had not received additional information from the facility.

During an interview with the SW on 11/4/21 at 2:46 p.m. she stated she and the Business Office Manager (BOM) checked the safe for Resident #151's missing possessions but were unable to locate them. The SW did not complete a grievance form. The SW stated she notified the Administrator (ADM) and department heads at their daily morning meeting. The Department of Inspections and Appeals (DIA) should be notified if items were not found and the ADM instructed the SW to report the incident; the SW did not notify DIA.

During an interview with the ADM on 11/10/21 at 9:58 a.m.. she stated she assumed her role in August, 2021. The ADM stated she completed Resident #151 admission on 8/9/21 and did not complete an inventory log of personal

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

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

(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 607	Continued From page 35	F 607		

possessions. The ADM stated if personal possessions are reported missing, the SW or Abuse Coordinator (the Director of Nursing [DON]), would file a grievance. All grievances are discussed at the department heads' daily morning meeting. The ADM stated she did not report Resident #151 missing possessions to DIA.

During an interview with Business Office Manager (BOM) on 11/10/21 at 10:10 a.m. BOM stated she was informed by the SW of #151's POA-reported missing items and she checked the safe for the items. The BOM stated department heads did not discuss Resident #151's missing items in their daily morning meeting. The BOM stated the SW or ADM would be the staff to notify DIA.

During an interview with DON on 11/10/21 at 10:28 a.m., DON stated the SW did not notify her of Resident #151's missing items. The DON stated she did not notify DIA of missing possessions.

Review of the resident's electronic health record and paper chart revealed no resident personal possessions log upon admission for Resident #151.

The facility policy on Abuse Prevention, dated 4/28/21 instructed:
a. Investigation: The Administrator, or designee, shall report any allegations of abuse, neglect, or misappropriation of resident property as well as report any reasonable suspicion of crime in accordance with Section 1150B of the Social Security Act to the Department of Health as required.
b. Alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of

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

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

(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 607	Continued From page 36 an unknown source and misappropriation of resident property are reported immediately, but not later than 24 hours after the allegation is made, to the administrator of the facility and to other officials (including State Survey Agency, and local law enforcement as required. c. Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident. d. All staff and others who may have unsupervised access to residents will read and have maintained in their facility personnel file, signed Abuse Prevention Policy. The facility policy titled Grievance/Missing Property, dated 4/28/21 directed: a. All residents, resident representatives and families have the right to report property/items that may be missing. b. The Administrator, Grievance Official & Department Heads will follow up on issues noted: 1. Grievances will be shared with other involved departments as needed. c. Social Service/Grievance Official is responsible for notifying resident representative, and Ombudsman, as appropriate, of resolution. d. If the investigation reveals suspected misappropriation, proceed in accordance with the Abuse Prevention Policy & Misappropriation of Property. e. Supervisory personnel will be responsible for notifying the resident, resident representative and/or family outcome of missing property investigation.	F 607		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		

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

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

(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 622	Continued From page 37	F 622		

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health

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

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

(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 622	Continued From page 38 or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for	F 622		

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

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

(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 622	Continued From page 39	F 622		

ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to provide discharge and medical information to the receiving health care institution at the time of discharge for two of four residents reviewed who transferred to the hospital (Resident #32 and #101). The facility reported a census of 50 residents.

Findings include:

1. Review of the Minimum Data Set (MDS) assessment dated 10/10/21 revealed Resident #32 readmitted to the facility from the hospital on 10/5/21.

Review of the facility's electronic health record (EHR) Census List revealed Resident #32 had transferred to the hospital on 9/23/21 and readmitted to the facility on 9/28/21, transferred to the hospital on 10/2/21 and re-admitted to the facility on 10/5/21, and transferred to the hospital on 10/10/21 and readmitted to the facility on 10/12/21.

The resident's Progress Notes dated 10/6/21 revealed he had severe abdominal pain, distention, and firmness on 10/2/21 and went to the Emergency Department (ED) for evaluation, and returned to the facility on 10/5/21. The Progress Notes dated 10/10/21 revealed the

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

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

(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 622	Continued From page 40	F 622		

resident sent to the ED. The Progress Notes dated 10/12/21 revealed the resident returned to the facility.

The resident's paper chart and EHR lacked documentation of a transfer form or information sent with the resident when he transferred to the hospital on 10/2/21 or 10/10/21.

In an interview 11/04/21 at 9:10 AM, Staff C, MDS Coordinator, reported no transfer form could be found for Resident #32. Staff C reported whenever a resident went to the hospital, staff printed off a transfer form from the EHR, but they make no copy for their records.

2. Review of the MDS assessment dated 9/2/21 revealed Resident #101 readmitted to the facility from the hospital on 8/26/21.

Review of the facility's EHR Census List revealed Resident #101 transferred to the hospital on 8/4/21 and readmitted to the facility on 8/9/21, transferred to the hospital on 8/21/21 and readmitted to the facility on 8/26/21, and transferred to the hospital on 9/24/21.

The Progress Notes recorded the resident admitted to the hospital on 8/4/21 and went to the ED for evaluation and treatment on 8/21/21.

The paper chart and EHR lacked documentation of a transfer form or information sent with the resident when he transferred to the hospital 8/4/21 and 8/21/21.

In an interview 11/04/21 at 9:10 AM, the MDS Coordinator reported no transfer form could be found for Resident #101. The MDS Coordinator

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

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

(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 622	Continued From page 41 reported whenever a resident sent to the hospital, staff printed off a transfer form from the EHR, but they make no copy for their records.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy review, the facility failed to provide	F 625		

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

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

(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 625	Continued From page 42	F 625		

notice to the resident and/or representative of the facility's bed-hold policy prior to and upon transfer to the hospital for one of four residents reviewed for transfers to the hospital or another facility (Resident #101). The facility reported a census of 50 residents.

Findings include:

Review of the Minimum Data Set (MDS) assessment dated 9/2/21 revealed Resident #101 had diagnoses of heart failure, diabetes, and chronic obstructive pulmonary disease. The MDS documented the resident readmitted to the facility from the hospital on 8/26/21.

Review of the facility's electronic health record (EHR) Census List revealed Resident #101 had transferred to the hospital on 8/4/21 and readmitted to the facility on 8/9/21, transferred to the hospital on 8/21/21 and re-admitted to the facility on 8/26/21, and transferred to the hospital on 9/24/21.

The Progress Notes revealed the resident admitted to the hospital on 8/4/21, 8/21/21, and 9/24/21.

Review of Resident #101's clinical record revealed no documentation of any explanation to the resident and/or family member regarding the facility's bed hold policy when the resident admitted to the hospital 8/4/21 and 8/21/21.

In an interview 11/1/21 at 9:40 AM, the Director of Nursing (DON) reported the Social Worker (SW) as responsible to provide bedhold notices.

In an interview 11/1/21 at 9:45 AM, the SW

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

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

(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 625	Continued From page 43 reported she had a file with bedhold information in her office. The SW stated the nurses provided bedhold information to residents/family members when the SW was not at facility, then SW followed up with family on the bedhold notice. In an interview 11/3/21 at 12:45 PM, the DON reported no bedhold notices could be found for Resident #101. An undated Bed Hold Policy revealed Federal regulations require a nursing facility must provide written information to the resident and family member or legal representative that specifies the duration of the bed hold during which the resident is permitted to return and resume residence at the facility. The notice must be provided well in advance of any transfer and at the time of any transfer.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff	F 637		

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

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

(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 637	Continued From page 44 interview, the facility failed to complete a required Significant Change Minimum Data Set (MDS) assessment within the required fourteen days for 1 of 1 resident reviewed for hospice services (Resident #23). The facility reported a census of 50 residents. Findings include: The census line from admission revealed Resident #23 started hospice on 7/14/20 and hospice services ended 5/18/21. In an interview on 11/1/21 at 8:58 AM the hospice agency verified Resident #23 received hospice care from 7/14/20 to 5/18/21. In an interview on 11/1/21 at 9:11 AM the MDS Coordinator stated she completed a significant change MDS whenever a resident went on or off hospice services In an interview on 11/1/21 at 9:18 AM the Director of Nursing stated they did the significant change MDS assessment for the resident on 6/17/21 and she would expect a significant change to be done within the 14-day period.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to accurately complete Minimum Data Set assessments for two of	F 641		

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

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

(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 641	Continued From page 45	F 641		

nineteen residents reviewed (Resident s#53 and #3). The facility reported a census of 50 residents.

Findings include:

1. Review of the admission Minimum Data Set (MDS) assessment dated 10/15/21 revealed Resident #53 admitted to the facility 10/8/21, and had diagnosis of hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) of 5, indicating severe cognitive impairment. Resident #53 had no behaviors and required the assistance of one with all activities of daily living. The MDS coded the resident had no catheter and as incontinent of bowel and bladder.

The Nursing Admission Screening dated 10/8/21 revealed Resident #53 had a Foley (indwelling urinary) catheter.

The Physician Orders dated 10/8/21 instructed the resident required a Foley catheter related to urinary retention. On 10/12/21, a physician's order instructed to maintain a 16 French catheter with a 10 milliliter bulb to straight drainage and to change the catheter as needed.

In an interview 11/4/21 at 9:10 AM Staff C, MDS Nurse stated that catheters are noted on the MDS and the care plan whenever a resident had a catheter, so staff knew how to care for the resident. Staff C stated Resident #53 had a catheter upon admission to the facility and the MDS should have been coded for his catheter.

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

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

(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 641	Continued From page 46 2. The MDS assessment dated 7/21/21 recorded Resident #3 had diagnoses that included coronary heart disease, heart failure, diabetes, hypertension (high blood pressure), urinary tract infections, diabetes, hyperkalemia (high potassium), hyperlipidemia (high cholesterol), Non-Alzheimer's dementia, multiple sclerosis, depression, schizophrenia, asthma, and respiratory failure. The MDS documented she required the assistance of one staff for bed mobility, transfers, and toilet use. The resident had a BIMS score of 10 out of 15, indicating moderately impaired cognition. Observation on 10/26/21 at 8:26 AM revealed Resident #3 with oxygen (O2) at 3 1/2 liters (L) by nasal cannula. Observation on 10/27/21 at 9:48 AM revealed Resident #3 with oxygen at 3 ½ L per nasal cannula. The resident's MDS assessment of 10/15/21 lacked documentation of Resident #3 requiring continuous O2 or BIPAP.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		

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

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

(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 655	Continued From page 47 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility policy review, the facility failed to develop a baseline care plan within 48 hours of admission and provide the resident and resident's representative a written summary of the baseline	F 655		

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

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

(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 655	Continued From page 48	F 655		

care plan for one of seven residents reviewed (Resident #101). The facility reported a census of 50 residents.

Findings include:

The admission Minimum Data Set (MDS) assessment dated 7/19/21 recorded Resident #101 admitted to the facility on 7/12/21 from the hospital, and had diagnoses of debility, heart failure, atrial fibrillation, hypertension (HTN), diabetes, and chronic obstructive pulmonary disease (COPD). The MDS documented the resident had a Brief Interview for Mental Status score of 13, which indicated intact memory and cognition. The MDS indicated the resident had a catheter, fell with injury prior to admission, required oxygen, and had occupational and physical therapy services.

The electronic health and paper records lacked a baseline care plan for the resident's admission on 7/12/21.

In an interview 11/3/21 at 12:45 PM, the Director of Nursing reported no baseline care plan could be found for Resident #101.

In an interview 11/4/21 at 9:10 AM, the MDS nurse reported she developed care plan for residents. The MDS nurse reported when Resident #101 admitted to the facility, she was on a leave of absence. The MDS nurse confirmed no baseline care plan had been completed for Resident #101.

The facility's Comprehensive Person Centered Care Plan policy, reviewed on 1/24/19, instructed a baseline care plan would be developed within

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

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

(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 655	Continued From page 49 48 hours of admission and updated when the resident's condition changed as applicable until completion of the comprehensive care plan. The initial information and goals on the baseline care plan were based on admission orders and resident input. A copy of the baseline care plan is provided to the resident or resident's representative and a care conference IDT (interdisciplinary) note documented.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		

F 656 Continued From page 50 F 656

(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, and staff and resident interviews, the facility failed to develop, implement and update a comprehensive person centered care plan for 4 of 19 residents reviewed, (Residents #2, #23, #50, and #53). The facility reported a census of 50 residents.

Findings:

1. The Minimum Data Set (MDS) assessment dated 10/6/21 indicated Resident #50 had a diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain.. The resident had a BIMS score of 15 of 15, indicating intact memory and cognition. Resident #50 required the assistance of 1 staff with bed mobility, transfers, toileting, and set up assistance for eating. The assessment documented that Resident #50 required a feeding tube. The MDS also

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

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

(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 656	Continued From page 51	F 656		

documented Resident #50 had moisture related skin damage during lookback period with ointment application.

Observation on 10/27/21 at 1:29 p.m. revealed Staff B, Licensed Practical Nurse (LPN) reviewed Resident #50's 10/21 Treatment Administration Record (TAR) and physician order for Dermaceptin to gastric tube (GT) site. Staff B donned gloves, placed a barrier on the resident's table, placed wound supplies on a barrier, removed paper tape from around GT site that had secured a moistened split 2x2 gauze. Staff B stated the drainage appeared to be gastric fluids. Two additional sites above the GT were observed and all three sites were red and excoriated. Resident #50 grimaced in pain with removal of the dressing. Staff B applied wound cleanser to open wounds, then she applied Dermaceptin ointment to all three wounds and covered only the GT site with a 2x2 split gauze dressing leaving the two other areas open to air. Staff B removed her gloves and washed her hands. Resident #50 stated the ointment drastically minimizes her pain as they felt like a burn.

During an interview on 11/4/21 at 9:09 a.m. Staff C, LPN/MDS Coordinator stated that Care Plans update quarterly and as needed. Staff C stated when updating a Care Plan she utilized Activities of Daily Living (ADL) sheets, History and Physical (H&P) records, and new physician orders. Staff C stated wound care would be on a resident's Care Plan. Staff C stated Care Plans update within 24 hours when the resident has a change. Staff C stated she often will work the floor and is not able to update the Care Plan.

The resident's Baseline Care Plan dated 6/9/21

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

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

(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 656	Continued From page 52	F 656		

lacked documentation of current or a history of skin integrity issues. The resident's current Care Plan dated 9/20/21 lacked documentation of Resident #50's actual skin breakdown, measures to prevent skin breakdown, staff directives, or physician ordered treatments from admission date of 6/9/21 to present.

The resident's Treatment Administration Record (TAR) dated 11/1 to 11/30/21 recorded:
a. Dermaciptin to Gastric tube (GT) peri wound skin twice per day (BID) and night shift for redness and excoriation. Start Date 7/19/21 -Discontinue Date 11/11/21.
b. Skin tears cleansed with normal saline (NS), apply steri strips, and dry dressing, or cover with Tegaderm (or equivalent), check every shift, change as needed (PRN) every 12 hours as needed for Skin Tear. Start Date 6/10/21.
c. Inspect split with each medication administration and change if soiled or wet only sign when the sponge changed every 4 hours. Document sponge change - Start Date 10/29/21.
2. Resident #2's MDS assessment dated 10/21/21 recorded diagnoses that included chronic kidney disease, Type 2 diabetes, and major depressive disorder. The MDS documented the resident had a BIMS score of 12, indicating moderately impaired memory and cognition. The MDS revealed the resident required dialysis while living at the facility.

Review of the physicians' orders dated 10/27/21 for Resident #2 revealed daily weights, direction to auscultate bruit (whooshing sound heard through a stethoscope of a fistula site), and palpate thrill (gentle vibration of fistula site) of Resident #2's new fistula every shift. A fistula is an abnormal connection of two body parts, such

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

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

(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 656	Continued From page 53	F 656		

as a vein and artery, done surgically.

Review of Resident #2's Care Plan lacked information regarding daily weights, auscultating the bruit, and palpating thrill of Resident #2's new fistula. The Care Plan also lacked guidance for taking blood pressure on the opposite extremity of the fistula.

During interview on 11/9/21 at 11:03 AM, Staff C stated resident weights are obtained monthly and weekly. The Staff C stated if a resident had any order besides monthly weights, she expected them to be on the care plan.

3. Resident #23's MDS assessment dated 9/8/21 documented Resident #23 had diagnoses of dementia, anxiety disorder, unsteadiness on her feet, dysphagia, muscle weakness, and difficulty in walking. The MDS indicated the resident had a BIMS of 11, indicating moderately impaired memory and cognition. The MDS assessment revealed Resident #23 displayed total dependence on two staff for transfers.

The resident's current Care Plan directed she required assistance of one staff for all transfers.

4. The admission MDS assessment dated 10/15/21 identified Resident #53 had diagnoses that included hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The resident had a BIMS score of 5, which indicated severe cognitive impairment. Resident #53 required the assistance of one staff for bed mobility, transfer, toileting, bathing, and personal hygiene, and set-up assistance for eating. The MDS indicated the resident was incontinent of bowel and

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

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

(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 656	Continued From page 54	F 656		

bladder, fell in the last month and last 2-6 months, and at risk for developing pressure ulcers/injuries, had moisture associated skin damage (MASD) and had pressure reducing devices for his chair and bed. The MDS also documented he required daily anticoagulant medication.

The Care Area Assessment (CAA) summary (a tool used in the development of the resident's care plan) triggered cognitive loss, communication, activity of daily living (ADL) function, urinary incontinence and indwelling catheter, falls, nutritional status, and pressure ulcer as problem areas that needed addressed. The CAA documentation indicated staff had a plan to proceed with care plan problems for cognitive loss, communication, ADL function, urinary incontinence and indwelling catheter, psychosocial well-being, mood state, activities, falls, nutritional status, pressure ulcer and pain.

The resident's Care Plan dated 10/21/21 revealed focus areas for Resident #53 that included long term placement at the facility, little or no activity involvement, impaired cognition, do not resuscitate code status, communication, and nutrition. The care plan lacked information pertained to his ADL needs, fall interventions, high risk mediations such as anticoagulants, catheter care and skin care

Review of current physician orders revealed Resident #53 had the following orders dated:
a. 10/8/21 Catheter related to urinary retention.
b. 10/12/21 Maintain 16 French/10 milliliter bulb Foley catheter to straight drain and change as needed for bypassing or occlusion.
c. 10/12/21 Foley catheter care q shift discontinue

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

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

(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 656	Continued From page 55 on 10/29/21. d. 10/29/21 Foley catheter care q shift. e. 10/12/21 Record Foley catheter output every shift. f. 11/05/21 Apply Collagen pad to coccyx wound bed, cover with bordered gauze and apply house barrier cream to surrounding area. Perform treatment daily at bedtime for coccyx wound and as needed. g. 10/08/21 Xarelto Tablet 10 milligrams (MG). Give 1 tablet by mouth one time a day for blood thinner. In an interview on 11/04/21 at 9:10 AM, Staff C stated that any wound care, catheters, falls, high risk medications etc. should be on the care plan so staff know how to care for the resident. Care plans were to be updated with any new orders within 24 hours. Staff C also stated there was currently not another nurse updating the care plans in her absence. A corporate nurse was trying to help out when able. Changes were also passed on to staff through report and in the communication tab in Point Click Care (facility medical records software). Per the MDS instructions in section V under the CAA Summary, it instructed that for each triggered Care Area, staff are to indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in the assessment of the care area. The Care Plan Decision column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the car plan.	F 656		
F 657 SS=D	Care Plan Timing and Revision	F 657		

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

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

(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 657	Continued From page 56 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident, family member and staff interviews and facility policy review, the facility failed to involve the resident and resident's representative in care conferences, and in making decisions about his or her plan of care and care plan development for 3 of 19 residents reviewed (Resident #5, #46, and #47).	F 657		

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

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

(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 657	Continued From page 57	F 657		

Findings include:

1. Review of the admission Minimum Data Set (MDS) assessment dated 7/30/21 revealed Resident # 5 admitted to the facility on 7/23/21 and had a diagnoses of diabetes, coronary artery disease, hypertension, renal insufficiency, chronic obstructive pulmonary disease, and Parkinson's disease. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderately impaired memory and cognition. The MDS indicated the resident having a family or a close friend involved in discussions about his care as very important.

The Progress Notes dated 7/23/21 - 10/24/21 lacked documentation regarding care conferences or discussions with the resident or resident's representative regarding his care plan.

The Electronic Health Record (EHR) recorded a care conference IDT (interdisciplinary team) notes on 10/23/21 and 10/29/21 only.

The facility records lacked documentation of care conferences held or discussion with the resident or resident's representative regarding his care plan.

In an interview 10/25/21 at 2:17 PM, Resident #5 reported he had never attended a care conference since admission to the facility. The resident reported he didn't know when care conferences were held.

In an interview 11/2/21 at 2:15 PM, Staff C, MDS Coordinator reported the Social Worker (SW) set up the care conferences. Staff C stated she was

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

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

(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 657	Continued From page 58	F 657		

uncertain who attended the care conferences or how often the care conferences held. Staff C acknowledged she had never attended a resident's care conference. Staff C reported she had worked at the facility for 6 months and recently acquired the MDS position.

In an interview 11/2/21 at 2:30 PM, the SW reported she printed off a MDS schedule to see which residents were due for MDS updates, and then set up care conferences for the residents. The SW stated she contacted family or the resident's representative and made them aware of whenever a care conference was due and arranged a date and time. The SW stated she also let the resident know about the care conference. The SW reported a care conference would be documented under the assessment tab in the EHR under "Care Conference". The SW reported care conferences were held within 3 weeks of a resident's admission, at least quarterly, or whenever the resident had a significant change.

In an interview 11/3/21 at 11:00 AM, the SW confirmed no care conference notes were present for Resident #5 other than the 10/23 and 10/29/21 notes. The SW stated there was a 3 week period when she hadn't worked at the facility and someone was supposed to cover for her in her absence.

The policy titled Interdisciplinary Care Plan Meeting, reviewed 1/24/19, revealed IDT meetings are held in conjunction with the completion of the resident assessment instrument (RAI) for all residents to facilitate the provision of necessary care and services to attain or maintain the highest practicable physical,

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

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

(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 657	Continued From page 59	F 657		

mental, and psychosocial well-being of the resident and to promote the participation of the resident, and if applicable, the resident's representative, family, or legal representative in the planning of care. IDT care plan meetings are held with an initial RAI assessment, quarterly, whenever significant changes, and as needed. The SW notified the resident and representative prior to each meeting and encourage them to attend the meeting and solicit their input. If unable to attend, documenta a note in the medical record and the steps used for inclusion of the resident / representative, as well as the care plan reviewed with the resident/resident representative. A care conference IDT note would be entered in the EHR.

2. The admission MDS assessment dated 4/21/21 revealed Resident #46 admitted to the facility on 4/14/21 and had a diagnoses of hemiplegia, seizures, asthma, depression, and anxiety disorder. The MDS documented the resident had a BIMS score of 14, which indicated intact memory and cognition. The MDS indicated the resident deemed having family or a close friend involved in discussions about her care as very important.

The Progress Notes dated 4/14/21 - 10/24/21 lacked documentation regarding care conferences or discussions with the resident or resident's representative regarding her care plan.

The EHR record revealed no care conference IDT (interdisciplinary team) notes.

The facility records lacked documentation of care conferences held or discussion with the resident or resident's representative regarding her care

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

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

(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 657	Continued From page 60 plan. In an interview on 10/26/21 at 9:43 AM, Resident #46 stated no care conference had been held since her admission to the facility 4/21. In an interview 11/03/21 at 11:00 AM, the SW stated the facility had no care conference notes for Resident #46. 3. The MDS assessment dated 10/8/21 recorded Resident #47 entered the facility on 1/27/21. Resident #47's MDS indicated a BIMS score of 3, indicating severely impaired memory and cognition. The resident's diagnoses included hypertension, diabetes mellitus, hyperlipidemia, quadriplegia, depression, and metabolic encephalopathy. The MDS indicated the resident deemed having family or a close friend involved in discussions about her care as somewhat important. The resident's Care Plan dated 10/8/21 identified Resident #47 planned long term care placement at the facility. An intervention by the SW included to invite the resident's family and/or significant other to attend care conferences by phone due to COVID 19 restrictions. The EHR recorded Resident #47's had a family member listed as the emergency contact and next of kin. The resident's Progress Notes from admission to 11/9/21 lacked documentation regarding care conferences. The EHR documented a care conference IDT (interdisciplinary team) note on 5/6/21 only.	F 657		

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

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

(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 657	Continued From page 61 The facility records lacked documentation of care conferences held or discussion with the resident or the resident's representative regarding her care plan. In an interview on 10/26/21 at 12:20 PM, Resident #47's family member reported the facility had not contacted him about care planning or the meetings to discuss the resident's goals. In an interview on 11/4/21 at 10:38 AM, the SW reported she notified the resident and resident's family of upcoming care conferences. She stated that approximately 2 weeks prior to the date of the care conference she sent out a letter to the family or representative notifying them of the upcoming care conference. She identified that she didn't always get them mailed out timely, and in such cases she called them instead to let them know of the care conference. She reported she offered the family or representative the ability to be involved in person (if able), by phone or virtually if they desired. The SW stated didn't document the contacts she had made to the families or representatives but knew she should document when contacted them. The SW stated she planned to begin scanning the letters sent into the EHR system.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

(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 658	Continued From page 62	F 658		

by:
1. The MDS assessment dated 10/10/21 revealed Resident #32 had cerebral palsy, non-Alzheimer's dementia, anxiety disorder, schizophrenia, and mild intellectual disabilities. The MDS documented the resident as totally dependent on one staff for dressing, and totally dependent on two staff for bed mobility and transfers. The MDS documented the resident had no falls and no skin problems during the look-back period

The care plan revised 7/9/21 revealed the resident required assistance with activities of daily living related to dementia, schizophrenia, and weakness, and had a potential for impaired skin integrity. The staff directives included perform a head to toe assessment weekly, report any bruises or open areas to the nurse, and apply TED hose in the morning and remove at bedtime (HS).

The Order Summary Report dated 9/3/21 revealed TED hose on during the day and off at HS for edema (swelling), and weekly skin checks by a licensed nurse every 7 days on day shift. Indicate "Y" if skin intact and "N" if skin not intact.

The treatment administration record (TAR) 9/1 - 9/20/21 and 10/1 - 10/31/21 revealed no staff initials documented for TED hose application 10/22 - 10/26/21 and 10/28/21, and only a checkmark documented on 10/27/21. The TAR revealed no staff initials documented for weekly skin checks by a licensed nurse on 9/13/21, 9/20/21, 9/27/21, 10/6/21, 10/13/21, 10/20/21

Review of the facility's EHR revealed staff completed the last initial wound assessment on

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

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

(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 658	Continued From page 63	F 658		

10/11/2020 and provided a weekly wound assessment on 10/20/20. The most recent skin observation tool assessment dated 6/7/21 revealed no new skin issues found.

The paper chart and EHR lacked documentation to show staff completed any other skin assessments.

Observation on 10/25/21 at 12:33 PM revealed Resident #32 wore fuzzy yellow and black striped socks on his feet and had a dark bruised area on his left shin/lower leg.

During observation on 10/27/21 at 12:30 PM, Resident #32 sat in a high back wheelchair. His feet rested on the wheelchair pedals and he wore bootie socks on his feet but no TED hose.

In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported staff should document skin assessments every week on the TAR if a resident had no open wounds or skin issues, and should document a weekly wound assessment or use the skin observation tool in the EHR if a resident had a skin problem.

In an interview 11/8/21 at 3:05 PM, the MDS Coordinator stated she expected staff follow to physician's orders and provide treatments as ordered.

2. The annual MDS assessment dated 9/22/21 revealed Resident #34 had diagnoses of Alzheimer's dementia, anemia, malnutrition, and cellulitis to her left lower limb. The MDS revealed the resident had a risk for pressure ulcer but had no skin conditions during the look-back period. The MDS documented the resident as totally

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

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

(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 658	Continued From page 64	F 658		

dependent on one staff for bathing and dressing.

The care plan revised 3/3/20 revealed the resident had a risk for skin issues and pressure ulcer development related to thin fragile skin, anemia, and protein-calorie malnutrition. The staff directives included inspect the resident's skin weekly, administer medications and treatments as ordered, and follow facility policies and procedures for prevention of skin breakdown.

The order summary report dated 11/4/21 revealed A & D ointment to BLE's BID at bedtime for dry skin had a start date 7/8/17, skin prep to bilateral heels at bedtime for prophylaxis had a start date 2/4/18, and weekly skin checks performed by a nurse every Monday on night shift had a start date 9/26/16.

The TAR dated 10/1-10/31/21 lacked the following documentation:
No A & D ointment applied to BLE's at bedtime 18 of 31 times,
No weekly skin checks documented on Mondays on 10/4, 10/11, 10/18, 10/25/21
No skin prep to bilateral heels at bedtime for 18 of 31 times.

3. The MDS assessment tool, dated 7/21/21, listed diagnoses for Resident #3 that included coronary heart disease, heart failure, diabetes, hypertension (high blood pressure), urinary tract infections, diabetes, hyperkalemia (high potassium), hyperlipidemia (high cholesterol), non-Alzheimer's dementia, multiple sclerosis, depression, schizophrenia, asthma, and respiratory failure. The MDS listed his BIMS (Brief Interview for Mental Status) score as 10 out

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

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

(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 658	Continued From page 65	F 658		

of 15, indicating moderately impaired cognition. The resident required assistance of 1 staff for bed mobility, transfers, and toilet use.

The Medication Administration Record (MAR) dated 10/1/21-10/31/21 revealed:

a. Insulin Detemir 100 unit/milliliter(ML) subcutaneously (SQ) at bedtime for diabetes. Inject 40 units at bedtime. The facility failed to administer insulin, assess resident blood sugar prior to administration, or document the site of the injection 14 of 31 doses.
b. Novolog insulin 100 unit/ML, inject 13 units SQ three times per day (TID) for diabetes. The facility failed to administer Insulin, assess resident blood sugar prior to administration, or document the site of the injection for 11 out of 93 doses.
c. Lisinopril tablet 10 milligram(MG), give 10 MG by mouth in the morning for high blood pressure, hold if systolic blood pressure (SBP) <100 or heart rate (HR) <60. The facility failed to follow parameters and hold medication, document SBP, HR, or to administer Lisinopril as prescribed for 11 of 31 doses.
d. Albuterol Sulfate Nebulization Solution 1.25 MG/ML. 1 application inhale orally via nebulizer every morning and at bedtime for COPD. The facility failed to administer 4 doses out of 62 and failed to document failed to monitor resident vital signs while administering nebulizer 16 out of 62 doses.
e. Metoprolol Tartate tablet 25 MG. Give 1 tablet by mouth two times(BID)per day for hypertension, hold if SBP <100 or HR <60. The facility failed to follow parameters and hold medication, document SBP, HR or to administer Metoprolol for 39 out of 62 doses.

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

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

(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 658	Continued From page 66 The MAR dated 11/1/21-11/15/21 revealed: a. . Insulin Detemir 100 unit/ML SQ at bedtime for diabetes. Inject 40 units at bedtime. The facility failed to assess resident blood sugar prior to administration for 1 of 15 doses between the dates 11/1-11/15/21. b. Novolog insulin 100 unit/ML, inject 13 units SQ TID for diabetes. The facility failed to administer Insulin, assess resident blood sugar prior to administration, or document the site of the injection for 21 out of 45 doses. c. Lisinopril tablet 10 MG, give 10 MG by mouth in the morning for high blood pressure, hold if SBP <100 or HR<60. The facility failed to follow parameters and hold medication, document SBP, HR, or to administer Lisinopril as prescribed for 11 of 15 doses. d. Albuterol Sulfate Nebulization Solution 1.25 MG/ML. 1 application inhale orally via nebulizer every morning and at bedtime for COPD. The facility failed to administer 1 dose out of 15 and failed to document failed to monitor resident vital signs while administering nebulizer 1 out of 15 doses. e. Metoprolol Tartate tablet 25 MG. Give 1 tablet by mouth BID per day for hypertension, hold if SBP <100 or HR <60. The facility failed to follow parameters and hold medication, document SBP, HR or to administer Metoprolol for 14 out of 30 doses. Physician Order Summary dated 10/25/21 listed the following medications: a. Insulin Detemir Solution 100 unit/ML, Inject 40 unit SQ at bedtime related to diabetes. b. Lisinopril Tablet 10 MG Give 10 mg by mouth in the morning related to hypertension hold if SBP or HR <60.	F 658		

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

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

(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 658	Continued From page 67	F 658		

Continued From page 67
c. Novolog Solution 100 unit/ML (Insulin Aspart) Inject 13 unit SQ TID related to type 2 diabetes mellitus.
d. Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth BID related to hypertension hold if SPB less than 100 or pulse less than 60.
e. Albuterol Sulfate Nebulization Solution 1.25 MG/3 ML 1 application inhale orally via nebulizer every morning and at bedtime related to COPD with acute exacerbation.

The facility did not have specific policies for nebulizer treatments or blood glucose monitoring.

4. The Minimum Data Set (MDS) assessment dated 10/6/21 indicated Resident #50 had a diagnosis that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The resident had a BIMS score of 15 of 15, indicating she is cognitively intact. Resident #50 required the assistance of 1 staff with bed mobility, transfers, toileting, and set up assistance for eating. Resident #50 had moisture related skin damage during lookback period with ointment application.

Physician order for weekly skin check by licensed nurse every day shift, every 7 days, start date of 6/10/21.
Physician order dated 7/9/21 revealed: Apply Dermaceptin to gastric tube (GT) site BID.
TAR dated 7/1-7/31/21 (start date of 7/19/21) revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 18 out of 24 doses, and 2 out of 5 weekly skin checks

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

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

(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 658	Continued From page 68	F 658		

documented.

TAR dated 8/1-8/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 12 out of 62 doses, and 4 of 4 weekly skin check assessments. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). All scheduled dressing changes completed as ordered.

TAR dated 9/1-9/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT zero out of 62 doses, and 3 out of 5 weekly skin check assessment. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). The facility failed to change the dressing 48 out of 186 scheduled dressing change times.

Facility document titled Medication Administration Record (MAR) dated 9/1/21-9/30/21 revealed:
a. Bactrim DS tablet 800-160 MG, give 1 tablet via GT BID for GT site infection until 9/26/21. Facility failed to administer medication 2 out of 19 doses.
b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 6 out of 31 doses.
c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 16 out of 124 doses.

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

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

(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 658	Continued From page 69	F 658		

Physician Order Summary (POS) dated 9/3/21 revealed:
a. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner).
b. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting.

TAR dated 10/1-10/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times.

Facility document titled Medication Administration Record (MAR) dated 10/1/21-10/30/21 revealed:
a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. Facility failed to administer medication 10 out of 31 doses.
b. Clodidogrel Bisulfate (Plavix)tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 10 out of 31 doses.
c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 36 out of 124 doses.
d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. Facility failed to administer medication 9 out of 31 doses.
e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation.

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

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

(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 658	Continued From page 70 Facility failed to administer 9 out of 31 doses. Physician Order Summary (POS) dated 10/11/21 revealed: a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. TAR dated 11/1-11/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times. Facility document titled Medication Administration Record (MAR) dated 11/1/21-11/30/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 3 out of 60 doses Physician Order Summary (POS) dated 11/9/21 revealed: a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting.	F 658		

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

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

(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 658	Continued From page 71	F 658		

6. Review of the MAR for Resident #23 revealed a doctor's order for norvasc and to hold the medication for systolic blood pressure (SBP) less than 100 and/or a heart rate lower than 60.

Record review of Resident #23's MAR 10/1 - 10/31/21 for the medication norvasc revealed 6 times medication refusal but without documentation, and 5 days without vitals completed prior to administering the medication.

In September, Resident #23 had 2 days without vitals completed with one day not receiving medication. In August, Resident #23 had one day with no vitals and medication not given that day. In July, Resident #23 had 2 days of no complete vitals with medication not given. In June, Resident #23 had 7 days without full vitals and 8 days unclear if medication was given. In May, Resident #23 had 10 days without complete vitals and 7 days unclear if medication was given. In April, Resident #23 had 20 days without vitals on the MAR and 8 days of vitals could not be found in the electronic MAR and Treatment Administration Record (TAR), and 11 days unclear if medication was given.

In an interview on 11/04/21 at 11:54 AM, the DON, stated they had no Plans of Service (POS) for Resident #23 for the months of April, May, June, and July. A POS is a document a physician signs to state what cares are to be done for medications and treatments for a resident. The DON stated the orders are good for 60 days and she expected the POS be done at least every 60 days.

In an interview on 11/04/21 at 09:16 AM, the MDS coordinator stated she entered orders when she

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

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

(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 658	Continued From page 72 worked and there was no double check system in place. 7. The Minimum Data Set (MDS) assessment dated 10/6/21 indicated Resident #50 had a diagnosis that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The resident had a BIMS score of 15 of 15, indicating she is cognitively intact. Resident #50 required the assistance of 1 staff with bed mobility, transfers, toileting, and set up assistance for eating. Resident #50 had moisture related skin damage during lookback period with ointment application. Physician order for weekly skin check by licensed nurse every day shift, every 7 days, start date of 6/10/21. Physician order dated 7/9/21 revealed: Apply Dermaceptin to gastric tube (GT) site BID. TAR dated 7/1-7/31/21 (start date of 7/19/21) revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 18 out of 24 doses, and 2 out of 5 weekly skin checks documented. TAR dated 8/1-8/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT 12 out of 62 doses, and 4 of 4 weekly skin check assessments. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document	F 658		

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

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

(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 658	Continued From page 73	F 658		

sponge (start date of 8/17/21). All scheduled dressing changes completed as ordered.

TAR dated 9/1-9/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to document the ointment applied to Resident #50's GT zero out of 62 doses, and 3 out of 5 weekly skin check assessment. TAR reported staff to inspect split with each medication administration and change is soiled or wet every 4 hours document sponge (start date of 8/17/21). The facility failed to change the dressing 48 out of 186 scheduled dressing change times.

Facility document titled Medication Administration Record (MAR) dated 9/1/21-9/30/21 revealed:
a. Bactrim DS tablet 800-160 MG, give 1 tablet via GT BID for GT site infection until 9/26/21. Facility failed to administer medication 2 out of 19 doses.
b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 6 out of 31 doses.
c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 16 out of 124 doses.

Physician Order Summary (POS) dated 9/3/21 revealed:
a. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner).
b. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting.

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

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

(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 658	Continued From page 74	F 658		

TAR dated 10/1-10/31/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times.

Facility document titled Medication Administration Record (MAR) dated 10/1/21-10/30/21 revealed:
a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol. Facility failed to administer medication 10 out of 31 doses.
b. Clodidogrel Bisulfate (Plavix)tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner). Facility failed to administer medication 10 out of 31 doses.
c. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 36 out of 124 doses.
d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn. Facility failed to administer medication 9 out of 31 doses.
e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation. Facility failed to administer 9 out of 31 doses.

Physician Order Summary (POS) dated 10/11/21 revealed:
a. Atorvastatin calcium tablet 20 MG, give 20 MG via GT at bedtime for cholesterol.
b. Clodidogrel Bisulfate(Plavix) tablet 75 MG, give 75 MG via GT daily for anti-platelet (blood thinner).
c. Metoclopramide hydrochloric acid (HCL)

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

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

(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 658		F 658		

Continued From page 75
solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting.
d. First-Omeprazole suspension 2 MG/ML, give 20 ML via GT in morning for heartburn.
e. Lactulose solution 10 gram (GM)/15 ML, give 20 ML via GT in the morning for constipation.

TAR dated 11/1-11/30/21 revealed, Dermaceptin to GT peri wound skin BID every day and night shift for redness and excoriation. The facility failed to apply medication 29 out of 62 doses, and weekly skin check assessment completed for 2 out of 4 weeks. TAR documented to inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times.

Facility document titled Medication Administration Record (MAR) dated 11/1/21-11/30/21 revealed:
a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting. Facility failed to administer medication 3 out of 60 doses
Physician Order Summary (POS) dated 11/9/21 revealed:
a. Metoclopramide hydrochloric acid (HCL) solution 10 MG/ML via GT before meals and at bedtime for nausea and vomiting.

Based on record review and staff interviews, the facility failed to ensure residents seen by a physician/provider at least every 60 days for 4 of 4 residents reviewed for physician visits. The facility reported a census of 50.

Findings include:

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

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

(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 658	Continued From page 76 Documentation revealed the physician signed the physician order summary (POS) for Resident #50 on 9/21, 10/21, and 11/21 and lacked documentation the prior 3 months. Documentation revealed the physician signed the POS for Resident #46 on 9/21, 10/21, and 11/21 and lacked documentation the prior 3 months. Documentation revealed the physician signed the POS for Resident #31 on10/21 and 11/21 and lacked documentation the prior 4 months. Interview on 11/04/21 at 11:54 AM the Director of Nursing (DON) stated they had no POS for Resident #23 for the months of April, May, June, and July. A POS is a document a physician signs to state what cares are to be done for medications and treatments for a resident. The DON stated the POS orders good for 60 days and she expected the POS completed at least every 60 days. Interview on 11/17/21 at 12:13 PM the DON stated they only had the POS for a few of the months in the past 6 months for Resident #50, Resident #46, and Resident #31.	F 658		
F 677 SS=D	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 clinical record review, observation and	F 677		

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

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

(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 677	Continued From page 77	F 677		

resident and staff interviews, the facility failed to follow the plan of care to provide bathing assistance at least twice per week for 3 of 19 residents reviewed (#29, #50, and #53). The facility reported a census of 50 residents.

Findings:

1. The Minimum Data Set (MDS) assessment dated 9/15/21 indicated Resident #29 had diagnoses that included hypertension (high blood pressure), chronic lung disease, gastroesophageal reflux disease (GERD), hyperlipidemia (high cholesterol), arthritis, anxiety, depression, schizophrenia, asthma, respiratory failure, chronic pain syndrome. The resident had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact memory and cognition. Resident #29 required supervision for personal hygiene activities and physical assistance during part of bathing.

During observation and interview with Resident #29 on 10/26/21 at 8:54 a.m., she stated she does not receive showers routinely as the facility is short of staff. The observation revealed the resident appeared disheveled with greasy hair and an odor of urine.

During observation and interview with Resident #29 on 10/27/21 at 10:17 a.m., the resident stated she had not received a shower, but today was her day. Resident #29 stated she required the assistance of 1 for showers. Resident #29 stated she can brush her teeth at her sink but is unable to wash herself, as staff does not routinely pass out clean towels and washcloths. The resident was dressed but appeared disheveled.

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

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

(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 677	Continued From page 78	F 677		

Interview on 10/27/21 at 10:39 a.m. with Staff B, Licensed Practical Nurse (LPN) revealed Resident #29 could not change her scheduled day or time of showers. At 1:36 PM, Staff B reported the facility did not have not enough staff present to assist Resident #29 with a bath today.

Interview on 10/28/21 at 10:45 a.m. with Resident #29 revealed she did not shower yesterday on the evening shift. Observation at the time of the interview revealed the resident wearing clean clothes and with continued greasy hair.

The resident's Care Plan dated 9/28/21 documented Resident #29 required the assistance of 1 staff member for bathing/showering twice weekly and as necessary. Resident #29 may refuse to take a shower, has been educated on why it is important to take a shower but per preference, may not want to with an initiation date of 8/20/18. The facility lacked documentation that Resident #29 refused showers.

The form titled Baths/Shower, for 10/21, recorded Resident #29 as scheduled to bathe/shower every Wednesday and Saturday and the resident received 1 bath out of 9 for the month.

Upon request, the facility could not provide a Bath/Shower log for the resident for 11/21.

Review of the resident's Progress Notes of 10/1 - 11/23/21 and the monthly Bath/Shower forms revealed no documentation that Resident #29 refused offered showers.

2. The MDS assessment dated 10/6/21 indicated Resident #50 had diagnoses that included

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

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

(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 677	Continued From page 79	F 677		

anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain.. The resident had a BIMS score of 15 of 15, indicating intact memory and cognition. Resident #50 required supervision and set up for bathing. Resident #50 had moisture related skin damage during lookback period with ointment application.

Observation and interview with Resident #50 on 10/25/21 at 3:38 p.m. revealed she does not receive two baths per week as staff told her they are short of help. Resident #50's clothes appeared clean without odor.

Interview with Resident #50 on 10/27/21 at 1:17 p.m. revealed staff do not deliver washcloths or towels. She stated she showered on 10/26/21. Resident #50 stated she does not receive a shower twice per week.

Observation on 11/2/21 at 12:45 p.m. revealed Resident #50 with uncombed hair and clean clothes. Interview revealed that today was her shower day.

During an interview on 11/4/21 at 9:09 a.m., with Staff C, LPN revealed residents might ask for a shower on any day regardless if scheduled or not. Staff C stated if the shower aide does not have time to bathe all of the assigned residents they report to the following shift to complete.

During an interview on 11/4/21 at 2:20 p.m., Resident #50 stated she did not receive a shower this week.

The resident's Care Plan dated 9/28/21 recorded

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

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

(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 677	Continued From page 80	F 677		

Resident #50 required staff assistance of 1 for bathing/showering twice weekly and as necessary.

The form titled Baths/Shower for 10/21 documented Resident #50 as scheduled every Tuesday and Friday for a bath/shower. Resident #50 received 4 showers out of 9 for the month.

The form titled Baths/Shower for 11/21 recorded Resident #50 as scheduled every Tuesday and Friday for a bath/shower. The resident had received 1 shower out of 5 planned for the month.

Review of the resident's Progress Notes of 10/1 - 11/23/21 and the monthly Bath/Shower forms revealed no documentation that Resident #50 refused offered showers.

3. The MDS assessment dated 10/15/21 for Resident #53 recorded the resident admitted to the facility on 10/8/21. The resident's diagnoses included hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive, and cystitis. The MDS identified a BIMS score of 5, indicating severe cognitive impairment. The MDS indicated the resident required the assistance of one staff person for bed mobility, transfers, toilet use, dressing, personal hygiene, and bathing.

The resident's Care Plan dated 10/21/21 for Resident #53 did not address his need for assistance with activities of daily living (ADL)

The forms titled Baths/Shower indicated the resident scheduled for showers on Wednesday mornings and Saturday evenings. Review of the 10/21 form indicated Resident #53 refused a

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

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

(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 677	Continued From page 81	F 677		

shower/bath on 10/27/21, and no other initials documented for the month. The resident received a shower on 11/3/21.

The Progress Note dated 10/9/21 at 3:13 AM recorded Resident #53 admitted to the facility and had a diagnosis of failure to thrive. The resident was alert and oriented and able to make his needs known. Resident #53 required minimal assistance with activities of daily living and stand by assistance of one with a walker to use the bathroom. The resident's skin had areas of dirt and he had very dry skin on his lower extremities. His oral care was poor. Staff provided hygiene supplies but resident declined to use them.

Observation on 10/25/21 at 2:19 PM revealed the resident's hair appeared greasy and unkempt. During interview at the time, the resident stated the staff helped wash him up and dress him. The resident denied that staff offered him a bath but stated he didn't need one because he was clean.

Observation on 10/26/21 at 8:35 AM revealed resident appeared unshaven and unkempt, and his hair greasy and standing straight up, and he had a lot of facial hair. The resident reported he had not had a shower since his admission to the facility. The resident stated staff washed his up and washed his hair with a wash rag. The resident reported he declined a shower because he didn't like them.

Observation on 10/27/21 at 10:49 AM revealed resident wore a hospital gown and lying in bed. The resident's hair appeared greasy and messy, and facial hair and food on his face. Resident stated the staff had him sign a sheet stating he did not want a shower today. Resident reported

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

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

(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 677	Continued From page 82 he didn't want a shower because he could not walk or stand for a shower. The surveyor explained to resident he could sit on a shower chair with wheels and have a shower that way. He then acknowledged that would feel good. He stated he showered at home but had not showered since coming to the facility because he thought he would have to walk and stand for it. Observation on 11/2/21 at 11:40 AM revealed the resident as unshaven and had dried food particles on his face and around his mouth. Observation on 11/3/21 at 8:59 AM revealed resident to be unkempt in appearance, with a dirty blanket and bed linens. Staff reminded him it was a shower day for him and the resident shook his head in acknowledgement. On 11/3/21 at 11:17 AM, Staff T, Certified Nursing Assistant (CNA) gave Resident #53 a shower as he sat in a wheeled shower chair. Staff T performed the shower by washing resident's hair and body thoroughly. Resident #53 tolerated the shower well but complained of feeling very cold. In an interview on 11/2/21 at 10:35 AM, Staff J, CNA reported they documented shower/bath in a bath/shower book. Staff J provided the bath/shower book that included a schedule of days when residents were scheduled to receive their bath/shower. In an interview on 11/9/21 at 10:12 AM, the Director of Nursing (DON) stated she expected residents to be offered a shower/bath a minimum of 2 times per week. The resident baths/showers were scheduled and placed on a calendar in the shower book at the nurse's station. If a resident	F 677		

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

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

(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 677	Continued From page 83 declined their scheduled bath/shower, she expected staff to re-approach the resident and encourage a bath/shower at a later time, however never forcing them to complete. It was her expectation staff were minimally recording baths/showers and any refusals on the Monthly Baths/Showers sheets. The DON stated a Shower Day Skin Audit needed to be completed as well with their showers/baths but felt it most important for the Shower Day Skin Audit to be completed with any new skin areas or prior areas of concerns noted. She stated the facility did not have a bathing policy but they did utilize a shower aide for consistency and to ensure baths were being completed. The DON reported staffing sometimes required the bath aide gets pulled to cover the floor. When this happened she expected the evening shift to assist completing showers the day shift did not complete. The DON concluded that staffing on the evening shift was often worse than on the day shift. 5. The MDS assessment dated 10/21/2021 reveals Resident #4 had diagnosis of COVID-19, weakness, and major depressive disorder. The MDS revealed the resident had a BIMS score of 7, indicating severely impaired cognition. The MDS revealed the resident required supervision of one staff for eating. The care plan revised 5/18/21 revealed the resident had a history of dysphasia (difficulty swallowing) and weakness. The care plan indicated the resident had a choking episode in the past.	F 677		

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

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

(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 677	Continued From page 84	F 677		

The MDS assessment dated 8/4/21 revealed Resident #10 had diagnoses of Type 2 diabetes, heart failure, major depressive disorder, and chronic kidney disease. The MDS indicated the resident had a BIMS score of 15, indicating cognition intact. The MDS revealed the resident required supervision of one staff for eating.

The care plan revealed the resident had COVID-19 and an ADL deficit related to limited mobility. The staff directives included to provide set up assistance and monitor for signs and symptoms of dysphasia.

The MDS assessment dated 9/8/21 revealed Resident #23 had diagnoses of dementia, anxiety disorder, and dysphagia. The MDS indicated the resident had a BIMS of 11, indicating moderately impaired cognition. The MDS documented the resident required supervision of one staff for eating.

The MDS assessment dated 10/1/21 revealed Resident #40 had diagnoses of Alzheimer's disease, dementia, major depressive disorder, aphasia (loss of ability to understand or express speech), anxiety disorder, and dysphasia. The MDS indicated the resident had a BIMS of 4, indicating severely impaired cognition.

Resident #40's care plan revealed the resident needed assistance of one staff for eating, and required a mechanical soft diet with pureed meats. The care plan revealed staff to observe Resident #40 at meals for signs of aspiration or choking and report to the physician as indicated.

The MDS assessment dated 10/1/21 revealed

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

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

(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 677	Continued From page 85	F 677		

Resident #48 had diagnoses of dementia, major depressive disorder, and dysphasia. The MDS indicated the resident's BIMS score 6, indicated severely impaired cognition. The MDS revealed Resident #48 required supervision of one for eating.

Observation on 10/25/21 01:56 PM revealed Resident #40was in her room with had food in front of her from lunch and eating small bites. The resident was in her room without supervision.

Observation on 10/27/21 at 12:51 PM revealed Resident #40 ate ice cream and unsupervised by staff.

Observation on 10/28/21 at 09:17 AM Staff I, CNA, entered an area near rooms 200 and 201 and brought food and check on residents (Resident #4, Resident #10, Resident #23, and Resident #48).

Observation on 10/28/21 at 09:34 AM staff left the area by rooms 200 and 201, where residents reside, and Resident #4, Resident #10, Resident#23, and Resident #48 still eating breakfast unsupervised.

Interview on 11/03/21 at 09:50 AM the DON stated she expected staff CNA watched residents in Covid area and/or assisted residents that were care planned as requiring assistance.

Interview on 11/09/21 at 11:02 AM the MDS coordinator stated if a resident care planned as needed supervision or assistance with eating, she expected staff watch the resident, even if the resident resided in the Covid area.

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

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

(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 678	Continued From page 86	F 678		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)	F 678		

§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on facility nursing staff assignments, facility's staff cardiopulmonary resuscitation certification record review, staff interviews, and policy review, the facility failed to ensure staff on duty for each shift had current certification and training in cardiopulmonary resuscitation (CPR) for 14 of 30 days reviewed. The facility identified a census of 50 residents.

Findings include:

During entrance conference with the Administrator on 10/25/21 at 9:40 AM, the surveyor requested a list of staff who had CPR certification.

Review of Nursing Staff Assignment sheets 9/25/21 to 10/24/21 revealed no CPR certified staff on duty during the following dates/times:
a. 6 AM- 6 PM: 9/25/21, 9/26/21, 9/28/21, 9/30/21, 10/4/21, 10/10/21, 10/11/21, 10/18/21
b. 6 PM-6 AM: 9/29/21, 9/30/21, 10/2/21, 10/3/21, 10/4/21, 10/10/21, 10/16/21, 10/17/21, 10/24/21

On 11/3/21 at 11:37 AM, the Administrator provided a list of residents who resided at the facility and their code status according to the resident or resident representative IPOST (Iowa

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

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

(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 678	Continued From page 87 Physician's Order for Scope of Treatment) consent. The facility identified 29 of 50 residents who requested a full code status for CPR initiated if resuscitation measures were indicated. In an interview on 11/1/21 at 03:00 PM, the Director of Nursing reported she provided the records of facility and agency staff CPR certificates, and no other staff had CPR certification. In an interview 11/2/21 at 12:10 PM, the Business Office Manager reported no other facility staff or agency staff CPR certifications could be found. The facility's CPR Policy, reviewed 1/14/21, instructed the facility will provide basic life support, prior to the arrival of emergency medical services (EMS) including initiation of CPR to a resident who experienced cardiac arrest (cessation of respirations and/or pulse) in accordance with the resident advance directives. Licensed employees maintained a current CPR certification through skills assessment training for healthcare providers. The procedure included upon assessment of resident without vital signs and had a full code status, the nurse initiated CPR immediately and continued CPR until EMS arrived.	F 678		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		

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

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

(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 684	Continued From page 88	F 684		

accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, and resident and staff interviews, and policy review, the facility failed to consistently provide and document skin and other assessments, failed to consistently provide and document physician ordered treatments (including dressing changes) and medications (including but not limited to diuretics, heart medications, insulin, and antibiotics), and obtain and document daily weights. Due to these failures Resident #101 underwent three hospital admissions for such conditions as edema, congestive heart failure, maggots in his wounds, cellulitis, urinary tract infection, and sepsis. The resident passed away in the hospital after the emergent transfer on 9/24/21. These factors constituted an Immediate Jeopardy to resident health and safety. The facility reported a census of 50 residents.

Findings include:

1. The admission Minimum Data Set (MDS) assessment tool dated 7/19/21 revealed Resident #101 admitted to the facility on 7/12/21 from the hospital with diagnoses that included debility, heart failure, atrial fibrillation, hypertension (HTN), diabetes, chronic obstructive pulmonary disease (COPD), weakness, and urinary retention. The MDS documented the resident scored 13 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant the resident demonstrated intact cognitive abilities. The MDS revealed the resident required extensive

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

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

(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 684	Continued From page 89	F 684		

assistance of one staff for transfers, ambulation (walking), dressing, personal hygiene, toilet use, and bathing. The MDS documented Resident #101 as at risk for pressure ulcers although he had no skin conditions or issues during the 7 day lookback period (07/13/21 - 7/19/21). The MDS also documented the resident experienced shortness of breath (SOB) upon exertion, when lying flat and at rest, used oxygen, and took no medications such as diuretics.

The 5 day MDS assessment dated 8/16/21 revealed the resident admitted from the hospital 8/9/21 and had difficulty walking and weakness. The MDS documented the resident had no skin conditions and took no medications such as diuretics or antibiotics during the 7 day lookback period (8/10/21 - 8/16/21).

The MDS assessment dated 9/2/21 revealed the resident readmitted to the facility on 8/26/21 from the hospital. The resident had a BIMS of 11 (moderately impaired cognitive abilities). The MDS documented the resident required extensive assist of 1 staff for bed mobility and extensive assist of 2 staff for transfers, toilet use, and bathing. The MDS revealed the resident had open lesions other than ulcers, and took a diuretic during all 7 days of the lookback period.

The care plan initiated on 7/23/21 revealed the resident had a diagnosis of congestive heart failure (CHF), COPD, and HTN. The staff directives included give cardiac and antihypertensive medications as ordered, monitor vital signs, and notify the physician of significant abnormalities. Other interventions included monitor/document/report as needed (PRN) any signs or symptoms of CHF such as dependent

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

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

(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 684	Continued From page 90	F 684		

edema of legs and feet, SOB upon exertion, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, increased heart rate, lethargy, and disorientation. The care plan also documented the resident had potential/actual impaired skin integrity related to fragile skin. The staff directives included encourage good nutrition and hydration in order to promote healthier skin, and follow facility protocols for treatment of injury. Staff added the resident's weight fluctuated up and down due to fluid and edema to the care plan on 8/16/21. The staff directives included to weigh resident weekly for 4 weeks, then monthly unless ordered otherwise, and monitor and report significant weight loss of 3 pounds (lbs.) in one week.

The electronic health record (EHR) census list revealed Resident #101 admitted to the facility on 7/12/21, admitted to the hospital 8/4/21, readmitted to the facility 8/9/21, admitted to the hospital 8/21/21, readmitted to the facility 8/26/21, and admitted to the hospital 9/24/21.

Review of hospital discharge orders dated 7/12/21 revealed Resident #101 had diagnoses that included heart failure with reduced ejection fraction (measurement of the percentage of blood leaving the heart each time it squeezes), diabetes Type 2, atrial fibrillation, COPD, and HTN. Discharge orders directed staff to weigh Resident #101 daily, complete vital signs per facility guidelines, give medications as prescribed, and call the physician if the resident gained 3 lbs., or exhibited SOB, or any other symptoms.

The document included the following education regarding heart failure:

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

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

(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 684	Continued From page 91	F 684		

-Heart failure means the heart muscle doesn't pump as much blood as the body needs.
-Fluids start to build up in the lungs and other parts of the body and cause SOB at rest, swelling/edema in the legs, ankles, and feet, weight gain over a day or two, and feeling bloated.
-Treatment for heart failure includes taking medications, checking weights and symptoms daily, and management of other health problems such as diabetes and high blood pressure.

The Nursing Admission Screening assessment dated 7/12/21 revealed the resident admitted to the facility for therapy with diagnoses that included diabetes and anemia. The assessment documented the resident weighed 171.5 lbs., had "normal" lung sounds, and had no pitting edema. Staff had left blank the assessment area under Section L.

A Pressure Injury Risk assessment dated 7/12/21 documented a score of 13, which meant the resident had a moderate risk for developing a pressure ulcer.

The medication administration record (MAR) dated 7/1 - 7/31/21 lacked documentation of the following:

-No diuretic listed on the MAR.
-No daily weights from 7/13 - 7/31/21
-No pravastatin (medication for cholesterol) administered on 7/14-7/16, and 7/30/21
-No amiodarone (for atrial fibrillation) administered on 7/30/21 x 1 dose
-No albuterol nebulizer treatment administered on 7/12/21 x 2 doses, 7/13/21 x 2 doses, and 7/31/21 x 1 dose. In addition, staff had circled

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

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

(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 684	Continued From page 92 their initials 8 times with regard to the scheduled albuterol medication, but failed to document the description or reason why they held or did not give the medication as ordered on the reverse side of the MAR or in the medical records. The MARS dated 8/1 -8/31/21 had admit dates 7/12/21, 8/9/21, and 8/26/21. The MARS lacked documentation for the following: No daily weights 8/1, 8/2, 8/11-8/21/21, 8/27, 8/29, 8/30/21 No Keflex (antibiotic) twice a day (BID) for cellulitis on 8/14/21 x 1 dose (Keflex ordered on 8/13/21) No sulfa for infection on 8/27/21 x 2 doses (sulfa ordered on 8/27/21 but "NA" (not available) circled on MAR 8/27/21) No metoprolol for HTN on 8/1- 8/4/21, and 8/27/21 No amiodarone on 8/1 - 8/4/21 No Lasix (diuretic) 20 milligrams (mg) on 8/19/21 No albuterol nebulizer treatment administered 8/14/21 x 2 doses, 8/19/21 x 2 doses. The MAR dated 9/1- 9/30/21 lacked documentation for the following: No daily weights - 9/8/21, 9/11/21, 9/14/21, 9/19/21, 9/22/21 No metoprolol on 9/19/21 No potassium chloride on 9/14/21 and 9/19/21. No amiodarone given 9/19/21 (AM dose) and 9/22/21 (PM dose) No Lasix 40 mg given on 9/19/21 No albuterol nebulizer treatments 9/11/21 x 1 dose, 9/19/21 x 3 doses, 9/20/21 x 2 doses, 9/22/21 x 1 dose, 9/23/21 x 3 doses	F 684		

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

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

(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 684	Continued From page 93 The treatment administration record (TAR) dated 7/1 - 7/31/21, 8/1-8/31/21, and 9/1-9/20/21 lacked documentation for the following: No entry for oxygen tubing change 7/13/21-7/31/21 No oxygen tubing change on Wednesdays 8/11/21, 8/18/21 No neomycin/polymycin ointment to left eye 7/12-7/15, 7/19/21, 8/3, 8/10, 8/11, 8/13-8/16, 8/18, 8/27/21 (total of 18 of 40 doses not administered). In addition, staff initials circled 6 times but no description or reason documented on reverse side of MAR or in the medical records why medication not administered. Treatment to cleanse bilateral lower extremities (BLE) and cover with Kerlix daily for cellulitis (started 8/14/21) left blank /not done on 8/14, 8/17, 8/27, 8/30, 8/31/21, 9/1, 9/3/21 Treatment to cleanse BLE with soap and water, apply ABD pads to absorb drainage from legs, Kerlix, and secure with tubigrip BID- left blank/not done on 9/11, 9/12, 9/16, 9/17, 9/18, 9/19, 9/20, 9/22, 9/23/21 = total of 9 of 34 times not documented/done Assess left arm for sign/symptoms of infection and note appearance BID and change dressing PRN -left blank /not done 6 out of 20 times on 9/16, 9/18. 9/19, 9/22, 9/23, 9/24/21 Staff B wrote on TAR new order to cleanse BLE daily and apply A & D ointment, cover with ABD pads, wrap with Kerlix and ace wraps per nursing order, but entry not dated and had no initials for dates when the treatment completed. The MAR and TAR lacked documentation for weekly skin assessments. The EHR lacked documentation for skin observations or weekly wound assessments.	F 684		

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

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

(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 684	Continued From page 94	F 684		

The monthly bath/shower schedule revealed Resident #101 admitted on 7/12/21 and scheduled for shower on Wednesdays and Saturdays on the 6-2 shift. The schedule revealed no bath or shower given 7/12 - 7/20/21, or 8/7/21.

The Shower Day Skin Audit forms documented no skin abnormalities, open areas, unusual skin conditions, or reddened areas 7/24/21, 7/28/21, 9/6/21, 9/13/21, 9/16/21, and 9/23/21. The shower skin audit form 9/11/21 documented the resident had an abrasion, skin tear, and unusual redness but no nurse signature listed as reviewed the report and looked at the skin issues noted by the certified nursing assistant (CNA).
The records lacked shower day skin audit forms for the month of 8/2021.

The EHR revealed the following weights recorded:

7/12/21 at 4:11 PM 171.5 lbs.
7/20/21 at 12:22 PM 171.0 lbs.
7/27/21 at 10:53 AM 192.5 lbs.
7/28/21 at 4:04 PM 179.5 lbs.
8/12/21 at 11:25 AM 176.6 lbs.
8/20/21 at 2:07 PM 176.0 lbs.
9/3/21 at 3:33 PM 184.6 lbs.
9/5/21 at 2:10 PM 189.2 lbs.

A chest x-ray (CXR) report dated 7/18/21 revealed the resident had SOB and low oxygen saturations. The findings revealed hyper expanded lungs that could be seen in COPD, a small right pleural effusion, and evidence of pulmonary congestion. The CXR also showed scattered bilateral opacities compatible with

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

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

(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 684	Continued From page 95	F 684		

pulmonary edema versus atypical infection.

Daily skilled summary notes included the following:

On 8/2/21 temperature (T) 98.3, pulse (P) 64, respirations (R) 20, blood pressure (B/P) 138/74, pulse oximeter (PO) 95%. The resident had generalized scabs (no location listed) but no open areas, and pitting edema to BLE's. Weight stable.
On 8/3/21 - same vital signs listed from 8/2/21. Resident had generalized scabs, no open areas, and pitting edema to BLE's. Weight stable.
On 8/4/21 - same vital signs listed from 8/2/21. Resident had open areas, generalized scabs, and pedal edema. Weight stable.

An Emergency Department (ED) provider note dated 8/4/21 revealed the resident presented to the ED with bilateral leg swelling and leakage, and the swelling had spread to his abdomen. The resident denied chest pain, SOB, or chills. Weight 189 lbs. The resident had 3+ edema to lower legs extending to his abdomen. The resident previously hospitalized 7/5 - 7/12/21 for CHF exacerbation and atrial fibrillation. Ejection fraction 30 %. No diuretic listed on patient medication list although there is reference he was on bumex (diuretic) in the discharge summary. A chest x-ray showed worsening CHF with pulmonary edema vs. superimposed pneumonia and probable small right pleural effusion. Treatment included IV Lasix drip.

An After Visit Summary dated 8/9/21 revealed an order to start taking furosemide (Lasix) 40 mg BID and potassium chloride 20 milliequivalents (meq) daily. A medication list included the

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

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

(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 684	Continued From page 96	F 684		

medications to start and the medications to continue, except no Lasix listed. Care instructions included to take medications as prescribed, weigh daily, and call physician if resident had weight gain 2-3 lbs. in a day or 5 lbs. in a week.

The Nursing Admission Screening assessment dated 8/9/21 revealed the resident admitted to the facility from the hospital with heart failure. The assessment indicated the resident had normal lung sounds, slight pitting edema, lower extremity swelling, and scabs to his upper and lower extremities. Weight 179.5 lbs.

A physician order dated 8/13/21 revealed to start Lasix 40 mg for 5 days, then Lasix 20 mg daily, start Keflex 500 mg BID for 10 days for cellulitis, cover open areas on BLE's, and wrap with Kerlix daily until healed.

The progress notes revealed the following:

a. On 7/13/21 at 3:12 PM, nurse practitioner (ARNP) saw resident on 7/12/21 after resident admitted to the facility from the hospital. Resident seen in the ED on 7/5/21 for weakness and falls. Diagnoses included atrial fibrillation and CHF. Resident had history of diabetes type 2, COPD, and coronary artery bypass graft (CABG). No lymphadenopathy or bruising noted. Lungs clear to auscultation. Plan included to perform skin checks per protocol.
b. On 7/17/21 at 3:33 AM, resident awake most of the night and needed encouragement to lay down and wear oxygen as his oxygen level dropped whenever he got up without oxygen.
c. On 7/17/21 at 10:54 AM, staff found resident on floor lying on his right side with a large amount

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

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

(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 684	Continued From page 97 of blood from his right forehead. Assessment done. Sent to the ED. d. On 7/18/21 at 10:15 AM, resident complained of SOB and feeling trapped in his body. B/P 112/58, T 97.7, P 53, R 24, PO 87% on oxygen at 3 liters per nasal cannula (L/NC). Resident refused to go to the ED. ARNP notified and ordered a stat CXR. e. On 7/18/21 at 12:00 PM, ARNP notified of CXR report and ordered Prednisone 40 mg for 5 days. f. On 7/19/21 at 7:47 PM, seen by ARNP due to SOB and hypoxia. CXR on 7/18/21 showed COPD exacerbation, scattered opacities, and a small right pleural effusion. Order to continue prednisone. g. On 7/27/21 at 4:15 AM, antibiotic arrived early this AM and will start on day shift 7/27/21. Drainage continues at this time. h. On 8/2/21 at 3:37 AM, has BLE edema 1+. Resident encouraged to elevate extremities. i. On 8/4/21 at 5:50 PM, resident admitted to hospital for exacerbation of CHF. j. On 8/5/21 at 11:20 AM (late entry), certified medication aide (CMA) brought to nurse's attention the resident appeared to be filling up with fluid. Resident had edema up past abdominal area. ARNP notified and order received to send resident to the ED for evaluation. K. On 8/10/21 at 5:41 AM, resident on oxygen at 3 L/NC. Pulse ox 92 %, lungs sound clear. On nebulizer treatment every 4 hours. Has 2-3+ pitting edema and redness to lower legs. l. On 8/11/21 at 5:45 AM, resident encouraged to elevate BLE but noncompliant. BLE reddened, has 2-3 + pitting edema, and legs draining serous fluid. j. On 8/13/21 at 8:22 PM, seen by ARNP for increased edema to BLE and weeping from open	F 684		

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

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

(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 684	Continued From page 98 areas. Has pitting edema 3+ to BLE. Weeping clear fluid to the point his socks are saturated. Skin around open area had redness and warmth. Diagnosed with cellulitis to bilateral lower limbs. New orders included: Lasix 40 mg daily for 5 days, then Lasix 20 mg daily. Keflex 500 mg BID for 10 days for cellulitis. Cover open areas to BLE and wrap with Kerlix daily until area healed, monitor edema, vital signs per protocol, and skin checks per protocol. k. On 8/20/21 at 8:29 AM, seen by ARNP. New order for Lasix 40 mg BID. l. On 8/21/21 at 11:29 AM, Staff B, Licensed Practical Nurse (LPN), called to the shower room. Resident #101 sat in a shower chair, dressing from lower legs and feet lying on floor. Dressing saturated with yellow fluid and smelled strongly of ammonia, and covered with maggots. Maggots observed in various stages of growth on resident legs and heels bilaterally. The dressing removed had date 8/17/21. Corporate Nurse and ARNP notified. Order received to send to the ED for evaluation and treatment of infested wounds. Resident was showered and legs wrapped in dry rolled gauze. Sent to the ED. m. On 8/22/21 at 11:40 AM, resident admitted to hospital for wound care. On IV vancomycin and rocephin (antibiotics for bacterial infections), and wound care consulted. n. On 8/29/21 at 8:39 PM, seen by ARNP on 8/27/21 for readmission to facility. Resident sent to ED on 8/21/21 after staff reported a strong ammonia smell and maggots to BLE. Treated with IV antibiotics and returned to the facility. Plan included orders to continue Bactrim, wound cares as ordered, Lasix as ordered, and skin checks per protocol. o. On 9/2/21 at 3:20 PM, attempted to place bilateral foam boots on resident to offload due to	F 684		

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

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

(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 684	Continued From page 99	F 684		

feet on pedals and he requested a blanket under his feet.
p. On 9/3/21 at 6:48 AM, left heel wound 3 centimeters (cm) x 3 cm open area and behind right great (toe) a 1.4 cm x 1 cm superficial area.
q. On 9/5/21 at 2:12 PM, BLE weeping secondary to edema. BLE cleansed with wound cleanser, A & D ointment applied to BLE's and ABD pads wrapped around calves, then rolled gauze and ace bandages applied to aide with edema. Resident encouraged to elevate his legs but he reported it is painful.
r. On 9/14/21 at 2:00 PM, resident has bilateral edema in lower extremities. Lower legs weeping and treated BID.
s. On 9/20/21 at 6:55 PM, seen by ARNP for edema and CHF. Edema worsened. Staff reported resident drinks fluids constantly and not always compliant with keeping legs elevated. Has 3+ pitting edema to BLE and weeping clear fluid. Lung sounds clear. Plan included: start 1500 ml fluid restriction, Lasix as ordered, vital signs per protocol, and monitor edema.
t. On 9/24/21 2:40 AM, resident had notable change in status. Complained of nausea, respiratory effort increased, increased fluid retention, and had decreased level of consciousness. Vital Signs included T 96.6, P 42, R 24, B/P 90/58; ARNP notified via phone and message left. Family notified. Transferred to the hospital.

Daily skilled summary included the following:

a. On 8/19/21, resident had open areas but no pressure ulcers. "NA" (not applicable) documented under section 4b for wound assessment. Resident had pedal edema but weight stable. The assessment lacked lung

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

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

(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 684	Continued From page 100 sounds and location of open areas. b. On 8/20/21, resident had open areas with generalized scabs, and pitting edema to BLE's. The bilateral lung bases had wheezing on expiration. The EHR/paper chart lacked a daily skilled summary assessment on 8/21/21. A physician order dated 8/21/21 directed staff to send resident to the ED for evaluation and treatment of infected wounds. An ED provider note dated 8/21/21 revealed the resident presented to the ED for evaluation of lower extremity pain from his feet to his upper lower legs, wounds, and increased drainage to his lower legs. A few open areas had purulent drainage, and had macerated areas between his toes on bilateral feet. Resident reported uncertain how long he had wounds but had increased redness and pain to his lower extremities. The resident reported his legs had only been wrapped once at the nursing facility. EMS reported concern for maggots to his lower extremities. Resident admitted to hospital for BLE cellulitis with open wounds. IV antibiotics vancomycin and ceftriaxone administered, and a wound nurse consulted. A hospital history and physical dated 8/21/21 revealed the resident sent to the ED with lower extremity wounds. The resident complained his legs were very painful the past couple of days. The resident told the physician his legs had only been wrapped once at the nursing facility. EMS brought the resident to the ED, and reported maggots but no maggots observed by ED staff. BLE's had erythema with open wounds, maceration around the toes, and purulent	F 684		

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

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

(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 684	Continued From page 101	F 684		

drainage. Weight 185 lbs. Diagnoses included BLE cellulitis with open wounds. Treatment included IV vancomycin and ceftriaxone, furosemide 40 mg BID, oxygen at 2 L/NC, and wound consult. The resident was previously hospitalized 8/4 - 8/9/21 for diagnoses of CHF, and diuresed after he had IV Lasix.

A physician's verbal order dated 9/7/21 included to cleanse bilateral legs with soap and water, paint left great toe and bilateral heels with betadine, and apply ABD pads to absorb drainage from legs from shin to knees, apply Kerlix, and tubigrip.

Specialty Wound Physician notes documented the following:

a. On 7/22/21, resident had a bruise/contusion to right upper arm and a wound (2 cm x 1 cm x 0.2 cm) to the side of his nose due to eye glasses. No edema to LE's.
b. On 8/12/21, resident status post hospitalization for CHF exacerbation. Resident had a wound (2 cm x 1 cm x 0.1 cm) to the side of his nose due to eye glasses, and skin tear to lateral elbow. Right distal elbow wound resolved.
c. On 8/19/21, resident asked about swelling in his legs. BLE's had severe edema, heavy weeping, and the dressings on his legs soaked. No evidence of any open areas. Diagnoses included chronic venous insufficiency and diabetes. Treatment recommendations included elevation of legs, utilize absorbent pads with Kerlix wrap dressings, monitor for moisture associated wounds given the large amount of weeping, and consider compression with tubigrip to LE's BID.
d. On 9/2/21, resident had a left posterior ankle

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

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

(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 684	Continued From page 102	F 684		

wound 2 cm x 3 cm x immeasurable. The wound had heavy serous drainage and black necrotic tissue to the wound bed. He also had an unstageable pressure wound to his right lateral first toe 1.5 cm x 1.5 cm with 90 % necrotic tissue. Recommendations included to float heels, elevate BLE's, and apply tubigrip socks every AM.
e. On 9/9/21, BLE's had moderate edema and stasis dermatitis. Wounds and moderate edema present. Right lateral first toe wound resolved. The left posterior heel wound measured 2 cm x 3 cm and had 50 % black necrotic tissue. Right anterior knee wound measured 2 cm x 1.5 cm x 0.1 cm and had moderate serous drainage. Right proximal medial shin wound measured 1 cm x 2 cm x 0.1 cm and had moderate serous drainage. Left anterior knee wound measured 1.5 x 1.5 x 0.1 cm and had moderate serous drainage.

Daily skilled summary assessment notes dated 9/20/21 and 9/23/21 revealed resident had fragile skin and open areas. The assessment included under Section 4-2b regarding skin condition to "see skin sheets". BLE had arterial ulcers and edema.

An ED provider note dated 9/24/21 revealed resident brought to the ED by EMS for wet lungs and 4+ pitting edema. The resident had diminished lung sounds bilaterally, and chronic bilateral leg wounds. Diagnoses included acute cystitis, bradycardia, hyperkalemia, and acute kidney injury secondary to urinary retention.

A hospital history and physical note dated 9/24/21 revealed the resident presented to the ED (on 9/21/21) for complaint of SOB, bradycardia (heart rate 40-50's), and hypotension. The resident had wounds on bilateral leg and pitting edema from

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

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

(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 684	Continued From page 103	F 684		

his abdomen to his extremities. Weight 187 lbs. CXR showed a small pleural effusion and mild pulmonary edema or atypical infection.

A hospital discharge summary dated 9/30/21 revealed Resident #101 passed away on 9/30/21.

In an interview 10/28/21 at 10:45 AM, Staff L, agency CMA, stated she had worked at the facility 3 months. Staff L reported Resident #101 had a lot of wounds all over his hands, face, and arms. The resident had a hard time breathing and incoherent at times. Some weeks he barely would eat food or drink fluids, then other times he would gorge himself with food and fluids. Staff L stated she assisted the nurse whenever a treatment and bandages applied to his legs. The resident had edema in his buttocks and legs, and his legs had fluids that seeped out.

In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported skin assessments documented weekly on the TAR if a resident had no skin issues. The DON stated she expected staff document in the EHR a weekly wound assessment or use the skin observation tool if resident had a skin concern noted.

In an interview 11/1/21 at 2:35 PM Staff B, Licensed Practical Nurse (LPN) reported she had worked at the facility since 7/2019. Staff B stated each resident supposed to have a skin assessment performed at least weekly, and skin assessment typically performed during resident cares or on their shower day. Staff B reported skin assessments documented in the treatment book by initialing the TAR if no areas of concern identified. If a skin issue or concern noted, then the nurse documented a skin note in the nursing

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

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

(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 684	Continued From page 104 progress notes on the EHR. Staff B stated if a resident had diagnosis of CHF, the standard of cares included apply oxygen, encourage resident to sit with feet elevated due to dependent edema, monitor lung sounds, administer diuretic as ordered, monitor for edema, and monitor weights daily to weekly depending upon the resident. Staff B stated obtaining weights considered a nursing intervention, and no physician order needed for weights. Staff B stated the CNA's wrote weights on paper and the nurse recorded the weights on the TAR, but the nurse had to remind staff to obtain weights on residents. If a resident took a medication such as Lasix prior to going to the hospital, and returned to the facility not on a diuretic medication, it would be a red flag, and the nurse needed to call the physician and check if he/she wanted Lasix or a diuretic continued or discontinued. Staff B stated a number of agency staff worked at the facility, and not as familiar with residents or realized a resident took a diuretic or other medication or the treatments prior to hospitalization and thus it would not be a red flag or as obvious to agency staff. Staff B reported changes for care plan not always communicated. Staff B reported Resident #101 had edema so bad, fluid leaked out of his legs. They applied A & D ointment, a nonstick dressing, ABD dressing, Kerlix, and ace wraps on his legs. However, she thought the treatment and dressing changes not done as often as it should've been. On the day Resident #101 went to the hospital, one of the CNA's requested Staff B to come to the shower room right away. When Staff B arrived to the shower room, the resident's dressing from his legs lay on the floor covered with maggots. Staff B reported she saw the maggots crawling on his leg, and feet in-between his toes. Staff B reported she	F 684		

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

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

(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 684	Continued From page 105	F 684		

rinsed his legs off then applied a Kerlix dressing to his legs, and sent him to the hospital. Both of his legs appeared red and macerated, and looked like hamburger, and his heels and calves looked macerated and wet. Staff B reported 8/21/21 as the date of the incident. The date listed on the dressing was 4 days old (8/17/21). The resident's treatment should've been on the paper MAR for staff to perform the treatment but doesn't think it was listed on his TAR or MAR. His legs got progressively worse, and nobody was brave enough to call the physician or follow up and get his treatment changed.

In an interview 11/02/21 at 10:35 AM Staff J, agency CNA, reported they had a bath/shower book for the CNA to document whenever they gave a resident a shower/bath. Staff J showed the surveyor the bath/shower book that also included a schedule in the front of the book for days/shift when a resident scheduled for a bath/shower.

In an interview 11/02/21 at 10:40 AM, Staff C, LPN, reported shower sheets filled out with a skin assessment. The completed paper shower/bath sheets located in medical records.

In an interview 11/02/21 at 11:44 AM, Staff C, LPN, reported skin assessments documented under the assessment tab in the EHR. Staff C reported no other areas where staff documented skin assessments other than the bath audit sheets. Staff C stated she also documented skin check in the MDS section M whenever a MDS assessments completed.

In an interview 11/03/21 at 11:20 AM, Staff F, CNA, reported she had worked at the facility

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

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

(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 684	Continued From page 106 since 10/2020 and assigned as shower aide and CNA. Staff F stated she notified the nurse whenever a resident had a change in condition or had a skin issue. Staff F reported she filled out a shower skin audit form whenever she gave a resident a shower, and marked on the body map if she noticed any kind of skin issue. She gave the shower sheet to the nurse, and initialed the shower book whenever a shower completed. Staff F reported Resident #101 had very fragile skin and always had fluid leaking from his legs. During his shower, she used disposable wipes on his legs because the washcloths were rough and tore the skin on his legs. The nurses wrapped his legs with gauze. In an interview on 11/3/21 at 1:45 PM, an ED nurse stated when Resident #101 came to the ED on 8/21/21, his legs were extremely weepy, and stuck to the blankets. His legs were supposed to be wrapped at the care facility but looked like they hadn't been changed in weeks. The ED nurse stated no date listed on the dressings when he came to the ED. She asked the resident if someone at the care facility was supposed to help him get ready and the resident said yes. The ED nurse reported if staff at the care center helped him put his pants on they would've seen his soiled and wet dressings. The ED nurse reported when they removed the dressings on Resident #101's legs, his legs were very edematous, had blisters, pitting edema, and his legs were weeping. EMS reported there were maggots in the wound but she did not see any maggots. Resident #101 admitted to the hospital with cellulitis to both legs and a urinary tract infection (UTI), and received IV antibiotics. The ED nurse reported the resident discharged 8/26/21 and sent back to the care facility, but then	F 684		

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

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

(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 684	Continued From page 107	F 684		

came back to the ED on 9/24/21. He later went into arrest and passed away.

On 11/04/21 at 09:50 AM, the administrator reported no other shower or bath sheets were found for Resident #101.

In an interview 11/4/21 at 11:10 AM, Staff V, agency LPN, reported weekly skin check documented on the TAR. Staff V stated if a resident had any open areas or skin issues, document under assessment tab on the skin observation tool in the EHR. If a resident had no skin issues, then documented a note on the skin observation tool "no skin issues". The MDS nurse entered orders in the EHR whenever a resident came from the hospital. Staff V stated the admission assessment usually done by the MDS nurse.

In an interview 11/4/21 at 1:20 PM, Staff I, agency CNA, reported she had worked at the facility for 3 months. Staff I stated whenever a resident had a change in condition or a skin issue, she let the nurse know right away. Staff I reported she had a horrible experience one day when she took Resident #101 to the shower room. She gave Resident #101 a shower on his previous shower day before 8/21/21, and a nurse put bandages on his legs after she gave him his shower. The resident was supposed to have dressing changed on his legs every shift, but she noticed the date on the dressing she saw on 8/21/21 was over 3 days old. Resident #101's legs were usually wet from his knees down. On 8/21/21, the nurse told her to remove the bandages on his legs in the shower. When she removed the bandages, they were dripping with fluid and there were what appeared to be maggots on both of his legs - it

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

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

(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 684	Continued From page 108	F 684		

was horrible! When she removed his socks, there were maggots that fell out of his heel, and they were coming out of the sores on his legs. She requested Staff B, LPN, come to the shower room right away. The dressing had the date and initials of when the dressing was changed last. The nurse took pictures, she was so upset. Staff B told her to wash his legs off, so she tried to clean his legs as much as possible. The resident complained of his legs burning. EMS came into the shower room and took him to the ED. Resident #101 had open sores everywhere. He had sores and maggots on his right leg at the top of the calf, right shin, left shin, and the majority of maggots came out of his left heel. The maggots were in various colors brown, white, and tan. There were dead ones, live ones, little ones, and big ones. She had seen maggots before at another facility where she worked so when she saw the maggots on Resident #101's legs, she was familiar with what it was.

In an interview 11/8/21 at 9:00 AM, Staff BB, LPN, reported she only workedat the facility 8 weeks for an agency assignment. Resident #101 had CHF, and his legs had sores and weeping. He ended up going to the hospital but unsure why. She cleansed and wrapped his legs with gauze, sometimes BID, then daily, and as needed. Staff BB reported treatments documented on the paper MAR located on the treatment cart. Skin assessments documented on paper MAR. Staff BB stated the CNA's did some skin assessments whenever they gave the resident a shower, and the CNA signed off if the resident had no skin issues. If the resident had a skin concern then the nurse called the physician to get orders. Staff BB reported if a resident had diagnoses of CHF, she monitored intakes and outputs, limited salt

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

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

(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 684	Continued From page 109	F 684		

use, ensured Lasix administered, and took care of wounds if the resident had wounds. Resident #101 noncompliant with elevating his legs and had oxygen. Staff BB reported at times she was the only nurse working. If couldn't get things done, she would call someone in to help her, or step in and work as a CNA in order to get the job done.

In an interview 11/8/21 at 12:10 PM the Nurse Practitioner reported she expected staff to notify her immediately if a resident had a change in condition or something happened. Resident #101 went to the hospital for heart failure. He always had edema in his legs, but one of the nurses reported he had increased edema in his abdomen. He had orders for Lasix. He had horrible open areas on his legs, and had a daily treatment for non-adhesive dressing and Kerlix daily. She ordered daily weights, but when Resident #101 refused daily weights, she requested staff obtain weights at least weekly. One of the nurses called her on Saturday 8/21/21 and reported maggots were found when she removed Resident #101's dressings on his legs. She told the nurse to send the resident to the ED. At that time, the facility had a lot of flies. The nurse practitioner confirmed if dressing changes were not done for 3 days or more, maggots could develop and be seen in the wound. The surveyor reviewed orders written for medications, antibiotics, and treatments. The nurse practitioner confirmed she was aware nurses had not given the medications. The nurse practitioner reported the facility had been short staffed, and had dealt with staffing issues for a while. The nurse practitioner stated whenever she wrote orders, often times orders were not done. The nurse practitioner reported Resident #101 may

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

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

(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 684	Continued From page 110	F 684		

Continued From page 110

not have gone to the hospital if orders and treatments had been completed, and if treatments and dressing changes had been done as ordered, the resident would not have had maggots develop in his wounds.

In an interview 11/8/21 at 3:05 PM, Staff C, LPN/MDS nurse reported she had worked at the facility for 6 months, but was on a leave of absence, and returned in 8/2021. Staff C reported she saw Resident #101 when he readmitted to the facility on 8/9/21, and completed his admission assessment. Staff C stated she observed a little bit of edema and swelling in his legs on 8/9/21, but then he had pitting edema 2-3+ a day or two after he returned to the facility. His lungs sounded clear on 8/9/21. Staff C reported the resident didn't require dressing changes when he first came from the hospital, but then he started to see a wound doctor. Staff C recalled a staff person called to let her know Resident #101 went to the hospital because they found maggots in his wounds. Staff CC told her she planned to round with the wound physician but then Staff B called her and said she found maggots on his legs and sent him to the ED.

The last time she saw the resident was when he came back from the hospital on 8/9/21 and she only did his admission assessment. Staff C recalled Resident #101 went to the hospital a third time after his readmission at the end of August. Staff L, agency CMA told Staff GG, agency LPN, Resident #101 looked a little full, but the agency nurses didn't want to step on any toes. Staff C told staff they needed to trust nursing judgement. Staff told her Resident #101 went to the hospital because he had a lot of fluid

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

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

(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 684	Continued From page 111	F 684		

build-up, and the ARNP recently placed him on fluid restriction. On 9/3/21, Staff II showed her dressings hadn't been changed for Resident #101 and another resident. Dressings were dated 8/29. She requested Staff II place the dressings in a bag and place them in her office, and she would show them to the DON. Staff C reported she expected staff to let the oncoming shift know if a treatment not done. Staff C acknowledged awareness of documentation for some resident's treatments not done and medication not given. Staff C reported she expected staff to follow physician's orders and provide treatments and dressing changes as ordered. Staff C reported there were no other documentation of skin assessments other than the ones in the EHR under the assessment tab labeled skin observation tool or weekly wound assessment, or if documented in a daily skilled assessment. Staff C reported she believed if treatments had been completed as ordered, Resident #101's condition and leg wounds may not have worsened or deteriorated. Staff C stated if things were not documented, they considered the treatments or or orders not completed or done.

In an interview 11/09/21 at 10:55 AM, Staff A, CNA/medical records, reported the CNA's obtained resident weights, then she documented weights in an email, and a nurse documented weights in the EHR. Staff A reported staff expected to weigh residents daily or monthly.

On 11/10/21 at 08:15 AM, Staff A, Medical Records, reported no additional documentation found for Resident #101.

In an interview 11/10/21 at 8:30 AM Staff V, agency LPN, reported she checked the paper

(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 684	Continued From page 112 MAR for medications and punched out the medication from the medication card for the date indicated according to the calendar date and if scheduled for AM, PM, HS (bedtime), etc. Staff V reported she signed her initials on the MAR after medications administered. If she noticed medication not given, she let the staff person know. Otherwise we do not give the medication if it wasn't given by another nurse or CMA. If medication was not administered because the medication not available or resident refused, then initial and circle on the MAR. If medication not available, then medication ordered from pharmacy or obtained from the e-kit. If medication not given, refused, or not available, she documented a "0" on the MAR. In an interview 11/10/21 at 12:10 PM, the DON reported she expected nursing staff to document or sign the skin assessment on the TAR weekly if resident's skin intact. Staff documented on skin observation tool if an area identified such as a bruise or MASD, and document an initial weekly wound assessment if area identified as pressure or arterial or venous wound until the area healed. The DON reported the nurse on duty entered orders for resident, the nurse or DON who rounded with the provider entered and processed the physician's orders timely. The nurse entered the physician's order in the EHR whenever a verbal or telephone order received. The DON stated she expected staff to obtain medication from their PYXIS ADU (auto dispensing unit) if unable to find medication. The DON acknowledged there was a disconnect with staff and obtaining weights on residents. The DON reported CNA's weighed residents, and she expected weights obtained monthly as a standard. Staff A entered weights in the EHR by	F 684		

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

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

(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 684	Continued From page 113 the 10th of the month. The DON reported weekly weights were obtained on Sundays, and daily weights recorded on the MAR. If a resident had diagnoses of CHF, she expected staff to listen to lung sounds, monitor edema, monitor respiratory effort, monitor for increased weight, administer diuretics, and place on fluid restriction if a non-compliant resident. The DON reported Resident #101's skin on his LE's peeled off and his legs had a lot of weeping. His legs were wet all of the time and he had extensive moisture between his toes. The DON stated they consulted a wound specialist to see the resident, but uncertain when wound care started to see him. In an interview 11/10/21 at 4:15 PM, Staff CC, RN, reported she worked at the facility 3-4 months from 6/2021 until 9/2021. Staff CC recalled Resident #101 came to the facility in 7/2021 and she completed his admission assessment. Resident #101 developed swelling in his legs, but unable to recall if he had edema when he first came in. Staff CC stated various staff entered admission orders, it depended upon staff availability. Sometimes the nurse who did the admission or the MDS nurse entered the orders if not working the floor. The floor nurse completed the assessments and documented the assessment in the EHR. Treatments and medications should be documented on the paper MAR/TAR. If a treatment or dressing change was not done, document on the TAR the reason for the inability to do the treatment or dressing change. If medication not available, we would contact pharmacy or use PYXIS system to obtain the medication. The facility used lots of agency staff and the DON and MDS nurse covered the floor quite a bit. Staff CC stated the DON and	F 684		

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

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

(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 684	Continued From page 114 MDS nurse were supposed to check the MAR's, TAR's, and assessments, but it didn't get done because they worked the floor. She wrote a list of residents who didn't get medications or treatments, then checked with staff to see if they gave the medication(s). She asked staff why medications or treatments not done, and they told her they didn't have time. Staff CC reported if medication or treatment were not given, she would go to the medication cart and look at the punch backs on the medication cards. Sometimes the medications still remained in the medication cart. Staff CC reported skin assessments were documented on the EHR, no skin assessments on paper. Staff CC reported a wound care physician saw Resident #101 for a spot on his nose where his glasses dug in. Staff CC stated she had wrapped Resident #101's legs to protect them. She wanted to put padded sleeves on his legs but they didn't have any, so she applied dressings instead. His legs looked good. Staff CC was not sure when the wounds on his legs developed, she believed the resident had bumped his leg when going in or out of a transport van. He had an ABD pad on his left leg where there were two open spots and one area on his right leg. She lotioned his legs well and covered the spots because they wept from the open areas. The areas were superficial and almost healed. A CNA gave him a shower on the weekend in 8/2021 and found maggots on his legs and dressing. Staff told her the date listed on the dressings hadn't been changed for 4 days. It was the last day she had seen him and changed the dressings. Staff sent Resident #101 to the hospital in 8/2021 because he had maggots in his dressings. Staff CC reported if Resident #101 had received treatments and medication as ordered, he potentially could have	F 684		

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

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

(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 684	Continued From page 115	F 684		

avoided going to the hospital or a decline in his condition and also his wounds and legs would not have had maggots. Staff CC decided she could no longer work at the facility due to the culture and work conditions, and residents not getting proper care.

An all staff meeting book with education provided to staff revealed the following on 5/21/21: each resident must have a skin assessment/observation completed weekly. A schedule had been created for each person who needed assessed for each shift and day. If a resident had pressure/venous/stasis/arterial wound, enter note "see weekly wound assessment". Measurements and assessments done weekly by the wound care. Staff must look at the rest of resident's skin to ensure they don't have an open area. Skin tears and bruises documented on the "skin observation tool". The skin observation tool is located under the assessment tab in the EHR. If skin intact, scroll to the bottom and document "no impairments in skin integrity". Three staff and the DON signed document they had read the information or in attendance for the education.

A Medication Administration Preparation and General Guidelines policy dated 12/17 revealed medications administered as prescribed in accordance with good nursing principles and practices. The individual who administered the medication recorded directly on the resident's MAR after the medication administered. At the end of each medication pass, the person who administered the medications reviewed the MAR to ensure necessary doses administered and documented. Staff initialed in the space provided under the date and on the line for that specific

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

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

(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 684	Continued From page 116 medication dose administered by the person who administered the medication. If a dose of regularly scheduled medication withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage needed initialed and circled. An explanatory note then entered on the reverse side of the record. The physician is notified if a vital medication withheld, refused, or not available. A notification of change in resident's condition policy reviewed 11/1/18 revealed the attending physician/physician extender and resident's representative notified of a change in a resident's condition per standards. A "skin management guidelines" revised 7/2017 revealed all residents assessed for skin integrity upon admission, and the assessment documented in the EHR. A Braden scale assessment completed quarterly, annually, and when resident had a change in condition. Skin assessment completed to identify at risk residents for potential breakdown or ulcerations and to provide treatment that promoted prevention of ulcerations and healing of existing ulcerations. Risk factors included impaired mobility, comorbid conditions such as diabetes, impaired blood flow such as lower extremity arterial insufficiency, impaired cognition, incontinence, hydration deficits, and malnutrition. Nurse aides completed body audits and turned body audit forms into the nurse to review for changes in skin condition. The attending physician determined the etiology of ulcers and the treatment plan, and the area monitored closely during treatment to evaluate appropriateness of the treatment regime.	F 684		

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

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

(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 684	Continued From page 117	F 684		

A policy for "skin management guidelines overview" revised 7/2017 revealed residents at risk or with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed, and provided appropriate treatment to encourage healing and/or skin integrity. Ongoing monitoring and evaluation provided to ensure optimal resident outcomes.

A Chronic Heart Failure Overview policy dated 10/2016 revealed residents who had diagnosis of heart failure needed assessed to provide the most appropriate interdisciplinary interventions, care plans, and education for management of condition, as well as prevent exacerbations, avoid unplanned hospitalization, and improve quality of life. A key goal of the program included prevention of avoidable re-admissions of residents to hospital settings.

The facility was notified of the Immediate Jeopardy (IJ) was removed on 11/16/21 when the facility implemented and completed the following:

1. Nursing Administration provided skin assessments for all facility residents from 11/10/21 - 11/11/21.

2. All current professional staff received education regarding assessment and documentation of relevant resident conditions, physician notification with clinical changes, following physician orders, medication administration expectations, provision of ordered treatments, and completing skin assessments on 11/5/21 - 11/16/21.

3. 100% audit of weight tracking completed to

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

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

(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 684	Continued From page 118	F 684		

ensure that all residents have a current weight in accordance with orders on 11/10/21.

4. On 1/10/21, a weight monitoring system was established through Interdisciplinary Team (IDT) review.

5. 100% of medication and treatment records were audited on 11/10/21

6. A plan was developed to review weekly skin assessments on the next business day through the Quality Assurance Performance Improvement (QAPI) team to ensure that staff documented notifications and changes appropriately.

7. Audits of Medication & Treatment Records, weight orders, and weight recording will occur 5 times weekly.

8. The QAPI team will review monthly for 3 months to ensure ongoing compliance.

9. All education will be incorporated into orientation of new hires and agency staff during the onboarding process effective 11/16/21.

2. The annual MDS assessment dated 9/22/21 revealed Resident #34 had diagnoses that included Alzheimer's dementia, anemia, malnutrition, and cellulitis to her left lower limb. The MDS revealed the resident had a risk for pressure ulcer but noted no skin conditions during the look-back period. The MDS documented the resident as totally dependent on one staff for bathing and dressing.

The care plan revised 3/3/20 documented the

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

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

(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 684	Continued From page 119	F 684		

resident as at risk for skin issues and pressure ulcer development related to thin fragile skin, anemia, and protein-calorie malnutrition. The care plan directed staff to inspect the resident's skin weekly, administer medications and treatments as ordered, and follow facility policies and procedures for prevention of skin breakdown.

The order summary report dated 11/4/21 directed staff to apply A & D ointment to bilateral (both) lower extremities (BLE) twice daily (BID) at bedtime for dry skin starting 7/8/17, apply skin prep to bilateral heels at bedtime for prophylaxis starting 2/4/18, and provide weekly skin checks by a nurse every Monday on night shift starting 9/26/16.

The TAR dated 10/1-10/31/21 lacked the following documentation:

No A & D ointment applied to BLE's at bedtime (HS) on 18 of 31 evenings
No weekly skin checks documented on Mondays on 10/4/21, 10/11/21, 10/18/21, & 10/25/21
No skin prep to bilateral heels at HS on 18 of 31 evenings.

3. The MDS assessment dated 10/10/21 revealed Resident #32 had diagnoses that included cerebral palsy, non-Alzheimer's dementia, anxiety disorder, schizophrenia, and mild intellectual disabilities. The MDS documented the resident as totally dependent on one staff for dressing, and totally dependent on two staff for bed mobility and transfers. The MDS also documented the resident did not fall and had no skin issues during the look-back period

The care plan revised 7/9/21 revealed the

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

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

(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 684	Continued From page 120 resident required assistance with activities of daily living related to dementia, schizophrenia, and weakness, and had a potential for impaired skin integrity. The care plan directed staff to product a head-to-toe assessment on a weekly basis and report any bruises or open areas to the nurse, and apply TED hose in the morning and remove them at HS. The Order Summary Report dated 9/3/21 directed staff to apply TED hose during the day and remove at HS for edema and provide weekly skin checks by a licensed nurse every 7 days on day shift. The order further directed staff to "Y" if skin intact and "N" if skin not intact. The treatment administration record dated 9/1 - 9/20/21 and 10/1 - 10/31/21 revealed no staff initials documented for TED hose application from 10/22/21 - 10/26/21 and 10/28/21. The form contained only a checkmark on 10/27/21, and no initials documented for weekly skin checks by a licensed nurse on 9/13/21, 9/20/21, 9/27/21, 10/6/21, 10/13/21, and 10/20/21 Review of the facility's EHR revealed staff completed the last initial wound assessment on 10/11/2020, did a weekly wound assessment completed on 10/20/20, and documented no new skin issues noted on the most recent skin observation tool dated 6/7/21. Review of the the resident's paper or hard chart and the resident's EHR lacked documentation to show staff completed any additional skin assessments. During observation on 10/25/21 at 12:33 PM, Resident #32 wore fuzzy yellow and black striped	F 684		

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

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

(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 684	Continued From page 121	F 684		

socks on his feet. The resident's left shin/lower leg revealed a dark bruised area.

During observation on 10/27/21 at 12:30 PM, Resident #32 sat in a high-backed wheelchair; his feet rested on bilateral wheelchair pedals. The resident wore bootie socks on his feet but no TED hose.

In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported staff were to document skin assessments every week on the TAR if a resident had no open wounds or skin issues, and document a weekly wound assessment or use the skin observation tool on the EHR if the resident had an identified skin concern.

In an interview 11/8/21 at 3:05 PM, the MDS Coordinator stated she expected staff follow to physician's orders and perform treatments as ordered.

2. The annual MDS assessment dated 9/22/21 revealed Resident #34 had diagnoses that included Alzheimer's dementia, anemia, malnutrition, and cellulitis to her left lower limb. The MDS revealed the resident had a risk for pressure ulcer but noted no skin conditions during the look-back period. The MDS documented the resident as totally dependent on one staff for bathing and dressing.

The care plan revised 3/3/20 documented the resident as at risk for skin issues and pressure ulcer development related to thin fragile skin, anemia, and protein-calorie malnutrition. The care plan directed staff to inspect the resident's skin weekly, administer medications and

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

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

(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 684	Continued From page 122 treatments as ordered, and follow facility policies and procedures for prevention of skin breakdown. The order summary report dated 11/4/21 directed staff to apply A & D ointment to bilateral (both) lower extremities (BLE) twice daily (BID) at bedtime for dry skin starting 7/8/17, apply skin prep to bilateral heels at bedtime for prophylaxis starting 2/4/18, and provide weekly skin checks by a nurse every Monday on night shift starting 9/26/16. The TAR dated 10/1-10/31/21 lacked the following documentation: No A & D ointment applied to BLE's at bedtime (HS) on 18 of 31 evenings No weekly skin checks documented on Mondays on 10/4/21, 10/11/21, 10/18/21, & 10/25/21 No skin prep to bilateral heels at HS on 18 of 31 evenings. 3. The MDS assessment dated 10/10/21 revealed Resident #32 had diagnoses that included cerebral palsy, non-Alzheimer's dementia, anxiety disorder, schizophrenia, and mild intellectual disabilities. The MDS documented the resident as totally dependent on one staff for dressing, and totally dependent on two staff for bed mobility and transfers. The MDS also documented the resident did not fall and had no skin issues during the look-back period The care plan revised 7/9/21 revealed the resident required assistance with activities of daily living related to dementia, schizophrenia, and weakness, and had a potential for impaired skin integrity. The care plan directed staff to product a head-to-toe assessment on a weekly basis and	F 684		

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

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

(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 684	Continued From page 123 report any bruises or open areas to the nurse, and apply TED hose in the morning and remove them at HS. The Order Summary Report dated 9/3/21 directed staff to apply TED hose during the day and remove at HS for edema and provide weekly skin checks by a licensed nurse every 7 days on day shift. The order further directed staff to "Y" if skin intact and "N" if skin not intact. The treatment administration record dated 9/1 - 9/20/21 and 10/1 - 10/31/21 revealed no staff initials documented for TED hose application from 10/22/21 - 10/26/21 and 10/28/21. The form contained only a checkmark on 10/27/21, and no initials documented for weekly skin checks by a licensed nurse on 9/13/21, 9/20/21, 9/27/21, 10/6/21, 10/13/21, and 10/20/21 Review of the facility's EHR revealed staff completed the last initial wound assessment on 10/11/2020, did a weekly wound assessment completed on 10/20/20, and documented no new skin issues noted on the most recent skin observation tool dated 6/7/21. Review of the resident's paper or hard chart and the resident's EHR lacked documentation to show staff completed any additional skin assessments. During observation on 10/25/21 at 12:33 PM, Resident #32 wore fuzzy yellow and black striped socks on his feet. The resident's left shin/lower leg revealed a dark bruised area. During observation on 10/27/21 at 12:30 PM, Resident #32 sat in a high-backed wheelchair; his feet rested on bilateral wheelchair pedals. The	F 684		

(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 684	Continued From page 124 resident wore bootie socks on his feet but no TED hose. In an interview 11/01/21 at 10:25 AM, the Director of Nursing (DON) reported staff were to document skin assessments every week on the TAR if a resident had no open wounds or skin issues, and document a weekly wound assessment or use the skin observation tool on the EHR if the resident had an identified skin concern. In an interview 11/8/21 at 3:05 PM, the MDS Coordinator stated she expected staff follow to physician's orders and perform treatments as ordered. 4. The MDS assessment dated 9/15/21 indicated Resident #29 had diagnoses that included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), gastroesophageal reflux disease (GERD), hyperlipidemia (high cholesterol), arthritis, anxiety, depression, schizophrenia, asthma, respiratory failure, chronic pain syndrome. The MDS documented resident had a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating the resident demonstrated intact cognitive abilities. The MDS also documented Resident #29 required assistance of one staff with bed mobility, transfers, toileting and set up assistance for eating. Observation on 10/26/21 at 9:03 a.m. revealed Resident #29 had wounds on her lower abdomen and right hip. The resident reported staff are supposed to apply "silver" to wounds daily but they do not do it. An undated Duoderm dressing on the resident's right hip contained a small amount of serosanguinous drainage was almost	F 684		

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

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

(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 684	Continued From page 125	F 684		

off. The left lower abdominal wound dressing fell off days prior according the Resident #29. The resident's bilateral upper arms contained multiple abrasions.

In an interview on 10/27/21 at 1:36 p.m., Staff B, LPN stated she would be unable to complete Resident #29's wound cares today because the facility does not have enough staff for her to complete all of the scheduled treatments.

On 10/28/21 at 10:45 a.m., Resident #29 stated she did not shower yesterday on the evening shift or have her wounds treated. Resident stated she often does not receive her medications timely. Resident #29 appeared to be in clean clothes with greasy hair.

Interview on 11/1/21 at 10:28 a.m. with Staff L, Certified Medication Aide (CMA) revealed Resident #29 has been out of Mupirocin (Bactroban) ointment for week. She reported nurses reorder all medications and added she had notified the nurse that would complete treatments the resident needed that medication refilled.

On 11/1/21 at 10:38 a.m., the pharmacy revealed the facility had not requested a medication refill of Mupirocin since 8/13/21.

A physician order dated 1/21/20 directed staff to complete a weekly skin assessment.

A physician order dated 5/27/21 directed staff to apply Mupirocin ointment 2% to all open areas topically every morning and at bedtime for open areas until healed.

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

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

(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 684	Continued From page 126	F 684		

Review of facility records revealed a lack of weekly skin assessments for 25 weeks between 4/12/21- 11/8/21.

A Care Plan entry dated 3/26/21 revealed Resident #29 had scratches at different stages of healing on her abdomen and buttocks and directed staff to apply Mupirocin ointment 2 % to all open areas in the morning and at HS until healed. The Care Plan also directed a licensed nurse to provide a weekly head-to-toe assessment.

The MAR dated 10/1/21-10/31/21 directed staff to apply Mupirocin ointment 2% (Bactroban), to all open areas topically every morning and at bedtime until healed. The MAR showed staff failed to apply the ointment on 40 of 62 occasions when ordered.

The MAR dated 11/1/21-11/15/21 directed staff to apply Mupirocin ointment 2 % to all open areas in the morning and at HS until healed. The MAR revealed the facility failed to apply medication on 20 of the 32 opportunities ordered.
5. The MDS assessment dated 10/10/21 revealed Resident #32 had cerebral palsy, non-Alzheimer's dementia, anxiety disorder, schizophrenia, and mild intellectual disabilities. The MDS documented the resident as totally dependent on one staff for dressing, and totally dependent on two staff for bed mobility and transfers. The MDS documented the resident had no falls and no skin problems during the look-back period

The care plan revised 7/9/21 revealed the resident required assistance with activities of daily living related to dementia, schizophrenia, and weakness, and had a potential for impaired skin

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

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

(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 684	Continued From page 127	F 684		

Continued From page 127

integrity. The staff directives included perform a head to toe assessment weekly, report any bruises or open areas to the nurse, and apply TED hose in the morning and remove at bedtime (HS).

The Order Summary Report dated 9/3/21 directed weekly skin checks by a licensed nurse every 7 days on day shift. Indicate "Y" if skin intact and "N" if skin not intact.

The treatment administration record (TAR) 9/1 - 9/20/21 and 10/1 - 10/31/21 revealed no staff initials documented for weekly skin checks by a licensed nurse on 9/13/21, 9/20/21, 9/27/21, 10/6/21, 10/13/21, 10/20/21

Review of the facility's EHR revealed staff completed the last initial wound assessment on 10/11/2020 and provided a weekly wound assessment on 10/20/20. The most recent skin observation tool assessment dated 6/7/21 revealed no new skin issues found.

The paper chart and EHR lacked documentation to show staff completed any other skin assessments.

Observation on 10/25/21 at 12:33 PM revealed Resident #32 wore fuzzy yellow and black striped socks on his feet and had a dark bruised area on his left shin/lower leg.

During observation on 10/27/21 at 12:30 PM, Resident #32 sat in a high back wheelchair. His feet rested on the wheelchair pedals and he wore bootie socks on his feet.

In an interview 11/01/21 at 10:25 AM, the Director

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

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

(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 684	Continued From page 128 of Nursing (DON) reported staff should document skin assessments every week on the TAR if a resident had no open wounds or skin issues, and should document a weekly wound assessment or use the skin observation tool in the EHR if a resident had a skin problem. In an interview 11/8/21 at 3:05 PM, the MDS Coordinator stated she expected staff follow to physician's orders and provide treatments as ordered. 6. The annual MDS assessment dated 9/22/21 revealed Resident #34 had diagnoses of Alzheimer's dementia, anemia, malnutrition, and cellulitis to her left lower limb. The MDS revealed the resident had a risk for pressure ulcer but had no skin conditions during the look-back period. The MDS documented the resident as totally dependent on one staff for bathing and dressing. The care plan revised 3/3/20 revealed the resident had a risk for skin issues and pressure ulcer development related to thin fragile skin, anemia, and protein-calorie malnutrition. The staff directives included inspect the resident's skin weekly, administer medications and treatments as ordered, and follow facility policies and procedures for prevention of skin breakdown. The order summary report dated 11/4/21 directed staff to apply A & D ointment to BLE's BID at bedtime for dry skin starting 7/8/17, apply skin prep to bilateral heels at bedtime for prophylaxis starting 2/4/18, and weekly skin checks completed by a nurse every Monday on night shift starting 9/26/16. The TAR dated 10/1-10/31/21 lacked the	F 684		

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

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

(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 684	Continued From page 129	F 684		

following documentation:
a. Staff failed to apply A & D ointment to BLE's at bedtime on 18 of 31 evenings directed.
b. Staff failed to document skin checks on Mondays on 10/4/21, 10/11/21, 10/18/21, and 10/25/21
c. Staff failed to apply skin prep to bilateral heels at bedtime on 18 of 31 evenings ordered.

7. The MDS dated 10/6/21 indicated Resident #50 had a diagnosis that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA or stroke)), and chronic pain. The MDS showed the resident had a BIMS score of 15, which meant she experienced intact cognitive abilities. The MDS documented Resident #50 required assist of 1 staff with bed mobility, transfers, toilet use and set-up assist for eating. The MDS also documented Resident #50 had moisture related skin damage during lookback period with ointment application.

A physician order directed a licensed nurse to complete a weekly skin check every day shift, every 7 days, starting 6/10/21.

A physician order dated 7/19/21 directed staff to apply Dermaceptin to gastric tube (GT) site BID.

The TAR dated 7/1/21 -7/31/21 revealed staff failed to apply the ordered Dermaceptin to the resident's skin around the G-tube every day and night shift for redness and excoriation on 18 of 24 opportunities from 7/19/21 - 7/31/21 and documented only 2 out of 5 weekly skin checks.

The TAR dated 8/1-8/31/21 revealed staff failed

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

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

(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 684	Continued From page 130	F 684		

to apply the ordered Dermaceptin to the resident's skin around the G-tube every day and night shift for redness and excoriation on 12 out of 62 opportunities and documented.

TAR dated 9/1-9/30/21 revealed staff failed to apply the ordered Dermaceptin to the resident's skin around the G-tube every day and night shift for redness and excoriation on 0 of 62 doses, and documented 3 of 5 weekly skin check assessments.

The TAR dated 9/1-9/30/21 directed staff to inspect the split sponge with each medication pass and change the soiled or wet dressing every 4 hours starting 8/17/21. The TAR revealed facility staff failed to change the dressing on 48 of 186 scheduled dressing changes.

The MAR dated 9/1/21-9/30/21 directed staff to administer Bactrim DS tablet 800-160 MG, 1 tablet via GT BID for GT site infection until 9/26/21. The MAR showed staff failed to administer 2 of the 19 doses ordered.

The TAR dated 10/1-10/31/21 revealed staff failed to apply the ordered Dermaceptin to the GT site every day and night shift for redness and excoriation on 29 of 62 occasions ordered, and documented a weekly skin check assessment on 2 of 4 weeks. The TAR also directed inspect split sponge with each medication administration and change if soiled or wet, every 4 hours document sponge. The facility failed to change the dressing 83 out of 186 scheduled dressing change times.

The TAR dated 11/1-11/30/21 revealed staff failed to apply the ordered Dermaceptin to GT peri-wound skin every day and night shift for

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

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

(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 684	Continued From page 131 redness and excoriation on 29 of 62 occasions ordered, and documented a weekly skin check assessment for 2 of 4 weeks. The TAR also documented staff failed to inspect the split sponge with each medication pass administration and change if soiled or wet every 4 hours on 83 of 186 scheduled times.	F 684		
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 clinical record review, observation, facility policy review and staff interviews the facility failed to a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for 1 of 2 residents reviewed for pressure ulcers (Resident #53). The facility failed to assess Resident #53's sacrum wound after first identifying the area upon admission on 10/8/21 and failed to treat the area to aid in healing and prevent further deterioration of the wound. The	F 686		

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

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

(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 686	Continued From page 132	F 686		

facility reported a census of 50 residents.

Findings include:

The Minimum Data Set (MDS) assessment tool identifies the definition of pressure ulcers:

Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.

Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue), may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.

Unstageable Ulcer: inability to see the wound bed.

Other staging considerations include:

Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of

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

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

(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 686	Continued From page 133	F 686		

persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.

Review of Resident #53's hospital record revealed he admitted to the facility on 10/8/21 from the hospital. He had reported to the emergency department on 10/1/21 for weakness and failure to thrive. Resident's family decided he required increased assistance with activities of daily living (ADL) and opted for long term care placement.

The MDS dated 10/15/2 revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 5, indicating he demonstrated severe cognitive impairment. The MDS documented Resident #53 had diagnoses that included: hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive and cystitis. The MDS revealed the resident experienced bladder and bowel incontinence; although the resident admitted to the facility with an indwelling catheter, the MDS did not reflect its use. The MDS revealed the resident required extensive assist of one person for bed mobility, transfers, dressing, toilet use and personal hygiene and total assist of one person for bathing. The MDS revealed the resident had a risk for development of pressure ulcer/injuries and had moisture associated skin damage (MASD). The MDS documented the resident had

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

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

(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 686	Continued From page 134 a pressure reducing device for his chair and bed. The MDS coded the resident took an anticoagulant. The MDS Care Area Assessment (CAA) Summary triggered concerns for cognitive loss, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, and pressure ulcer. The CAA's revealed staff planned to develop care plans for these areas. The care plan dated 10/21/21 lacked documentation of a focus area, goals or interventions for ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls or pressure ulcer. Pressure Injury Risk form dated 10/8/21 completed by Staff Z, Registered Nurse (RN) revealed a Braden score of 14, which assessed Resident #53 as at moderate risk for pressure injuries. Pressure Injury Risk form dated 10/10/21 completed by Staff Z, RN revealed a Braden score of 15, which assessed Resident #53 as at moderate risk for pressure injuries. Pressure Injury Risk form dated 10/17/21 completed by Staff C, Licensed Practical Nurse (LPN) and MDS nurse revealed a Braden score of 12, placing Resident #53 at high risk for pressure injuries. A Nursing Admission Screening/History form dated 10/8/32 at 12:00 PM completed by Staff C, LPN and MDS nurse documented Resident #53's height as 67 inches and weight as 100.5 pounds.	F 686		

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

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

(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 686	Continued From page 135	F 686		

Staff C documented an open area on the resident's sacrum measuring 1 centimeter (cm) in length, 1 cm in width, and 0.1 cm in depth. The note defined it as a moisture related breakdown to the sacrum area and revealed staff applied house barrier to the area. When the resident arrived from the hospital, staff found the area covered with an undated patch, which they removed and identified a foul odor emanating from the area.

A Skin Observation Tool dated 10/9/21 at 4:40 PM by Staff D, LPN, documented a Stage III pressure wound to the coccyx area measuring 3 cm in length, 5 cm in width, and 0.2 cm in depth. The documentation on the tool identified the resident admitted to the facility with a pressure ulcer that contained slough and a small amount of drainage was noted.

A Daily Skilled Summary form dated 10/10/21 revealed Resident #53 had an open area to his coccyx staff documented as a pressure ulcer.

The October 2021 Medication Administration Record (MAR) and Treatment Administration Record (TAR) contained no documentation of any prescribed treatments or other interventions to care for the pressure ulcer on Resident #53's sacrum/coccyx area.

The electronic health records (EHR) lacked any physician progress notes related to the pressure area on the resident's sacrum/coccyx area.

The nursing progress notes in the electronic health records revealed the following:

a. On 10/9/21 at 3:13 AM, the resident was

(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 686	Continued From page 136 admitted to facility with diagnosis of failure to thrive; the resident is alert and oriented and able to make his needs known and required minimal assistance with ADL. Staff assessed the resident's skin as warm and dry with areas of dirt on his skin and the skin on his lower extremities very dry. b. On 10/10/21 at 4:11 AM, skin very dry, lotion applied liberally over entire body. Area noted on coccyx - moisture barrier applied - see wound sheet. c. On 11/3/21 at 11:20 AM, during his shower, the resident complained that his bottom hurt, and his skin burned when staff changed his brief. Staff noted 1.3 cm by 0.3 cm open area with a pale red wound base. Call placed to provider to notify of area, then utilized wound formula - Dermaview 11 applied to coccyx. d. On 11/3/21 at 4:53 PM, the social worker notified the resident's son of a small wound found on his coccyx. e. On 11/5/21 at 1:01 AM, staff completed a dressing change as ordered to the resident's coccyx and he voiced no complaints. f. On 11/5/21 at 9:07 AM, the dressing to the resident's coccyx remained intact with no redness or swelling noted to surrounding area and the dressing remained clean and dry. g. On 11/5/21 at 3:52 PM, Resident #53 seen by wound physician and received orders to change wound treatment to collagen pad to wound bed, cover with bordered gauze and apply house barrier to surrounding area. Staff documented they updated the TAR, faxed pharmacy and communicated the new orders to Resident #53. h. On 11/6/21 at 12:18 AM, staff noted the dressing applied by wound physician remained intact to coccyx. i. On 11/7/21 at 12:29 AM, staff documented they	F 686		

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

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

(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 686	Continued From page 137 applied the dressing to coccyx wound as ordered and saw no drainage on the old dressing - the resident voiced no complaints j. On 11/7/21 at 9:52 AM, staff found the dressing to resident's coccyx clean, dry and intact. Resident #53 denied pain or discomfort. k. On 11/8/21 at 4:38 AM, staff changed coccyx dressing due to the dressing peeling and coming off skin. Area cleaned with normal saline, collagen applied and staff dressed the wound. Staff documented the wound as negative for drainage or odor, healing well, and pink. l. On 11/8/21 at 2:00 PM, staff noted the dressing to coccyx remained clean, dry and intact and the resident denied any pain or discomfort. m. On 11/9/21 at 4:09 AM, staff noted dressing intact to coccyx and the resident denied any pain or discomfort to the area - will continue to monitor. n. On 11/9/21 at 2:27 PM, the dressing to coccyx remained clean, dry and intact and the resident denied any pain or discomfort. o. On 11/10/21 at 4:22 AM staff documented the coccyx dressing remained intact and the resident denied pain or discomfort to the area - will continue to monitor. Clinical record review revealed the resident's EHR and hard or paper chart lacked assessments, treatment, and documentation of Resident #53's coccyx area pressure wound from 10/10/21 to 11/3/21. A physician order dated 11/3/21 at 1:28 PM directed staff to apply Dermaview II daily to the open area on Resident #53's coccyx. Change daily at bedtime and as needed. Another physician's order dated 11/8/21 at 3:20	F 686		

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

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

(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 686	Continued From page 138 AM directed apply collagen pad to coccyx wound bed, cover with bordered gauze, and apply house barrier cream to surrounding area every day at bedtime and as needed for coccyx wound. On 11/3/21 at 12:36 PM, the DON completed an Initial Wound Assessment tool that documented the facility identified the wound on 11/3/21 and deemed it a facility acquired Stage II pressure wound on the sacrum that measured 1.3 cm (length) x 0.3 cm (width) with an immeasurable depth. She assessed the wound as 95% granulation tissue and 5% epithelial tissue with no exudate noted. The form reflected the resident had predisposing factors of bowel incontinence and pendulous buttocks. The DON recorded the ulcer had a treatment ordered and the resident's bed and chair contained pressure reduction devices. The DON identified the resident reported burning when staff provided incontinence care. The form showed the facility notified the physician on 11/3/21 at 11:45 AM, the son at 11/3/21 at 3:00 PM, and also notified the dietician. On 11/3/21 Staff T, Certified Nursing Assistant (CNA) completed a Shower Day Skin Audit that showed Resident #53 had an open area on the coccyx/sacrum area and noted she reported her finding to the nurse. Observation on 11/3/21 at 11:17 AM, revealed Staff T, CNA, gave Resident #53 a shower while he sat on a shower chair. The resident flinched when staff washed his bottom, and he kept saying his bottom hurt and was tender to the touch. The resident, Staff T, CNA and the DON were unaware of any open areas on resident's bottom. Once back in his room, staff transferred him to the bed and the DON assessed his	F 686		

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

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

(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 686	Continued From page 139 bottom. When the resident's buttocks were separated an open area was noted on the coccyx. The wound bed was red and had depth. The resident stated the area burned and was painful whenever he had a soiled brief and staff provided incontinence care. In an interview on 11/4/21 at 8:39 AM, Resident #53 stated his bottom felt better. He reported he had a bandage on the area. Observation revealed an approximately 1 inch cushion in his wheelchair seat, but nothing extra noted on the mattress for pressure relief. In an interview on 11/4/21 at 8:44 AM, Staff C, LPN and MDS nurse, reported all of the mattresses at the facility were pressure reducing mattresses and that is why she coded the resident's MDS to reflect a pressure relieving device for his bed. In an interview on 11/10/21 at 8:43 AM, the DON stated she expected staff to conduct a weekly skin assessment including a head-to-toe assessment of every resident in the facility set up on the TAR. If staff identified an area of concern they should initiate a Skin Observation tool if was a skin tear, shearing or moisture related issue. If the areas identified were a pressure related, vascular, arterial or any stageable wound, staff should complete a Wound Assessment. The DON added the CNA would notify the nurse if they identified a wound and she expected the nurse to complete a wound assessment, notify the physician, and initiate a treatment in accordance with the wound care protocol. The physician would then review the plan and set up a treatment for the area, although any nurse can initiate the treatment per the facility standing	F 686		

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

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

(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 686	Continued From page 140 orders. They would then contact the wound nurse regarding the issue. Staff C, LPN was the facilities certified wound nurse and she completed rounds with the wound physician weekly or every other week to follow the wounds in the facility. The DON stated it was her expectation that all wounds would be assessed and documented weekly. A Wound Assessment should be completed on all arterial, venous or pressure areas weekly and Skin Observation tool completed for all other wounds. The physician would be notified initially and with any changes of concern in the wound. The physician would then determine if further intervention or a change in treatment was indicated. The physician/nurse practitioner reviewed notes in the electronic health system and reviewed the notes entered by the facility wound physician. The DON stated the staff get education and training on-line through Health Care Academy, including wound care training annually. She added the facility had specific training related to wound care for the licensed staff and more general skin care information for the non-licensed staff. She stated staff should complete Braden Scales for each resident upon admission and then at least quarterly thereafter. The Skin Management Guidelines dated 7/2017, revealed upon admission, all residents are assessed for skin integrity by completing an assessment and documenting in the electronic health record. Following admission; the Braden Scale is completed quarterly, annually and with a change of condition, for their risk for development of pressure injury. Nurse aides complete body audits. The body audits are given to the licensed nurse to review for changes in skin condition post shower. Appropriate preventative measures	F 686		

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

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

(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 686	Continued From page 141 implemented on all resident identified at risk, and interventions documented on the care plan. Residents admitted with skin impairments will have appropriate interventions implemented to promote healing, a physician order for treatment, wound location and characteristics documented in the electronic health record, referral to rehabilitation services, Registered Dietician to assess nutritional needs, their family notified of presence of skin impairment and care plan implemented. A care plan is developed upon admission, identifying the contributing risks for breakdown, including history of skin impairment and the interventions implemented to promote healing and prevent further breakdown. At-Risk Review Meetings will be conducted to review/discuss: new admission with wounds present, resident identified at risk or with compromise, treatment modalities and interventions, recommendations based on interdisciplinary evaluation and weights will be monitored and dietary consumption reviewed. According to the Skin Management Guidelines dated 7/2017, residents who are at risk or with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed and provided appropriate treatment to encourage healing and/or integrity. A pressure injury is defined as any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure injuries are usually over bony prominences and are staged to classify the degree of tissue damage observed. Per education provided to the facility staff on 5/21/21, each resident was to have a skin assessment/observation completed weekly. The measurements and assessments were being	F 686		

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

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

(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 686	Continued From page 142 done weekly by wound care but staff were to look at the rest of their skin to make sure they do not have other open areas. This did not include things like skin tears and bruises as they show up on the Skin Observation Tool. The manufacturer's guidelines for the Therapeutic 5 Zone Support Mattress documented the mattress provided pressure redistribution and shear/friction reduction. The deluxe horizontal, cross cut foam mattress provided comfort, support and pressure redistribution over 5 therapeutic pressure zones.	F 686		
F 689 SS=E	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 clinical record review, observations, staff interviews, facility policy review, and review of manufacturer's directions, the facility failed to secure medications, keep alarmed doors closed to and from the outdoors for 10 residents (Residents #2, #4, #10, #23, #24, #33, #40, #41, #42 and #48), failed to ensure foot pedals on wheelchairs while transporting residents for 1 of 8 residents reviewed (#32), and failed to lock the brakes on wheelchair when staff transferred a resident (#32) for 1 of 8 residents observed for transfers. The facility reported a census of 50.	F 689		

F 689 Continued From page 143 F 689

Findings include:

1.a. The Minimum Data Set (MDS) assessment dated 10/15/2021 recorded Resident #4 had diagnoses of weakness, history of falling, dysphasia (difficulty swallowing), and major depressive disorder. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 7, indicating severely impaired cognition. Resident #4's care plan documented the resident required assistance of one staff for transfers and ambulation.

b. The MDS assessment dated 9/8/21 documented Resident #23 had diagnoses of dementia, anxiety disorder, unsteadiness on feet, dysphagia, muscle weakness, and difficulty in walking. The resident had a BIMS of 11, indicating moderately impaired cognition. Resident #23's care plan recorded the resident required assistance of one staff for transfers and ambulation, and as non-compliant with asking for assistance for transfers.

c. The MDS assessment dated 9/22/21 revealed Resident #33 had diagnoses of dementia, schizoaffective disorder, history of falling, and cognitive communication deficit. The resident had a BIMS of 3, indicating severely impaired cognition. Resident #33's care plan revealed the resident had a history of wandering, had a wander alert bracelet, and transferred and ambulated independently with a walker.

d. The MDS assessment dated 10/1/21 revealed Resident #40 had diagnoses of Alzheimer's disease, dementia, major depressive disorder, aphasia (loss of ability to understand or express

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

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

(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 689	Continued From page 144	F 689		

speech), anxiety disorder, and dysphasia. The resident had a BIMS of 4, indicating severely impaired cognition. Resident #40's care plan revealed the resident transferred with assistance.

e. The MDS assessment dated 10/1/21 revealed Resident #48 had diagnoses of dementia, major depressive disorder, and dysphasia. The resident had a BIMS of 6, indicating severely impaired cognition. Resident #48's care plan revealed the resident used a 4-wheeled walker and ambulated independently.

Observation on 10/26/21 at 1:43 PM revealed the treatment cart located in the COVID designated area (for COVID positive residents) left unlocked. Medications including insulin, trazadone, finasteride, and various other medications were inside a cardboard box. The box sat on top of the treatment cart. An orange box which contained insulin for Resident #2 sat on top of the treatment cart.

Observation on 10/26/21 at 2:02 PM revealed Staff U, Certified Medication Aide (CMA), entered the COVID area and looked at the medications on the treatment cart. Staff U brought medication cups with names listed on them and pills from the Non-COVID area. Staff U pulled medications from the treatment cart and placed pills in the labeled medication cups. At 2:04 PM, Staff U left the labeled medication cups on the treatment cart and started to hand out medications to residents in their rooms. Staff U left all of the other labeled medication cups on the treatment cart unsecured. At 2:15 PM, Staff U continued to pass medications to residents in the COVID area and left medications on the treatment cart as she passed the medication to residents. At 2:28 PM,

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

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

(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 689	Continued From page 145	F 689		

Staff U left the COVID area. Staff U left medications and the treatment cart unlocked.

During observation on 10/26/21 at 2:35 PM, the medications sat on top of the treatment cart and treatment cart unlocked in the COVID designated area without staff present.

During interview on 10/26/21 at 2:44 PM Staff V, Licensed Practical Nurse (LPN) stated medications were not normally left out on carts. Staff V stated did not know who left the medications on top of the cart in the COVID designated area. Staff V then placed the medications into the treatment cart.

Observation on 10/27/21 at 12:59 PM revealed Staff B, LPN, entered the COVID designated area, and pulled medications out of the treatment cart for residents no longer in the COVID area. Staff B left the medications on the treatment cart and then went and passed pills to current residents in the COVID area. Medications left on the treatment cart included 8 pill packs and insulin for Resident #2. The treatment cart remained unlocked while Staff B passed medications. At 1:11 PM Staff B locked the treatment cart.

2. On 10/28/21 at 9:13 AM, the surveyor entered the building from an unlocked exterior door on the West side. No alarm sounded and no staff were present in the area. The area separated a COVID designated side from a and Non-COVID designated side, near rooms 200 and 201.

Observation on 10/28/21 at 9:17 AM revealed Staff I, Certified Nurse Aide (CNA), entered the building from an unlocked exterior door on the

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

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

(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 689	Continued From page 146	F 689		

West side, by rooms 200 and 201, and brought breakfast for residents.

Observation on 10/28/21 at 9:29 AM revealed the treatment cart unlocked and with medications inside for residents in rooms 200 and 201.

Observation on 10/28/21 at 9:34 AM revealed staff exited a door and no alarm sounded by the door. The door to the outside is the only way to get to the area where 200 and 201 rooms are located. The door to this area remained unlocked and cracked open. Residents ate breakfast throughout the observation.

Observation on 10/28/21 at 9:42 AM, no staff in the isolation hall or by rooms 200 and 201.

Observation on 10/28/21 at 9:47 AM revealed a staff member entered the isolation hall to check on residents in that area. A plastic barrier wall separated the isolation area from rooms 200 and 201.

Observation on 10/28/21 at 10:00 AM of revealed the door to room 200 remained closed for residents, and no visual of residents can be done by staff from the isolation area. Room 201 was located around a corner and staff are unable to see into the room from the isolation area. The door to room 201 open.

During observation on 10/28/21 at 10:14 AM Staff V entered to check treatment cart in the area where rooms 200 and 201 are located. Staff V started taking treatment items and looking at medications. Staff V then then exited without checking on residents. Staff V left the treatment cart unlocked. The door did not alarm upon exit.

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

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

(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 689	Continued From page 147	F 689		

Observation on 10/28/21 at 11:10 AM revealed Staff V entered to look at treatment cart. At 11:11 AM Staff V left the area by rooms 200 and 201, and left the exterior door cracked open. No alarm sounded when Staff V left the area and no other staff were in the area. Staff V did not check on residents and left the treatment cart unlocked.

Observation on 10/28/21 at 11:50 AM revealed staff entered the 200 and 201 area to check on residents.

Review of current orders for Resident #10 and Resident #48 revealed they would like to have cardiopulmonary resuscitation (CPR) and Resident #4 and Resident #23 preferred no resuscitation.

Review of current Care Plans for Residents #10, #48, #4, and #23 revealed all at risk for falls.

During interview on 11/9/21 at 11:02 AM, the MDS Coordinator reported she expected medications to be stored in a locked cart.

The facility's policy entitled Medication Storage in the Facility, Storage of Medications dated 11/18 instructed that medications and biologicals to be stored safely, securely, and properly. Medications are stored in a medication cart or other designated area except for those requiring refrigeration or freezing.

3. Review of the MDS assessment dated 10/10/21 revealed Resident #32 had diagnoses of cerebral palsy, Non-Alzheimer's dementia, anxiety disorder, schizophrenia, and muscle atrophy. The MDS indicated the resident had a

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 689	Continued From page 148 BIMS score of 8, which indicated moderately impaired cognition. The MDS documented the resident required total dependence on two staff for transfers, and locomotion on and off the unit. The resident's Care Plan updated on 7/9/21 recorded he had weakness and a risk for falls related to cognition and unawareness of safety needs. The resident's Fall Risk Assessment dated 10/5/21 revealed a moderate fall risk. During observation on 10/25/21 at 12:22 PM, Staff E, CNA, wheeled Resident #32 in a high back wheelchair from the upper dining room to his room approximately 50 feet. The wheelchair had no wheelchair pedal on the right side. The resident's right leg and foot dangled in the air approximately 6 inches from the floor during the transport. During observation on 10/26/21 at 8:27 AM, Staff F, CNA, wheeled Resident #32 in a high back wheelchair from his room to the shower room located on the 100 hall without foot pedals at least 100 feet. The resident's legs and feet hung down toward the floor while Staff F pushed him. During observation on 10/26/21 at 8:55 AM, Staff K, CNA, wheeled the resident in a high back wheelchair from the 100 hall shower room to his room without foot pedals on. The resident's heels and feet were within 1-2 inches off the floor during the transport. During observations 10/25/21 at 12:33 PM, Staff E and Staff I, CNA, placed an EZ stand lift in front of the resident's high back wheelchair. Staff	F 689		

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

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

(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 689	Continued From page 149	F 689		

placed the resident's feet on the EZ stand platform, then placed a sling behind the resident's back and attached the sling straps to the EZ stand lift. Staff I used the remote to lift the resident up. Staff left the wheelchair brakes unlocked on the wheelchair. After Staff E provided incontinence cares for the resident, Staff I positioned him in the EZ stand in front of a lift recliner. Staff E positioned the lift recliner in the highest up position and had the resident's bottom seated on the front edge of the recliner seat. As Staff I used the remote to lower the resident, Staff E then started to lower the lift recliner, until they had the resident seated in the recliner. Staff then removed the sling behind the resident's back.

In an interview 11/10/21 at 12:10 PM, the Director of Nursing (DON) reported she expected that staff locked the brakes on the wheelchair whenever they transferred a resident from the wheelchair. The DON stated it depended upon how large the resident was and whether or not the recliner lift seat was kept in the up or down position when a resident transferred into the lift recliner. A larger resident, may need to have the recliner seat up in order to position the resident further back in the recliner.

In a Primecare Drive Sit to Stand Lift owner's manual revealed wheelchair brakes locked whenever transferred a resident from a wheelchair and used the sit to stand lift. Ensure the desired surface (such as a chair) ready and whenever transferred the resident, position the resident over the chair or commode, press the down button on the remote, and lower the resident onto the desired surface. Then lock the rear swivel casters on the lift and unhook the sling from the lift.

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

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

(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 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation,	F 690		

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

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

(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 690	Continued From page 151	F 690		

staff interview, and facility policy review, the facility failed to provide complete pericare and incontinence cares in a manner to prevent cross contamination and potential infection for 2 of 6 residents observed for incontinence cares (Residents #31 and #32). The facility reported a census of 50.

Findings include:

1. The Minimum Data Set (MDS) assessment dated 9/15/21 revealed Resident #31 had diagnoses of Non-Alzheimer's dementia and cerebrovascular accident (stroke). The MDS documented the resident had impaired short and long-term memory, and required total dependence on one staff for bed mobility, dressing, toileting and personal hygiene. The MDS indicated the resident had incontinence, and had moisture associated skin disorder (MASD).

The resident's Care Plan, updated 5/11/21, identified bowel and bladder incontinence and she required assistance with ADL's (activities of daily living) related to hemiparesis (paralysis on one side of the body) and dementia. The Care Plan documented a history of urinary tract infections (UTI) and directed staff to check and change resident frequently and as required for incontinence, wash, rinse and dry perineum, and observe skin for breakdown.

During observation on 10/28/21 at 9:48 AM, Staff G, certified nurse assistant (CNA), and Staff E, CNA, washed their hands and donned a pair of gloves. Staff E removed the resident's brief as the resident lay in bed, then Staff E changed her gloves. Staff E took a disposable wipe and cleansed across the resident's lower abdomen

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

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

(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 690	Continued From page 152	F 690		

and the upper creases of her groin using the same wipe. Staff G instructed Staff E she needed to change her gloves and only to use one wipe for each time she cleansed. Staff E removed her gloves, hand-sanitized, and donned another pair of gloves. Staff G took a disposable wipe and cleansed the vaginal area from back to front, then used the same wipe and cleansed the area again from back to front. Staff G rolled the resident onto her left side. Staff E took a disposable wipe, and cleansed the buttocks area in a downward and then an upward motion. Staff E continued to cleanse the buttock area with another disposable wipe in the same fashion. Staff E changed her gloves, sprayed the buttocks area with perifresh spray, then took a disposable wipe and cleansed the resident's buttocks area again front to back. Staff E changed her gloves, rolled the underpad under the resident's bottom, placed a clean pad and clean brief under the resident, then rolled the resident onto her right side. Staff G removed the soiled pad under the resident, rolled the resident onto her back, attached the tabs on her brief, then removed her gloves. Staff C, MDS Nurse, observed the cares as well.

In an interview 10/28/21 at 10:15 AM, Staff C, Licensed Practical Nurse /MDS Nurse, reported she had a concern with how incontinence and pericare was performed on Resident # 31 on 10/28/21 Staff C reported she expected staff cleansed front to back whenever pericare/incontinence care was performed. Staff C stated Resident #31 had a high risk for UTI's and the potential for acquiring an infection easily. Staff C reported she needed to provide education to staff on the proper technique for pericares.

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

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

(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 690	Continued From page 153	F 690		

In an interview 11/4/21 at 9:10 AM, Staff C reported the facility had not completed audits regarding residents cares such as handwashing or pericares. Staff C reported she expected that staff washed their hands before and after cares, and expected gloves to changed after staff completed cares and whenever gloves dirty or soiled.

The facility's policy titled Perineal and Incontinence Care, revised 1/1/14, directed that incontinence care is provided for cleanliness and comfort for the resident and to prevent infections and skin irritations. The procedural steps included:
a. Gather equipment and place on a clean surface
b. Perform hand hygiene and apply gloves
c. Remove soiled brief/underpad by rolling the brief and underpad
d. Cleanse perineal area from front to back, and use a clean cloth for each area cleansed. For females, separate the labia and cleanse on one side, then the other side, and then the center of the labia toward the rectal area. For males, retract the foreskin and cleanse the tip of the penis using a circular motion starting from the urethra and work outward. Cleanse the shaft and scrotum.
e. Cleanse rectal area and buttocks.
f. Assure all areas affected by incontinence have been cleansed.
g. Remove gloves, and perform hand hygiene.
h. Apply clean gloves.
i. Apply protective ointment
j. Remove gloves and perform hand hygiene. Apply clean gloves.
k. Apply clean brief and reapply clothing.
l. Remove gloves and perform hand hygiene.

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

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

(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 690	Continued From page 154 2. Review of the MDS assessment dated 10/10/21 revealed Resident #32 had diagnoses of cerebral palsy, Non-Alzheimer's dementia, mild intellectual disabilities, and infectious gastroenteritis. The MDS documented the resident had moderately impaired cognition. The MDS indicated the resident had incontinence and displayed total dependence on two staff for bed mobility, transfers, and toilet use, and total dependence on one staff for dressing and hygiene. The resident's Care Plan revised on 7/9/21 recorded he had bladder incontinence daily related to dementia, bladder muscle dysfunction, and impaired mobility, and potential for impaired skin integrity related to incontinence and immobility. The staff directives included to check the resident for incontinence frequently and change as required and provide good pericare. During observation on 10/25/21 at 12:33 PM, Staff E and Staff I, CNA, donned gloves, and provided incontinence cares for Resident #32 as he stood on a platform of a sit to stand lift. Staff I removed the resident's soiled brief; the brief had brown stool present. Staff E took disposable wipes, reached under the resident's bottom, and cleansed his buttocks in an upward and downward motion, and used the same disposable wipe to cleanse each buttock. Staff E took two disposable wipes and cleansed the resident's groin in an upward and downward motion on each side. Staff I then placed a clean brief on the resident's buttocks, pulled the brief between his legs and up toward the groin area, and attached the tabs on the brief. Staff removed their gloves.	F 690		

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

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

(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 690 Continued From page 155 F 690

In an interview 10/28/21 at 10:15 AM, Staff C reported she expected staff cleanse front to back whenever pericare or incontinence care is performed.

F 692 SS=D Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) F 692

§483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review, staff interviews, and facility policy review, the facility failed to monitor a resident with who experienced significant weight loss for 1 of 19 residents reviewed (Resident #102). The facility reported a census of 50 residents.

Findings include:

F 692 Continued From page 156 F 692

The Minimum Data Set (MDS) assessment dated 3/8/21 recorded Resident #102 had diagnoses that included Non-Alzheimer's dementia, cancer and depression. The MDS assessment identified a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further revealed Resident #102 required supervision with transfers and set-up with eating.

The resident's Care Plan with a revision date 4/1/21 documented Resident #102 had a nutritional problem with a goal to maintain adequate nutritional status by maintaining current weight, having no signs or symptoms of malnutrition and consuming at least 50% of meals thorough next review with a target date of 5/31/21. The Care Plan directed staff to provide, serve diet as ordered, monitor intake and record every meal, weigh and record per facility protocol

Weight records documented the following weights for Resident #102:
a. 2/28/21 109.0 pounds
b. 3/4/21 102.0 pounds
c. 3/7/21 103.0 pounds
d. 3/14/21 100.0 pounds
e. 3/28/21 100.5 pounds
f. 3/29/21 100.5 pounds
g. 4/8/21 100.5 pounds

The Progress Note dated 3/18/21 at 1:32 PM, the Registered Dietician documented Resident #102 had a significant weight loss of 9 pounds or 9% in the past month with staff direction to continue to monitor the resident's weekly weights.

The clinical record lacked weights obtained

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

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

(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 692	Continued From page 157 following 4/8/21. Review of facility policy titled Weight and Hydration Overview with an issue date February 2016 recorded a resident's nutritional status will be monitored on a regular basis. The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significant gain or loss is a crucial part of the assessment process. Significant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem. Review of the resident's Progress Notes revealed Resident #102 expired 6/28/21 at 7:10 PM. During an interview 11/3/21 at 12:29 PM, the Administrator stated the facility could not locate documented weights for Resident #102 following the weight obtained on 4/8/21.	F 692		
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 clinically indicated and consented to by the resident; and	F 693		

(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 158 §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 clinical record review, observations, staff interviews, and facility policy review, facility staff failed to ensure a gastrostomy tube (g-tube) as connected properly for one of three residents observed for g-tube use (Resident #31). The facility reported a census of 50 residents. Findings Include: The Minimum Data Set (MDS) assessment dated 9/15/21 recorded Resident # 31 had diagnoses of cerebrovascular accident (stroke), hyponatremia, anemia, Non-Alzheimer's dementia, and dysphagia (difficulty swallowing). The resident had total dependence on one staff for eating and required a feeding tube. The MDS indicated the resident received 51% of more of their total calories and 501 milliliters (ml)/day or more average fluid intakes via tube feeding. The resident's Care Plan revised on 9/16/21 documented the resident had dysphagia and required a G-tube for nutrition. The staff directives included provide tube feeding and water flushes as ordered, check tube replacement, and monitor for signs of tube dislodgement or dysfunction. The Order Summary Report dated 9/3/21 instructed staff to change the g-tube tubing with	F 693		

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

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

(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 159	F 693		

each new bottle of tube feeding hung, starting 3/5/21.

The resident's Medication Administration Record (MAR) dated 10/1 - 10/31/21 directed staff to:
a. Check tube placement every morning and at bedtime.
b. Tube feeding at 75 cc (cubic centimeter)/hr (hour) via g-tube start at 3:00 PM and end at 5:00 AM.
c. Flush tube with 200 cc water every 6 hours for g-tube and hydration. The MAR had no documentation of water flushes on 10/3, 10/4 (12 AM and 4 AM), 10/10 (6 PM), 10/16 (6 PM), 10/17 (12 AM and 4 AM), 10/18 (12 AM and 4 AM).
d. Change tubing with each new bottle last documented as changed on 10/26/21.
e. Record the amount of water flush daily at noon and clear the pump after intake recorded. The MAR showed no documentation of water flush amount 10/5, 10/6, 10/7, 10/8, 10/17, 10/18, 10/19, 10/20, 10/21, 10/22, 10/25.

During observation on 10/25/21 at 1:01 PM and 2:56 PM, Resident #31 lay in bed on her back. A bottle of Jevity 1.5 tube feeding formula and a bag of water hung on a pole near the resident's bed. The tubing was draped and hung over the top of the pole, and the end of the tubing had no cap and was exposed to air, and the tubing had no date listed on it.

During observation on 10/27/21 at 9:05 AM, a bottle of tube feeding formula and tubing hung on a pole near the resident's bed. The end of tubing was uncapped and exposed to air.

During observation on 10/27/21 at 12:25 PM, the

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

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

(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 160 resident's feeding pump had a water flush running at 200 ml/hr. A bottle of Jevity formula had 200 ml left in the bottle. The Jevity 1.5 bottle had the date and time of 10/25/21 at 2200 (10 PM) written on the bottle. The water reservoir bag had no date listed. Resident #31 lay in bed on her back and the head of her bed was elevated at 20 degrees. At the time, the MAR documented Staff B's initials for infusion of the water flush. During observation on 10/27/21 at 1:08 PM, Staff C, Licensed Practical Nurse (LPN), donned a pair of gloves, obtained a syringe, and uncovered the resident. Staff C found a plug attached to end of the resident's g-tube port, and water flush infusing onto the pad under the resident. Staff C stated the pad under the resident appeared wet. Staff C stated the tube feeding was not hooked up and she didn't know why a plug for the tubing was attached to the resident's g-tube. Staff C planned to look into what happened and who attached the plug to the g-tube. When informed the tube feeding and water flush were not connected that morning and the date on the Jevity bottle 10/25/21 at 10:00 PM., Staff C confirmed this would have been the date the bottle had been hung. Staff C stated the tube feeding should be changed out at 3:00 PM whenever staff hung a new bottle of formula. Staff C reported a new bottle of Jevity sat on the shelf by the resident's bed and apparently was not hung or changed out 10/26/21 at 3:00 PM when scheduled. Staff C reported enteral formula needed to be changed out every 24 hours. On 10/27/21 at 1:35 PM, Staff C stated she looked at the MAR for Resident #31. Staff V, an	F 693		

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

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

(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 161 agency LPN, documented she hung Jevity on 10/25/21. Staff C reported that Resident #31 had an order for her Jevity infusion to start at 3:00 PM and end at 5:00 AM. The nurse who worked 10/26/21 didn't change the Jevity bottle at 3:00 PM. Staff C stated she wasn't sure who started the infusion on 10/27/21. In an interview 10/27/21 at 1:54 PM, Staff B, LPN, reported she hooked up the water flush for Resident # 31 at 12:00 PM on 10/27/21 because the resident got a 200 ml water flush every 6 hours, and they record the volume according to reading on the pump. At the time, Staff C told Staff B she found a cap attached to Resident #31's g-tube and the flush infusing into the pad under the resident. Staff B reported she was responsible for the infusion not being hooked up correctly. Staff C also stated the date listed on the Jevity bottle was 10/25/21. Staff B then stated she hadn't even looked at the date on the bottle when she connected the water flush. Staff B stated it's good the tubing wasn't connected to the resident's g-tube because the water in the bag was probably moldy or not good. The facility's Medication Administration General Guidelines policy dated 12/17 revealed the individual who administered a medication dose recorded the administration on the resident's MAR after giving the medication. The person who administered the medication initialed on the MAR in the space provided under the date, and on the line for the specific medication administered. If a dose of regularly scheduled medication is withheld, refused or not available, or given at a time other than the scheduled time, initial and circle in the space on the front of the MAR. The physician would be notified if a vital	F 693		

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

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

(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 162 medication was withheld, refused or not available.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and interview, and facility policy review, facility staff failed to follow oxygen administration orders for 1 resident (#3), failed to obtain oxygen orders for 1 resident (#46) and failed to date oxygen tubing for 2 of 3 residents reviewed on oxygen (Residents #3 and #46). The facility reported a census of 50 residents. Findings: 1. The MDS (Minimum Data Set) assessment tool, dated 7/21/21, listed diagnoses for Resident #3 included coronary heart disease, heart failure, diabetes, hypertension (high blood pressure), urinary tract infections, diabetes, hyperkalemia (high potassium), hyperlipidemia (high cholesterol), non-Alzheimer's dementia, multiple sclerosis, depression, Schizophrenia, asthma, and respiratory failure. The MDS stated the resident required assistance of 1 staff for bed mobility, transfers, and toileting. The MDS listed his BIMS (Brief Interview for Mental Status) score	F 695		

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

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

(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 695	Continued From page 163 as 10 out of 15, indicating moderately impaired cognition. The resident's Care Plan, dated 10/15/21, listed Resident #3 with O2 settings via nasal cannula 2-4L, to keep oxygen >90%. The Care Plan also documented Resident #3 had a CPAP machine nightly related to obstructive sleep apnea. Observation on 10/26/21 at 8:26 a.m. revealed Resident #3 with oxygen (O2) running at 3 1/2 liters (L) by nasal cannula. The oxygen tubing did not have a date of it's last change. Resident #3 stated her O2 should be between 3 -4 L/NC. Observation on 10/26/21 at 11:02 a.m. revealed Resident #3 with O2 the concentrator at 3 ½ L/NC and a portable O2 tank set at 3 L/NC. Resident #3 transferred to wheelchair for lunch. Observation and interview on 10/27/21 at 9:48 a.m. with Resident #3 revealed O2 concentrator set at 3 ½ L/NC. Resident #3 stated staff will increase the O2 to 4 L/NC if needed. O2 tubing not dated. Observation on 11/1/21 at 9:41 a.m. of Resident #3 with O2 on at 3 L/NC via oxygen concentrator and undated O2 tubing. Observation on 11/01/21 11:41 a.m. revealed Staff T, Certified Nursing Assistant (CNA) and Staff AA (CNA) assisted Resident #3 with a transfer into the wheelchair. Once in the wheelchair Staff T asked Resident #3 how many liters of O2 she wore then placed the portable O2 tank at that amount and pushed Resident #3 out to lunch. The O2 tubing on portable tank was undated.	F 695		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 695	Continued From page 164	F 695		

Observation on 11/16/21 at 2:10 p.m. revealed Staff C, LPN (Licensed Practical Nurse) turned on Resident #3's BIPAP with settings of 4/8.

During an interview 10/27/21 at 9:54 a.m., Staff B, LPN stated Resident #3's O2 should be at 3 L/NC and that there are no parameters to titrate (increase or decrease) the liters. Staff B reported the resident did not have a Bilevel positive airway pressure (BIPAP) or Continuous positive airway pressure (CPAP). Staff B was not aware of Resident #3's Kardex and if it indicated Resident had either CPAP or BIPAP.

During an interview on 11/15/21 at 4:04 p.m. Staff C stated O2 tubing will be marked with a piece of tape indicating it has been changed and the O2 tubing is changed weekly. Observation at the time of the interview revealed a bucket on the resident's bedside table with tubing inside of it labeled "CPAP."

During an interview on 11/15/21 at 4:06 p.m. Staff V, LPN stated Resident #3 wore a BIPAP at night. Staff V checked the BIPAP setting and stated it said Pressure Support (PS) 4/8. The resident's BIPAP tubing was undated and the mask had a tear.

During an interview on 11/16/21 at 2:25 p.m. a call to BIPAP vendor verified Resident #3 had a BIPAP unknown setting and last physician order received in 2017. On 11/17/21 at 2:38 p.m., the BIPAP vendor stated the resident's last sleep study was completed 12/20/17. The vendor stated the BIPAP is in auto mode, she was not able to verify the BIPAP setting were correct. The vendor stated Resident #3 last wore the BIPAP

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

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

(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 695	Continued From page 165	F 695		

10/5, 10/17, 10/23, and 11/7/21 as it transmitted to her computer. The facility is responsible for maintenance of the BIPAP device as the resident owns the machine.

The current Order Summary Report, dated 11/15/21, listed an order for oxygen 3 liters continuously. The order directed staff to assist with CPAP mask placement every night and check placement every night related to obstructive sleep apnea with BIPAP settings at 19/15 with 3L O2.

Physician order dated 11/9/21 directed staff to set the the BIPAP settings at 19/15 with 3L O2.

The resident's Treatment Administration Record (TAR) dated 10/2/21-10/31/21 lacked documentation that staff applied the CPAP at night for 31 of 31 days. The TAR dated 11/1/21-11/30/21 also lacked documentation that staff applied the CPAP at night for 12 of 15 days between 11/1-11/15/21.

The facility failed to document physician order for BIPAP, instead documenting CPAP usage.

The facility's undated policy titled Oxygen Therapy Overview, instructed:
a. Place tubing in a labeled and dated bag when not in use.
b. Change tubing weekly and as needed (PRN).

The resident's Physician Orders, dated 10/25/21 directed staff to:
a. Change humidifier tubing weekly at bedtime every Wednesday.
b. Change oxygen tubing every week at bedtime every Wednesday

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

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

(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 695	Continued From page 166	F 695		

c. May apply oxygen via nasal cannula at 3L/NC continuous every morning and at bedtime.
d. BIPAP settings 19/15 with 3L/02.

The TAR of 10/1 - 10/31/21 documented to change the oxygen and humidifier tubing weekly at bedtime every Wednesday. The facility lacked documentation for 4 of 4 days.

Per https://www.sleepassociation.org/sleep-apnea/cpap-vs-bipap/ BIPAP refers to Bilevel or two-level Positive Airway Pressure. Like CPAP, this sleep apnea treatment works by sending air through a tube into a mask that fits over the nose. While CPAP generally delivers a single pressure, BiPAP delivers two: an inhale pressure and an exhale pressure. These two pressures are known as inhalation positive airway pressure (IPAP) and exhalation positive airway pressure (EPAP).

2. The MDS assessment dated 10/8/21 documented Resident #46 had diagnoses of chronic lung disease, seizure disorder, and anxiety disorder. The MDS indicated the resident had a Brief Interview for mental status (BIMS) score of 14, indicated intact memory and cognition. The assessment documented the resident required oxygen during the 14-day look-back period.

The Care Plan updated on 4/28/21 revealed the resident had oxygen therapy related to respiratory illness and COPD, and had a risk for contracting an infection. The staff directives included provide oxygen as ordered and monitor for signs or symptoms of respiratory distress.

The Order Summary Report dated 9/3/21 lacked

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

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

(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 695	Continued From page 167 documentation to show the resident had a physician's order for oxygen. The Medication Administration Record and TAR dated 10/1 - 10/31/21 lacked documentation for oxygen use and contained no dates to show when the staff last changed the oxygen tubing or humidifier bottle. During observation on 10/25/21 at 2:37 PM, an oxygen concentrator had a humidifier bottle and oxygen tubing attached and sat next to the resident's bed. The oxygen tubing and humidifier bottle had no date listed to indicate when staff last changed that equipment. During observation on 10/26/21 at 9:35 AM, Staff I, certified nursing assistant (CNA) assisted Resident #46 into bed and applied oxygen per nasal cannula. The oxygen tubing and humidifier bottle had no date listed to show when staff placed the items in the room. During observation on 10/27/21 at 8:55 AM, Resident #46 had oxygen on via nasal cannula. The oxygen tubing and humidifier bottle had no date listed to indicate when staff changed the tubing and bottle. In an interview 10/26/21 at 9:35, Resident #46 reported she used oxygen continuously and thought staff changed the oxygen tubing every 2-3 weeks, but was uncertain when the oxygen tubing or humidifier bottle were last changed. In an interview 11/4/21 at 9:10 AM, Staff C, MDS Coordinator reported a physician's order was required whenever a resident used oxygen and stated the expectation that staff change oxygen	F 695		

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

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

(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 695	Continued From page 168 tubing weekly. In an undated policy titled Oxygen Therapy Overview directed oxygen is a drug prescribed by the physician. Oxygen concentrators and their filters should be maintained for optimal function, and staff should change oxygen tubing and high flow devices weekly and PRN (as needed).	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: DESCRIPTION: Based on clinical record and policy review, observations, and staff, resident, and family interviews, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 2 residents reviewed (Resident #50). The facility reported a census of 50 residents. Findings: 1. The Minimum Data Set (MDS) assessment dated 10/6/21 indicated Resident #50 had diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine,	F 697		

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

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

(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 697	Continued From page 169	F 697		

Continued From page 169
dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain. The MDS documented the resident scored 15 of 15 possible points on the Brief Interview for Mental Status (BIMS) test, which meant she demonstrated intact cognitive abilities. The MDS also documented Resident #50 required assist of 1 staff with bed mobility, transfers, and toilet use, and set-up assist for eating. Resident #50 had moisture related skin damage and ointments applied during the lookback period.

Review of the resident's Care Plan revealed a lack of information, planning, interventions, and staff directives related to management of the resident's pain.

In an observation on 10/25/21 at 3:42 p.m., Resident #50 sat in her recliner. The resident reported she often had to wait a long period for staff to bring her pain medication for gastric tube (GT) site pain. She stated she had a scheduled a pain pill at 8 a.m. today but did not receive a pain pill until noon, and described her current pain level as 8 out of 10 (0=Nothing. 10=the worst pain ever felt). The resident appeared to be in pain with facial grimacing observed whenever she moved.

On 10/27/21 at 1:11 p.m., Resident #50 reported her current pain level as 5 out of 10. The resident stated she received a pill at noon and commented the nurses do not try to keep my pain controlled and not all nurses apply Dermaceptin as ordered twice per day. She added when staff needed to change her dressing, her pain increased and she now required a Fentanyl patch plus the Hydrocodone for pain. Resident #50 stated since

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 697	Continued From page 170	F 697		

the physician started the Fentanyl patch, the nurses do not seem to think she needed the Hydrocodone and took longer to medicate her.

On 11/1/21 at 11:00 a.m., the resident's tube feeding (TF) infused through her GT. Observation revealed the resident in visible pain and alternating her position while she sat. Resident #50 reported she had a rough weekend; the facility ran out of her pain medicine and the nurse did not change her dressings as ordered. She specified that the primary source of her pain is her GT and abdominal wounds when not treated with ointment.

During an interview on 10/27/21 at 2:34 p.m., Staff C, LPN, explained the nurses documented skin assessments in the electronic health (EHR), under the assessments tab tilted Skin Observation Tool.

In a subsequent interview on 11/01/21 at 11:30 a.m., Staff C, Licensed Practical Nurse (LPN) reported the facility did not have a process for reordering medication, but usually when a medication runs low, the certified medication aide (CMA) or LPN will place a sticker on the reorder form and fax it to the pharmacy.

During an interview on 11/1/21 at 11:35 a.m., the Administrator (ADM) reported the facility had no specified process for reordering medication; it is not one person's responsibility to reorder narcotics or other frequently used medications.

During an interview on 11/1/21 at 1:15 p.m., the Director of Nursing (DON) stated Staff C, LPN gave Resident #50 Hydrocodone at 7:00 a.m. on 11/1/21. At 2:50 p.m., the DON added the

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

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

(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 697	Continued From page 171 resident received a Hydrocodone at 7:30 a.m. today, but she failed to sign out the narcotic and Staff C gave the resident Tylenol at noon. During an interview on 11/1/21 at 3:30 p.m., Staff C, LPN reported the DON had removed Hydrocodone from the facility Emergency Kit (E-kit) 11/1/21 and administered the medication to Resident #50. Staff C stated the facility ran out of Hydrocodone for Resident #50 over the weekend and since the facility pharmacy is located in Minnesota, the refill will not arrive until 11/2/21 at approximately 2 a.m. On 11/01/21 at 3:30 p.m., the resident reported an improvement of pain from 10 out of 10, to 9 out of 10 after Staff C, LPN changed her abdominal dressing. Resident #50 stated the dressing change decreased her pain level more than the pain medicine did. On 11/1/21 at 3:40 p.m., Staff C, LPN, stated she gave the resident Tylenol at noon today, but did not sign the medication record. She also said she was not aware the resident did not have a physician order for Tylenol. On 11/1/21 at 3:45 p.m., the DON reported she placed a call to the facility physician to obtain Hydrocodone from the E-Kit for Resident #50. On interview on 11/2/21 at 9:39 a.m., Staff C, LPN said nursing staff are to document the effects of pain medicine in the progress notes. During an interview on 11/4/21 at 9:09 a.m., Staff C, LPN, stated the facility wound physician would visit Resident #50 11/4/21. She explained the physician visits the facility every week and had	F 697		

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

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

(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 697	Continued From page 172	F 697		

not seen Resident #50 prior to 11/4/21, as she had not needed a wound doctor. Staff C stated she updated the Care Plan for each resident quarterly or PRN and added that wound cares would be on a Care Plan if ordered. Staff C reported she looked at Activities of Daily Living (ADL) sheet, History & Physical (H&P), and physician orders to update Care Plans, which were updated within 24 hours.

During an interview on 11/03/21 at 9:50 a.m., the DON stated she expected Staff C, PLN to update the residents' Care Plan within 24-48 hours.

During an interview on 11/3/21 at 12:00 p.m., the DON revealed the Certified Nurse Assistants (CNA's) Shower Day Skin Audit is where staff document the resident skin on shower days. DON stated the Certified Nurse Assistants (CNA's) would have been aware of Resident #50's abdominal wounds and therefore did not make mention of them on the tools. DON stated the expectation would be for staff to draw on the body diagram Resident #50's abdominal wounds.

During an interview on 11/04/21 at 2:23 p.m., Staff C, LPN stated she could not locate prior documentation of Resident #50's abdominal wounds in her medical records.

During an interview on 11/22/21 at 5:45 p.m., Wound Physician stated she has been rounding on residents at the facility since September 2021. Wound Physician made an initial round on Resident #50 on 11/11/21.

During an interview on 12/6/21 at 10:00 a.m., Power of Attorney (POA) stated Resident #50 admitted to the facility with abdominal wounds

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

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

(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 697	Continued From page 173 present. POA stated the wounds have gotten worse and she had asked for a wound doctor to see Resident #50 in September. The DON told the POA that Staff C, LPN was a wound nurse. The MAR dated 10/1/21-10/31/21 lacked documentation to show staff gave Hydrocodone for pain on 10/25/21. The Individual Residents Controlled Substance Record for Hydrocodone-Acetaminophen (APAP) 5/325 mg, 1 tablet by mouth every 4 hours as needed for pain, revealed the documentation on 10/25/21 appeared altered from 12:00 p.m. to 8:00 a.m.; documentation dated 10/31/21 revealed 1 remaining Hydrocodone at 3 p.m. A MAR, dated 10/1/21-10/31/21 lacked documentation to show staff administered the resident's Fentanyl patch on 10/19/21 and 10/22/21. A Physician Order Summary (POS) dated 10/11/21 revealed: a. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet via GT every 4 hours as needed for pain. b. Fentanyl patch 72 hour 25 microgram (MCG)/hour, apply transdermally every 72 hours related to acute ischemia of intestine. Review of the MAR, dated 11/1/21-11/3/21 revealed no documentation to indicate staff administered Hydrocodone as needed for pain on 11/1/21-11/3/21. The MAR dated 11/1/21-11/30/21 revealed staff gave Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet two times per day for pain on	F 697		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 697	Continued From page 174 11/1/21 at 7:30 a.m. and 8:30 p.m. The Individual Residents Controlled Substance Record, dated 11/1/21 revealed: a. 6:03 p.m.: Zero Hydrocodone on hand, 1 received from E-kit, 1 given, 0 remaining b. 10:05 p.m.: Zero Hydrocodone on hand, 2 received from E-kit, 1 given, 1 remaining c. 11/2/21 2:00 a.m.: 1 Hydrocodone on hand, 0 received, 1 given, 0 remaining The MAR, dated 11/1/21-11/30/21 lacked documentation of staff administration of Fentanyl patch on 11/1/21. The Physician Order Summary dated 11/4/21 revealed the following orders: a. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet via GT every 4 hours as needed for pain. b. Hydrocodone-Acetaminophen tablet 5-325 mg, give 1 tablet by mouth two times per day for pain b. Fentanyl patch 72 hour 25 microgram (MCG)/hour, apply transdermally every 72 hours related to acute ischemia of intestine. The Baseline care plan dated 6/9/21 lacked documentation of current or past skin integrity issues. The resident's Care Plan lacked staff directives related to cares and interventions from skin breakdown. A physician order dated 6/9/21 directed licensed nurse to complete weekly skin check.	F 697		

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

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

(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 697	Continued From page 175 A Skin Assessment Tool, dated 10/14/21 in the EHR revealed Resident #50 had one excoriated area around the GT site only. The resident's record did not have any other Skin Assessment Tools documented. The facility documents in the EHR titled Weekly Wound Observation, dated 10/28/21, revealed blank documentation. The resident's record did not have any other Weekly Wound Observations. The facility policy titled Medication Ordering and Receiving from Pharmacy, dated 12/2017 directed: a. Reorder medication five days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand. b. The refill order is called in, faxed, sent electronically or otherwise transmitted to the pharmacy. The pharmacy label is pulled and transmitted to the pharmacy. Resident #50 chart lacked a physician order for Tylenol. A Shower Day skin audit form for 10/1-10/29/21 revealed Resident #50 did not have any open areas noted six times by three different staff members. Facility document titled Medication Administration -Preparation and General Guidelines, dated 12/2017 revealed: Documentation: the individual who administers the medication dose records the administration. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered	F 697		

(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 697	Continued From page 176 and documented. When PRN meds are administered: Date, time of administration, dose, route of administration; complaints or symptoms for which the med was given; results achieved from giving the dose and the time results were noted; signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medications. Resident #50 Progress Note, from date range of 6/21/21 through 11/20/21 revealed: a. 6/21/21 Nurse Practitioner (NP) requested to see resident for increased pain at GT site with redness and irritation, green/yellow drainage from insertion site on gauze and around tube. Plan to start on Keflex 500 milligrams (MG) x 7 days. Resident #50 stated Tylenol has not controlled pain. b. 6/21/21 NP documented to start Keflex 500 MG twice per day (BID) x 7; monitor GT site; monitor pain; skin checks per protocol c. 6/22/21 Staff DD, Registered Nurse documented she received nurse order to start Keflex 500 MG BID for x 7 days for skin infection and to start Hydrocodone-Tylenol (APAP) 1 tablet every 6 hours as needed (PRN) for pain. Faxed to Pharmacy at 2:15 a.m. d. 6/27/21 Staff Z, RN documented she changed GT dressing and noted 3 centimeter (CM) by 2 CM open abrasion approximately 1 inch above the left side of GT, no drainage from wound, Resident #50 stated tender to touch and pain med given e. 6/27/21 Staff EE, LPN documented open, red areas remain on abdominal creases f. 6/29/21 Staff FF, LPN documented Resident	F 697		

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

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

(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 697	Continued From page 177 #50 on antibiotics for skin infection surrounding GT, red and raw in some areas, painful per Resident. 7/4/21 NP ordered Dermaceptin BID to GT site BID 7/19/21 NP documented Resident #50 reported increased pain localized to GT site. Wound culture showed no growth. Resident evaluated in emergency department. 7/20/21 Staff CC, RN documented to start Hydrocodone-APAP 1 tablet every 4 hours for GT pain. 8/31/21 NP documented to see Resident #50 for increased pain. 9/6/21 Director of Nursing (DON) documented to start Bactrim (antifungal) BID for 10 days 9/10/21 Staff GG, LPN documented Resident #50 cried in pain during the night from pain at GT site. 9/17/21 Staff GG documented on Physician Progress Note for Bactrim DS tablet 800-160 MG, 1 tablet by GT for GT site infection until 9/26/21 9/26/21 Staff D, LPN documented GT site raw and extremely painful. Resident needs seen for pain management. 9/28/21 NP documented Resident #50 with increased pain at GT site, staff state red with odor, started Diflucan 150 MG x 3 days. 10/13/21 Staff HH, RN documented Resident #50 upset that the nurse had to call the pharmacy for more pain medicine. 11/4/21 Staff V, LPN documented Resident #50 Fentanyl patch increased, resident taking scheduled and PRN Hydrocodone with continued complaints of pain. 11/11/21 Wound Physician rounded on Resident #50 11/13/21 Staff B, LPN documented GT skin dark pink and draining, continued to be tender and	F 697		

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

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

(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 697	Continued From page 178 Resident appeared to be in pain. 11/20/21 Staff D, LPN documented GT site very red, raw, and painful. Facility policy titled Interdisciplinary Care Plan Meeting, dated 1/24/2019 directed: The initial Interdisciplinary Care Plan Meeting will be scheduled post completion of the initial Resident Assessment Instrument (RAI). Subsequent meetings will take place quarterly, upon significant changes, and as needed. Facility policy titled Comprehensive Person Centered Care Plan, dated 1/24/2019 directed: a. Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. b. For each problem, need, or strength a resident-centered measurable goal is developed. c. Upon change in condition, the Comprehensive Person Centered Care Plan or baseline Care Plan will be updated if: to reduce the risk/occurrences with a problem area, including goals and interventions to reduce the risk/occurrence.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 698		

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

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

(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 698	Continued From page 179	F 698		

by:
Based on clinical record review and staff interviews, the facility failed to monitor a dialysis resident's daily weight as ordered and to auscultate bruit (whooshing sound heard through a stethoscope of a fistula site) and palpate thrill (gentle vibration of fistula site) every shift as ordered for 1 of 1 residents reviewed for dialysis (Resident #2). The facility reported a census of 50 residents.

Findings include:

Resident #2's Minimum Data Set (MDS) assessment dated 10/21/21 recorded diagnoses of chronic kidney disease (stage 5 or end stage renal disease), diabetes, and major depressive disorder. The MDS documented the resident had a brief interview for mental status score of 12, indicating moderately impaired memory and cognition. The MDS indicated Resident #2 required dialysis while residing at the facility. The MDS documented Resident #2 entered the facility on 7/14/21.

Review of the Physician's Orders for Resident #2 revealed orders for daily weights (starting 7/26/21) and to auscultate bruit and palpate thrill every shift of Resident #2's new fistula (starting 7/26/21). A fistula is an abnormal connection of two body parts, such as a vein and artery, done surgically.

Review of the resident's Weight Records in the electronic health record (EHR) revealed only 7 weights documented since admission: 7/20/21, 7/27/21, 8/5/21, 8/12/21, 8/19/21, 9/2/21, and 10/8/21.

(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 698	Continued From page 180 Review of Treatment Administration Records of 8/21 through 10/21 revealed no bruit auscultated or thrill palpated each shift, and fistula not checked for 8 days: 8/9/21, 8/10/21, 9/7/21, 9/15/21, 9/28/21, 9/29/21, 9/30/21, and 10/19/21. During interview on 11/1/21 at 2:35 PM, Staff B, Licensed Practical Nurse (LPN), stated the Certified Nurse Aides (CNA) wrote weights on paper and gave them to the nurse to record on the TAR. During interview on 11/9/21 at 11:03 AM, the MDS Coordinator stated resident weights are measured monthly and weekly by CNA's, and nursing staff entered the weights in the EHR. The MDS Coordinator stated if a resident had an order for daily weights, she expected the weights to be done daily, and if any order besides monthly weights, it would be on the care plan.	F 698		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		

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

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

(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 725	Continued From page 181	F 725		

Continued From page 181

types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, and staff interviews, the facility failed to ensure staff responded and answered a resident's request for assistance within 15 minutes, and met residents needs in a timely manner for one of nineteen residents reviewed (Residents #11). The facility reported a census of 50 residents.

Finding include:

Review of the Minimum Data Set (MDS) assessment dated 8/11/21 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The MDS indicated the resident had diagnoses of cerebral palsy, anxiety disorder, and seizure disorder. The MDS recorded the resident displayed total dependence on two staff for transfers and toilet use, and total dependence on one staff for locomotion on and off the unit.

The resident's Care Plan, revised 6/8/21, documented the resident as at risk for falls and that she required assistance with activities of daily living. The staff directives included to anticipate

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

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

(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 725	Continued From page 182 and meet the resident's needs, and encourage resident to call for assistance. Observations on 10/27/21 revealed the following: a. At 10:45 AM, Resident #11 sat in a wheelchair at a table in the upper dining room, and hollered out why it took so long to find someone to help her. A dietary staff person was visible in the kitchen, but no other staff were in the area. The resident had no call light or way to call for assistance other than to yell. b. At 10:57 AM, Staff G, certified nursing assistant (CNA) walked by the resident and told Resident #11 she would help her in a little bit. Staff G then walked into another resident's room on the 100 hall. c. At 10:59 AM, Resident #11 cried out "if you don't lay me down, I'm not going to eat," then started to cry. d. At 11:01 AM, Staff H, CNA, wheeled Resident #11 in her wheelchair from the dining room to her room, then left the resident's room. e. At 11:04 AM, Staff H walked by Resident #11's room and told her staff was on the way, then went to obtain the mechanical lift and wheeled the lift into the resident's room. In an interview 11/4/21 at 9:10 AM, Staff C, Licensed Practical Nurse/ MDS Nurse reported she expected call lights to be answered within 15 minutes. Staff C reported no audits done for call lights and staff response times. In an interview 11/10/21 at 9:15 AM, the Administrator reported she expected staff responded to call light or assistance of a resident within 10-15 minutes.	F 725		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		

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

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

(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 727	Continued From page 183 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interviews, the facility failed to provide eight consecutive hours of Registered Nurse coverage seven days a week. The facility reported a census of 50. Findings include: Review of the facility forms titled Nursing Staff Assignment from 10/1 - 10/27/21 revealed no Registered Nurse scheduled to work on 10/3, 10/10, 10/16 and 10/17/21. Interview on 10/27/21 at 2:30 pm with Staff A Certified Nursing Assistant/Scheduler revealed that staff had set schedules and verified that on the above dates there were no Registered Nurse scheduled or who worked at the facility. During interview on 10/28/21 at 10:01 am with the Director of Nursing verified that she was not in	F 727		

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

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

(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 727	Continued From page 184 the facility on the above listed dates. The Director of Nursing stated she expected that the CMS guidelines related to the 8 hours of RN coverage a day be followed.	F 727		
F 760 SS=G	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 clinical record review, staff interviews, and policy review, the facility failed to ensure the residents were free from significant medication errors for two of eight residents reviewed with diagnoses of COVID-19 (Resident #16 and #34). The failure resulted in Resident #16's decline in condition and required admission to a higher level of care. The facility reported a census of 50 residents. Findings include: 1. The annual Minimum Data Set (MDS) assessment tool dated 11/5/21 revealed Resident #16 had diagnoses that included non-Alzheimer's dementia, anemia, pulmonary embolism (PE), chronic obstructive pulmonary disease (COPD), atrial fibrillation, breast cancer, and diabetes. The MDS revealed the resident had impaired short and long-term memory, poor appetite for 12-14 days during the 14 day look-back period, and was totally dependent on one staff for eating and activities of daily living (ADL's). The care plan revised 11/11/21 revealed the resident had diagnoses that included COPD,	F 760		

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

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

(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 760	Continued From page 185 anemia, dementia, diabetes and hypertension (HTN). The care plan documented the resident as at risk of contracting COVID-19 due to nursing facility and community living and had a risk of fatal complications of infection due to her advanced age and a compromised immune system. The care plan showed the resident moved to a transitional private room on 10/25/21 due to exposure to a COVID-19 positive resident. On 11/1/21, the resident tested positive for COVID-19 and moved to the COVID unit, and on 11/11/21, the facility deemed the resident recovered from COVID-19. Staff directives included administer medications as ordered and monitor for elevated temperature, respiratory symptoms such as cough, sore throat, and shortness of breath. The physician's progress notes dated 11/8/21 and entered on 11/9/21, revealed Resident #16 tested positive for COVID-19 on 11/1/21. The treatment plan included start vitamin C 500 milligrams (mg) daily (qd) for 30 days, vitamin D 5,000 international units (IU) qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days. The physician's progress notes dated 11/12/21 and entered on 11/14/21, documented the facility moved the resident was removed from isolation on 11/11/2021. The treatment plan included continue the vitamin D, vitamin C, aspirin, and zinc medications as ordered. Review of the physician order summary and electronic health record (EHR) revealed it lacked orders for vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30	F 760		

(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 760	Continued From page 186 days. The medication administration record dated 11/1 - 11/30/21 failed to contain documentation regarding the vitamin C 500 mg qd, vitamin D 5,000 IU qd, zinc 220 mg qd, and aspirin 325 mg qd ordered by the physician. The progress notes revealed the following: a. On 10/26/21 at 11:26 AM, resident moved to transitional hall due to roommate tested positive for COVID-19. Resident #16 tested negative for COVID-19. b. On 10/30/21 at 6:58 PM, resident seen by provider due to 14 residents and 3 staff at the facility tested positive for COVID-19. Resident #16 at high risk for COVID-19 due to history of COPD, PE, breast cancer, heart disease, dementia, diabetes, and HTN. c. On 11/1/21 at 7:19 AM, The resident's COVID point of care test is positive - resident moved to COVID unit. d. On 11/2/21 at 7:54 AM, Resident's PCR test (used to detect genetic material from a specific organism, such as a virus) results positive for COVID. e. On 11/9/21 at 10:35 PM, resident on droplet and contact precautions due to positive COVID-19 test. The resident had poor appetite and didn't want to eat supper, and not drinking fluids when offered - respiration easy and unlabored. No cough observed. Pulse oximeter 94% on room air. f. On 11/12/21 at 7:46 AM isolation discontinued on 11/11/21. g. On 11/13/21 at 11:34 AM, lungs sound diminished bilaterally in bases and transient wheezes audible. h. On 11/17/2021 at 4:55 PM, resident up for	F 760		

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

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

(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 760	Continued From page 187	F 760		

breakfast but would not stay awake and refused to eat. Resident asked to lie down. Staff returned resident to bed. Blood Pressure (B/P) 98/69, temperature (T) 97.9, pulse (P) 103, respirations (R) 13. Resident also refused lunch and asked to be left alone.
i. On 11/18/2021 01:48 resident up for evening meal and had a fair appetite. Resident assisted to lie down after dinner.
j. On 11/18/2021 at 04:00, resident has not voided this shift. Gave resident 240 cubic centimeters (cc) water.
Resident skin pale white and bluish in color on hip and in between knees and skin blanched poorly. Resident repositioned off of her right side.
j. On 11/18/2021 at 11:53 AM nurse summoned to resident's room. Resident less responsive and had significant change in her condition. B/P 106/56, P 94, R 23. Provider notified and attempted to notify family. Resident sent to the emergency department (ED).
k. On 11/19/2021 at 05:33, nurse from hospital contacted facility and advised Resident #16 passed away.

In an interview 11/23/21 at 09:31 AM, Staff D, Licensed Practical Nurse (LPN), reported usually the nurse that received the physician's order entered the order into the EHR, but it also depended on which nurse had time to enter the orders.

In an interview 11/23/21 at 09:46 AM, Staff Z, Registered Nurse (RN), reported the nurses entered physician orders whenever they received the orders.

In an interview 11/23/21 at 11:35 AM, Staff JJ, RN, reported the nurses entered orders whenever

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

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

(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 760	Continued From page 188	F 760		

they received new physician orders.

In an interview 11/23/21 at 12:50 PM, the Director of Nursing (DON) reported the facility had no policy for physician's orders. The DON stated physician's orders were just standard procedure. The DON explained whenever staff obtained an order, she expected them to enter the orders into the EHR, and process the orders. The DON reported the order summary report dated 10/11/21 were the most current orders for Resident #16. The DON provided a report of orders entered into the EHR after 10/3/21 for Resident #16; the report revealed only an order for a pain assessment entered on 11/4/21 but no medication orders entered.

In an interview 11/23/21 at 01:15 PM, the nurse practitioner (NP) confirmed she ordered the following for Resident #16 on 11/9/21:

Start vitamin C 500 mg qd for 30 days,
Start vitamin D 5,000 IU qd for 30 days
Start zinc 220 mg qd for 30 days
Start aspirin 325 mg qd for 30 days

The NP reported these medications were the standard cocktail of medications prescribed whenever a resident had COVID-19. The NP confirmed no staff contacted her about orders staff failed to order or administer as prescribed for Resident #16. The NP stated the resident didn't have many signs or symptoms of COVID-19 but had tested positive for COVID-19. The resident then stopped eating and had a decline in health, and was sent to the hospital.

A facility policy for Medication Administration Preparation and General Guidelines dated 12/17,

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

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

(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 760	Continued From page 189 directed staff to administer medication as prescribed in accordance with the prescriber's orders. 2. The annual MDS assessment dated 9/22/21 revealed Resident #34 had diagnoses of Alzheimer's dementia, anemia, malnutrition, and vitamin D deficiency. The MDS revealed the resident had impaired short and long-term memory and was totally dependent on one staff for ADL's. The care plan revised 11/9/21 revealed the resident had a risk of contracting COVID-19 due to nursing facility community living and at risk of fatal complications of infection due to her advanced age and a compromised immune system. The care plan revealed the resident moved to a COVID unit on 10/25/21 due to positive COVID-19 and symptoms of fatigue and malaise. The care plan documented the resident deemed recovered from COVID on 11/4/21 and directed staff to administer medications as ordered and monitor for elevated temperature, respiratory symptoms such as cough, sore throat, and shortness of breath. A physician's progress note dated 10/30/21 for date of service 10/29/21 revealed resident tested positive for COVID-19 on 10/26/21 but had no symptoms. The treatment plan included to: start vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days. The order summary report revealed aspirin 325 mg qd, vitamin C 500 mg qd, vitamin D 5,000 IU qd, zinc 220 mg qd had an order date 10/26/21 and an end date 11/26/21.	F 760		

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

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

(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 760	Continued From page 190	F 760		

The MAR dated 10/1 - 10/31/21 lacked medication entries/orders 10/29 - 10/31/21 for aspirin 325 mg qd, vitamin C 500 mg qd, vitamin D 5,000 IU qd, and zinc 220 mg qd..

In an interview 11/23/21 at 09:31 AM, Staff D, LPN, reported the nurse who received the physician's order entered the order in the EHR but it also depended on who had time to enter the orders.

In an interview 11/23/21 09:46 AM Staff Z, RN, reported the nurses usually entered orders in the EHR.

In an interview 11/23/21 at 12:50 PM, the DON reported the facility had no policy for physician's orders. The DON stated physician's orders were just standard procedure. The DON explained whenever an order obtained, she expected orders entered into the EHR, and the orders processed.

In an interview 11/23/21 at 01:15 PM, the NP confirmed she ordered to start vitamin C 500 mg qd for 30 days, vitamin D 5,000 IU qd for 30 days, zinc 220 mg qd for 30 days, and aspirin 325 mg qd for 30 days on 10/29/21.
The NP reported the medications were a standard cocktail she prescribed whenever a resident had COVID-19. The NP confirmed no staff contacted her about orders not implemented or medication not administered as prescribed.

F 761 SS=D — Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2) — F 761

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be

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

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

(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 761	Continued From page 191	F 761		

labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews, and facility policy review the facility failed to properly monitor the storage of refrigerated medications for 1 of 1 medication refrigerators, and failed to dispense medications from manufacturer labeled container. The facility identified a census of 50.

Findings include:

1. Review of the medication storage room in the downstairs area on 10/27/21 at 12:44 PM revealed a document titled Freezer/Refrigerator Temperature Log attached to the front of the refrigerator. Staff C, MDS Nurse was present

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

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

(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 761	Continued From page 192	F 761		

during the inspection of the medication storage room and verified that the Refrigerator Temperature Log sheet had not been documented since 5/9/21. Staff C stated the refrigerator temperature checks should be done by night shift as it is assigned to their duty list and temperatures should have been logged.

Medication in the downstairs storage room refrigerator during the inspection included:
a. Bisacodyl suppositories 10 mg (milligrams) in an opened box.
b. Levemir (insulin) 3 bottles for Resident #20.
c. Basaglar (insulin) 4 pens for Resident #2.
d. Lorazepam 3 vials for Resident #36.
e. Lantus (insulin) 3 vials for Resident #49.
f. Lantus (insulin) 3 vials for Resident #5.

In an interview on 10/27/21 at 1:00 PM, the Director of Nursing (DON) stated she expected medication refrigerator temperature logs be filled out.

In an interview on 10/28/21 at 10:11 AM, Staff C stated the medications in the refrigerator eventually would be used for the residents.

Review of a form titled 6 PM-6 AM Nurse Duties indicated that refrigerator temperatures needed to be logged every day.

Review of a Medication Storage facility policy dated 11/18 indicated the facility should maintain a temperature log in the storage area to record temperatures at least once a day.

2. During a medication pass observation on 10/26/21 at 11:40 AM, Staff X, Certified Medication Aide (CMA) reported she planned to

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

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

(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 761	Continued From page 193	F 761		

administer an extra strength (ES) Tylenol 500 mg tablet to Resident #15. When Staff X obtained the medication from the medication cart it was noted that the medication was not in a manufactured labeled bottle or individually dispersed packet or bubble pack. The medication was in a denture cup and Tylenol ES 500 mg written in marker on the lid of the denture cup. At the time, Staff X stated she knew it wasn't legal but she used a denture cup to store the ES Tylenol. The CMA proceeded to get the ES Tylenol tablet out of the container and added to the rest of the resident's medication she prepared for the resident.

In an interview on 11/4/21 at 10:15 AM, the DON stated she expected stock medications to be administered from a manufacturer's labeled bottle. The DON stated for resident specific medications, the facility utilized bubble cards or medication packets but all stock medications should be in their original manufacturer's bottles and labeled with a date when they were opened. The DON stated it would never be okay for staff to pass medications out of a denture cup.

Per the policy on Medication Storage in the Facility, dated 11/18, the policy directed the provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmacopeia (USP). Medications are kept in these containers. Nurses may not transfer medications from one container to another or return partially used medications to the original container. It further states drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's

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

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

(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 761	Continued From page 194 expiration date is reached.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, observations, staff interviews, and facility policy review, the facility failed to ensure staff prepared food by methods that conserved nutritional value for pureed food for 1 of 1 residents sampled on a pureed diet (Resident #40). The facility reported a census of 50 residents.

Findings include:

The Minimum Data Set (MDS) assessment dated 10/1/21 recorded Resident #40 had diagnoses of Alzheimer's disease, dysphagia (swallowing difficulties), and anoxic brain damage. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS revealed the resident required assistance of one person for eating.

Observation on 10/26/21 at 11:07 AM revealed Staff Q, Cook, added a cup of hot water to meat in a blender. Staff Q continued to add thickener

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

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

(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 804

Continued From page 195

and stated she added the thickener in case she had added too much water to the pureed meat contents. At 11:10 AM Staff Q scooped the pureed meat into a pan to be served to Resident #40.

Interviews on 10/26/21 at 01:01 PM with the Dietician and Dietary Manager revealed they expected staff to use something with nutrition or flavor instead of just water for pureed diets.

Review of the facility policy on Pureed Diet Guidelines, updated 10/4/21, Section 3 instructed staff to add milk, broth, or other liquid as needed for product consistency (usually 2-3 tablespoons per serving), and never puree with water.

F 812 SS=E

Food Procurement,Store/Prepare/Serve-Sanitary
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

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

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

(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 812	Continued From page 196 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure staff sanitized their hands after contamination in order to prevent food borne illness and handle food in a sanitary fashion for 1 of 2 dining observations. The facility reported a census of 50. Findings include: Observation on 10/26/21 at 11:45 AM Staff Q, Cook, started serving lunch. At 11:46 AM, Staff Q grabbed a grilled cheese sandwich by hand and placed it on a plate to serve to a resident. At 11:54 AM, without hand hygiene, Staff Q held meat with her hand and cut a portion of burnt meat off, then placed the meat on a plate to serve a resident. The Dietary Manager then gave Staff Q tongs to dish up meat, and Staff Q started using the tongs. At 11:55 AM, Staff Q threw the tongs into the meat and the handle touched the meat. Staff Q's phone rang at 12:23 pm, she took the phone out of her pocket and threw it under the tray cart. Without hand hygiene, at 12:24 PM Staff Q used her hand to hold the inside of Styrofoam boxes where she was going to serve the food. Staff Q repeated this 3 times. Interview on 10/26/21 at 1:03 PM the Dietician and Dietary Manager both stated the expectation that staff not touch food and plates with their hands, and staff used tongs when served food.	F 812		
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a	F 838		

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

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

(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 838	Continued From page 197	F 838		

facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

§483.70(e)(1) The facility's resident population, including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy,

(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 838	Continued From page 198	F 838		

pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to update their facility assessment annually. The facility assessment also included data from over a year ago and not updated upon facility review. The facility reported a census of 50.

Findings include:

Review of the Facility's Assessment revealed the assessment reviewed on 9/3/2021, and last updated on 3/2020. The data entered on the facility assessment updated 9/3/2021 had statistics and notes from 3/2020.

Interview on 11/17/21 at 11:19 AM, the Administrator stated they had nothing more current than the facility assessment provided.

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

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

(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 842	Continued From page 199	F 842		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,

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

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

(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 842	Continued From page 200	F 842		

medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and facility policy review, the facility failed to store resident medical and business related records in a confidential and secure manner. The facility reported a census of 50 residents.

Findings include:

Observations revealed the following:

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

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

(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 842	Continued From page 201	F 842		

Continued From page 201

a. On 10/28/21 at 1:00 PM, two boxes of medical records containing various forms and resident medical records sat on a couch near the front door and main lobby of the facility, and no staff in attendance of the records.
b. On 10/28/21 at 1:36 PM, the boxes of medical records continued to sit on the couch near the front entrance without staff in attendance.
c. On 10/28/21 at 2:37 PM, two boxes of resident records sat on a couch by the front entrance and lobby area, and no staff in the area.
d. On 10/28/21 at 3:05 PM, two boxes of resident records sat on a couch by the front entrance and lobby area, and no staff in the area.
e. On 10/28/21 at 3:19 PM, Staff A, Medical Records, stood in the front lobby area and handed a box that contained resident medical records to another staff member. Both staff then walked down the hall with the boxes of medical records.
f. On 11/02/21 at 1:00 PM, the medical records door observed partially open and a stack of resident medical records papers at least 12 inches high propped the medical records door open. The surveyor knocked on the door of medical records office, but no staff observed in the room or near the medical records area. The medical records room stored boxes and stacks of medical record papers with various resident names and personal health information including but not limited to residents' diagnoses, medications, social security numbers, insurance information, etc. At the time, a resident wheeled himself in a wheelchair past the medical records room and dining room.

In an interview 11/17/21 at 11:30 AM, the Administrator reported she expected medical

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

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

(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 842	Continued From page 202 records to be kept secure and the door to the medical records room locked when staff were not in the medical records office. The facility's Medical Records policy, reviewed 4/25/19, recorded that each resident had a medical record that shall be kept current, complete, legible and available at all times. The facility designated records such as the physician orders, nursing notes, progress notes, etc. for the legal medical record and these needed to be retained. The facility's Medical Records Retention and Destruction policy, dated 4/25/19, instructed that health information would be secured per HIPAA (Health Insurance Portability and Accountability Act) guidelines. 2. During observation on 11/2/21 at 12:52 PM, Resident #21 was in the medical records storage room without staff present in the room. Resident #21 stated she was just looking at some papers, sat the papers down and left the room. No staff were observed outside the medical records storage room in the lower dining hall while Resident #21 was in the medical records storage room. Observation on 11/2/21 at 1:26 PM the medical records door propped with files to keep the door open. No staff or residents were observed in dining area or medical records storage room.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		

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

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

(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 867	Continued From page 203 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on facility record review and policy review, and staff interview, the facility failed to have an effective quality assurance (QA) program in place to assist in the provision of quality care for residents. The facility identified a census of 50 residents. Findings include: Review of CASPER (Certification and Survey Provider Enhanced) report and facility records revealed repeated deficient practices identified during the facility's annual survey 7/24/19, complaint investigations completed 7/27/21, and the current survey and complaint investigations. The facility's QAPI (Quality Assurance Performance Improvement) policy reviewed on 8/20/20 described how the facility ensured care and services delivered met accepted standards of quality, identified problems and opportunities for improvement, and ensured progress toward improvement was achieved and sustained. Performance improvement is a proactive and continuous process with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and implementing new approaches to resolve systemic problems. In an interview 11/30/21 at 2:35 PM, the Administrator reported they had a turnover in administrative staff and department heads, and were working to build their team. The	F 867		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 867	Continued From page 204 Administrator reported she was aware of deficiencies and planned to put together a plan to address concerns identified, provide staff training and education, and start auditing resident records for accuracy and completeness. The Administrator reported a number of gaps in their records and processes, and planned to work through the whole problem. The Administrator reported the facility had no QA meeting minutes since the previous administrator left 8/21 and since the Director of Nursing took over the QAA role.	F 867		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on facility record review, facility policy review, and staff interview, the facility failed to ensure the Quality Assurance (QA) and Quality Assurance Performance Improvement (QAPI)	F 868		

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

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

(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 868	Continued From page 205 committee meetings held at least quarterly, and failed to ensure the required personnel attended the meetings. The facility reported a census of 50 residents. Findings Included: Review of the QA/QAPI meeting attendance sheets revealed meetings held on 1/29/21, 5/25/21, and 6/29/21 and no other meetings held in 2021. Review of the QA/QAPI meeting attendance sheets also revealed no Medical Director attended the meeting held on 5/25/21, and no Director of Nursing (DON) in attendance on 6/29/21. Review of the facility's QAPI policy last reviewed on 8/20/20, revealed the QAA committee will meet monthly. The team members included: a Licensed Nursing Home Administrator (LNHA), DON, Medical Director/Designee, infection preventionist, social service director (SSD), activities director, environmental services, human resources, dietary manager/designee, medical records, and pharmacy. In an interview 11/30/21 at 2:35 PM , the Administrator reported QA committee meetings held monthly, and the Medical Director and departments heads attended the meetings. The Administrator reported the Medical Director did not attend the QA meeting when they had a COVID-19 outbreak, and the facility had no DON in 6/2021.	F 868		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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

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

(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 880	Continued From page 206	F 880		

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:

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

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

(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 880	Continued From page 207	F 880		

Continued From page 207

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, observations, staff interviews and facility policy reviews, the facility failed to utilize infection control techniques to protect against cross contamination and potential infection when handling gastrostomy tubes, catheters, and performing hand hygiene for 3 of 19 residents reviewed (Residents #30, #50 and #53). The facility reported a census of 50 residents.

Findings Include:

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

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

(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 880	Continued From page 208 1. The Minimum Data Set (MDS) assessment dated 10/15/21 documented Resident #53 had diagnoses that included hypertension, Parkinson's disease, seizure disorder, malnutrition, adult failure to thrive and cystitis. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired memory and cognition. The MDS coded the resident always had bladder and bowel incontinence. The MDS lacked documentation of a catheter but had a Foley (urinary) catheter on admission. The MDS documented the resident required the assistance of one staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. A Physician Order dated 10/12/21 instructed use of a 16 French/10 milliliter bulb Foley catheter to straight drainage for Resident #53's urinary retention. The Care Plan dated 10/21/21 lacked a focus problem, goal or any interventions for the Foley catheter Resident #53 had in place. A Progress Note dated 10/9/21 at 3:31 AM recorded the resident's Foley catheter as patent and draining clear yellow urine via gravity without difficulty. Observations revealed the following: a. On 10/26/21 at 8:38 AM, the Foley catheter bag was attached to the bottom of the resident's wheelchair and a puddle of urine on the floor below the catheter bag. b. On 10/27/21 at 10:49 AM, the catheter bag sat on the floor.	F 880		

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

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

(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 880	Continued From page 209	F 880		

d. On 10/27/21 at 1:30 PM, the catheter bag continued to sit on the floor at the resident's bedside.
e. On 10/27/21 at 2:40 PM, the catheter bag continued to sit on the floor at his bedside.
f. On 10/27/21 at 3:00 PM, the catheter bag now inside a pillow case and hung from the bed frame.
g. On 11/3/21 at 8:56 AM, the catheter bag sat on the floor.
h. On 11/4/21 at 8:39 AM, the catheter bag hung on the bed frame and inside a pillow case.

In an interview on 11/10/21 at 8:43 AM, the Director of Nursing (DON) stated staff no longer needed to worry about keeping the catheter bag below the bladder due to valves in the catheter bag that prevented reflux of urine into the bladder. She stated it was her expectation that catheter bags be hung under the seat of the wheelchair on the cross bars or on the side of the wheelchair if cross bars were not present. The catheter bag hung from the bedframe whenever a resident in bed. The DON stated staff were trained on catheters and catheter care during their orientation. The DON stated it would never be acceptable to have a catheter bag left on the floor due to the high potential for contamination and possible subsequent infection.

The facility's Policy and Procedure for Catheter Care, dated 10/16, instructed staff to maintain consistent and adequate hygiene standards for residents with an indwelling catheter in order to maintain comfort, function and prevention of infection and other complications.

2. The MDS assessment dated 9/15/21 recorded Resident #30 had diagnoses of cerebrovascular

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

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

(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 880	Continued From page 210 accident (stroke), quadriplegia, and a gastrostomy. The MDS documented the resident required a feeding tube. The resident's Care Plan, revised 7/7/21, instructed she required a feeding tube related to a stroke and dysphagia (difficulty with swallowing), and had a history of infections. The staff directives included to administer medications as ordered. During observation on 10/27/21 at 11:49 AM, Staff B, LPN (Licensed Practical Nurse), prepared medication for Resident #30 then took the medication cup to the resident's room. Staff B placed the resident's feeding pump on hold, then donned a pair of gloves, placed the uncapped feeding tube tubing over the pole next to the bed, attached a syringe to the resident's g-tube, and checked placement of the tube. Staff B plugged the g-tube port, then opened the bathroom door with her gloved hand, turned on the faucet with her gloved hand, filled a plastic container with tap water, then turned off the faucet, and placed the container on a table next to the resident's bed. Staff B attached a syringe to the resident's g-tube, poured approximately 75 milliliters (ml) of water into the syringe, mixed the medication with 5 ml water, poured the medication into the syringe attached to the g-tube port, then poured approximately 75 ml water into the syringe. After the contents had been instilled, Staff B removed the syringe from the g-tube port, took the uncapped tubing that hung over the feeding pump and pole, and attached the tubing to the g-tube port. Staff B did not cleanse the end of the tubing prior to attaching the tubing to the g-tube. Staff B removed her gloves, set the feeding pump to infuse water and Jevity formula. Staff B then	F 880		

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

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

(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 880	Continued From page 211	F 880		

poured the left over water in the plastic container into the bag of water that presently hung on the pole.

The facility's policy for Enteral Tube Medication Administration, revised 8/14, recorded the following procedural steps:
a. Don gloves
b. Check tube placement using air and auscultation.
c. Check gastric contents for residual feeding, then return residual volumes to the stomach. Turn pump off,
d. Remove plunger from 60 ml syringe and connect the syringe to clamped tubing using the appropriate port.
e. Administer medication and flush tube with 15 ml of water based on facility policy
f. Clamp tubing and detach syringe.
g. Restart pump
h. Wash hands with soap and water.

The facility's policy titled Medication Administration - Preparation and General Guidelines, dated 12/17, directed the person administering medications adheres to good hand hygiene which included washing their hands thoroughly before beginning medication pass, prior to handling any medication, after coming in direct contact with a resident, and before and after administration of medications via enteral tubes.

In an interview 11/4/21 at 9:14 AM, Staff C, MDS Coordinator reported she expected that staff washed their hands before and after cares, and she expected gloves to be changed after staff completed cares and whenever the gloves were soiled.

F 880 Continued From page 212 F 880

3. The MDS assessment dated 10/6/21 indicated Resident #50 had diagnoses that included anemia, coronary artery disease (CAD), acute ischemia of intestine, dysphagia (swallowing difficulty), hypertension (high blood pressure), cerebral vascular accident (CVA), and chronic pain.. Resident #50 required the assistance of 1 staff with eating and utilized a feeding tube. The assessment also documented she had moisture related skin damage during lookback period with ointment application.

The resident's Care Plan contained a focus area of Alternative Nutrition with an initiation date of 6/10/21. An intervention directed staff to provide local care to G-Tube site as ordered and monitor for signs and symptoms of infection.

Observation on 10/27/21 at 1:29 p.m. revealed Staff B reviewed Resident #50's Treatment Administration Record (TAR) and physician order for Dermaceptin to the gastric tube (GT) site prior to entering Resident #50's room. Staff B donned gloves, placed a barrier on the table, placed wound supplies on the barrier, removed paper tape from around the resident's GT site secured by moistened split 2 x 2 gauze. Staff B stated the drainage appeared to be gastric fluids. The observation revealed two additional open areas above the GT site and all three sites were red and excoriated. Resident #50 grimaced in pain with removal of the dressing. Staff B applied wound cleanser to the open wounds, then she applied Dermaceptin ointment to all three wounds and covered only the GT site with a 2x2 split gauze dressing leaving the two other areas open to air. Staff B removed her gloves and washed her hands. Resident #50 stated the ointment

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

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

(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 880	Continued From page 213 drastically minimizes her pain as they feels like a burn. Observation on 11/2/21 at 12:40 p.m. revealed Staff D, LPN entered Resident #50's room and discontinued the resident's tube feeding without wearing gloves. Staff D drew up water that sat on the resident's bedside table with 30 l syringe, unclamped gastric tube with her bare hands, inserted the syringe and flushed the tube. Staff D repeated this process until she pushed a total of 250 ml of water. Staff D then hung the uncapped tubing over the pole. Staff D plugged the gastric tube and exited the room without performing hand hygiene. Observation on 11/3/21 at 2:00 p.m. revealed Resident #50's gastric tubing as uncapped, disconnected from resident and hanging from the pole next to her. During an interview on 11/4/21 at 9:09 a.m., with Staff C stated that staff expectations are to wear gloves when performing personal cares. Staff are to change their gloves if visibly soiled and sanitize in between the glove change. During an interview on 11/17/21 at 11:02 a.m. with Director or Nursing (DON)/Infection Preventionist (IP) stated she had not conducted any hand hygiene audits since arriving to facility in August, 2021. The facility's policy Infection Prevention Manual for Long Term Care - Using Gloves, dated 2009, instructed: a. Purpose is for resident and employee protection. b. Nonsterile gloves should be used primarily to	F 880		

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

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

(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 880	Continued From page 214 prevent the contamination of the employee's hands when providing treatment or services to the resident. c. Perform hand hygiene after removing gloves. d. Disposable gloves must be replaced as soon as practical when contaminated. e. Gloves should be used: when touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin. 1. When cleaning up spills or splashes of blood or body fluids. 2. When handling potentially contaminated items. 3. When handling potentially contaminated items. 4. When it is likely that hands will come in contact with blood, body fluids, or other potentially infectious materials. The policy on Contact Precautions, dated 2009, directed: a. Hand hygiene should be completed prior to donning gloves. b. Gloves should be worn when entering the room and while providing care for the resident. c. Gloves should be changed after having contact with infective material (i.e. wound drainage). d. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. e. After glove removal and hand hygiene, hands should not touch potentially contaminated environmental surfaces or items.	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program.	F 881		

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

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

(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 881	Continued From page 215 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility policy review, the facility failed to implement an Antibiotic Stewardship Program. The facility reported a census 50 residents. Findings: During an interview with the Director of Nursing (DON)/Infection Preventionist on 10/26/21 at 2:00 p.m. the DON stated she reviewed that resident ordered antibiotics meet criteria but she did not track or log resident or staff infections. The DON demonstrated record keeping which indicated facility percentages of infectious processes but failed to indicate which resident or room had the infectious process and the antibiotic the resident was prescribed. The facility document titled Reporting Employee Infections, dated 2009, directed: a. Any employee having an infection is responsible for reporting it to their supervisor, who will report it to the Infection Preventionist(IP). b. The IP nurse is responsible for completing and maintain the employee infection record whenever an infection is reported. c. The IP will follow the facility's policy on work restrictions for communicable diseases. d. A physician assessment may be required as appropriate.	F 881		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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

(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 881	Continued From page 216 The Role Description - Infection Preventionist, dated 2009, documented duties that included monitoring healthcare-associated infections.	F 881		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain freezers in good working order by having ice built up throughout the freezer for 1 of 2 freezers observed. The facility reported a census of 50. Findings include: Observation on 10/25/21 at 9:57 AM revealed the freezer log not marked and the appliance had heavy frost buildup throughout the unit. During interview on 10/25/21 at 12:35 PM, the Dietitian stated she expected freezers to be clear of ice buildup. The Dietitian stated their good freezer just went down and they sent an email to replace them. Interviews on 10/25/21 at 12:45 PM with the Dietitian and Dietary Manager (DM) revealed the facility did not use a cleaning log at this time due to being short staffed. They clean what they see, but have not kept a record of it. Observation on 10/26/21 at 12:47 PM revealed the freezer continued to have ice buildup.	F 908		

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

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

(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 908	Continued From page 217 During interviews on 10/26/21 at 1:08 PM, the Dietician and DM both stated they are working on getting a new freezer and are working on fixing that problem On 10/28/21 at 2:26 PM the DM provided an invoice for a new freezer dated 10/28/21 with the plan to receive the freezer by 11/4/21 per the invoice.	F 908		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, facility record review, and staff interviews, the facility failed to maintain an effective pest control. The facility identified a census of 50 residents. Findings include: Observation on 11/3/21 at 12:00 PM revealed a live cockroach in the employee bathroom that ran across the floor. The cockroach appeared to have entered through a crack in the baseboard. Three black roach hotels sat on the floor in the bathroom. A Maintenance Request form dated 9/27/21 recorded a request for the pest company to spray for bugs /roaches because a lot of bugs had been seen over the weekend in the dirty utility room, the nurse's station, and the bathroom on Side 1 hallway.	F 925		

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

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

(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 925	Continued From page 218 A Maintenance Request form dated 10/28/21 documented a request to spray for bugs again as lots of baby roaches could be seen everywhere on Side 1 in the facility. In an interview on 11/4/21 at 3:15 PM, the Administrator reported an extermination company came to the facility every two weeks for pest control since she identified a problem six weeks prior to this date. In an interview 11/8/21 at 8:47 AM, the Administrator reported she discovered a problem with cockroaches in 8/21 after she found a cockroach in her backpack. At the time, she asked staff if they had seen any bugs or cockroaches. Staff told her they had seen cockroaches. The Administrator reported cockroaches were found in the dirty utility room, the nurse's station, and in the basement. The Administrator reported they had an exterminator come in and treat the areas.	F 925		

F 567:

This is my credible allegation of compliance. This allegation does not constitute guilt, but that the facility is in compliance with F 567.

Residents 19, 26, 29, 36, 43, 46, 49, and 50 have access to their money for the weekends.

Any resident who wants access to their money on the week has access to money on the weekend.

Staff was re-educated on the process to deliver money on the weekends on 1/6/2022. Management will audit money and money delivery process to ensure money is available for residents on weekends. Problems will be corrected as they are observed during audits and further staff education will be provided as needed.

Facility management team will monitor that audits are completed with appropriate corrective action as needed. Problems will be corrected by the management team as they are identified.

F 568:

This is my credible allegation of compliance. This allegation does not constitute guilt, but that the facility is in compliance with F 568.

Residents 19, 22, 25, 36, 37, 49, and 50 are receiving appropriate financial statements on a quarterly basis.

All residents are receiving appropriate financial statements on a quarterly basis.

Staff was re-educated on the process of Resident Trust Management Service which includes providing quarterly financial statements to residents on 1/6/2022 The Business Office Manager and Administrator will continue to work on the quarterly financial statements for the residents so that they can be delivered per the facility process.

The facility's management team will monitor that quarterly financial statements are delivered to residents/responsible parties in a timely manner. Problems will be corrected as they are observed.

F 569:

This is my credible allegation of compliance. This allegation does not constitute guilt, but that the facility is in compliance with F 569.

Residents 11, 12, 19, 22, 25, 36, 37, and 49 and appropriate cash assets per Medicaid requirements and were notified of reaching maximum cash asset limit. Residents 152 and 153 estate probates were notified of cash remaining in their accounts and money was delivered to the estates properly.

All resident who use the facility's trust management will be notified if reaching their Medicaid cash asset limit. If residents pass away their probate/responsible party will be notified of any cash assets remaining in their accounts so that money can be distributed to them appropriately.

Staff was educated on the correct notification process for when residents are reaching their Medicaid cash asset limit on 1/6/2022 Staff was also educated on 1/6/2022 of the correct process for estate notification of remaining funds in the facility's trust management account for deceased residents. Staff was also educated on getting information of where to deliver the remaining money to during that education.

Facility's Management staff will assist in auditing of resident financial resources in the facility's trust management to assist in getting residents/responsible parties notified of getting close to Medicaid cash asset cap. Cash will be spent down to benefit the resident. Facility Management staff will also assist in reminding BOM to notify deceased resident's family/responsible party/estate contact person of remaining funds so that money can be returned appropriately.

Facility's Management Team will assist in auditing that Medicaid resident's money is audited routinely so that exceeding the allowable cap is not met and or surpassed. Problems will be corrected as they are observed. Deceased residents will be audited so that appropriate notifications were made to return any excess money in resident's account to the appropriate people. Problems will be corrected as they are observed.

F 580

This is my credible allegation of compliance. This allegation does not constitute guilt but that the facility is in compliance with F 580.

Residents 102, 23, 46, 52, and 9 are having families notified for room changes as well as physicians/families are being notified of changes in condition along with significant weight changes.

Facility residents and families are being notified per protocols of room changes. Resident's physicians and families are also being notified of resident changes in conditions as well as significant weight changes.

Staff was educated on 1/6/2022 of the process for notification of family for room changes as well as family/physician notification of changes in condition which include significant weight changes. Staff documentation will be audited for proper documentation of family/resident notification of room changes. Documentation will also be audited for proper family/physician notification of changes in condition as well as significant weight changes. Problems will be corrected as they are observed.

Facility's Management Team will monitor notification via stand up meeting process with problems of notification corrected as they are observed. Further education will be provided as needed.

F 584:

This is my credible allegation of compliance. This allegation does not constitute guilt but that the facility is in compliance with F 584.

The facility has a clean homelike environment which includes appropriate temperature control through out the facility.

Staff was educated on current house keeping protocols which included resident care equipment on 1/6/2022 This education also included how to request repairs and or maintenance requests. Maintenance and Housekeeping will continue to follow their routine cleaning schedules as well as routine preventative cleaning/maintenance schedules. Maintenance was educated on temperature requirements throughout the facility on 1/6/2022 Temperatures will continue to be checked and logged as part of the facility's routine maintenance programs.

The facility's management team will continue with walking rounds to monitor the cleanliness and temperatures throughout the facility. Problems will be corrected as they are observed with more education as needed.

F 607:

This is my credible allegation to F 607. This allegation does not constitute guilt but that the facility is in compliance with F 607.

Resident 151's personal property is accounted for.

Facility resident's personal property is accounted for.

Staff were educated on 1/6/2022 on the reporting requirements for missing resident property or the allegation of missing resident property. Staff were educated on the grievance protocols for missing resident property on 1/6/2022

Management staff will continue to investigate the allegations of missing resident property and follow reporting guidelines if missing items are not recovered. Family/responsible party will be notified of missing resident property per protocols.

Management will discuss missing resident property and report missing property per guidelines.

F 622

This is my credible allegation of compliance to F 622. This allegation does not constitute guilt but that the facility is in compliance with F 622.

Residents 101 and 32 no longer reside at the facility.

Residents who discharge and or transfer to another facility will have pertinent information shared with the new admitting facility to assist with a continuum of care.

Staff were educated on 1/6/2022 on the importance and protocols for relaying pertinent resident information to the new admitting facility for a continuum of care. Staff will be audited by nurse management for appropriate documentation r/t to the transfer of pertinent resident information to admitting facility during the discharge process. Problems will be corrected as they are observed and further education will be provided as needed.

Facility management will monitor that audits and education occur via their stand up meeting process. Problems will be corrected as they are observed and further education provided as needed r/t the discharging process.

F 625:

This is my credible allegation of compliance to F 625. This allegation doe not constitute guilt but that the facility is in compliance with F 635.

Resident 101 no longer resides in the facility.

When residents discharge/transfer to another facility a bed is being sent and or reviewed with the resident and or responsible party during the discharge/transfer process.

Staff were educated on 1/6/2022 on the proper process for discharging/transferring a resident which includes the completion of the Bed Hold to the resident/responsible party. Discharged/transferred resident's documentation will be audited to see if documentation addresses that the Bed Hold was completed with resident and or responsible party. Problems will be corrected as they are observed.

Facility management will monitor that Bed Holds were audited and that proper corrective action occurred from the audit findings. Problems will be corrected as they are observed.

F 637:

This is my credible allegation of compliance to F 637. This allegation does not constitute guilt but that the facility is in compliance with F 637.

Resident 23 no longer resides at the facility.

Residents who trigger for a Significant Change in Status MDS are having them performed per RAI guidelines.

Staff were educated on 1/6/2022 of the importance of completing a Significant Change in Status per RAI guidelines. Significant Change in Status also will include a change in pay such as Hospice. MDS's will be audited to see if a Significant Change in Status MDS was completed and or if one was needed. This audit will also include audits of hospice residents to see if a Significant Change in Status MDS was completed. Problems will be corrected as they are observed.

Facility management will monitor that audits are completed and Significant Change in Status MDS's were completed per RAI guidelines, as well as proper corrective actions were taken. Problems will be corrected as they are observed.

F 641:

This is my credible allegation of compliance to F 641. This allegation does not constitute guilt but that the facility is in compliance to F 641.

Residents 53 and 3 have current and accurate MDS's in their EMAR.

Residents in the facility have current and accurate MDS's completed and in their EMAR.

Staff was educated on 1/6/2022 on the importance of completing MDS's in a timely manner and per RAI guidelines. This education included establishing an assessment schedule for assessment completion and timing of required assessments.

MDS's, MDS schedule will be reviewed by interdisciplinary team weekly to ensure all residents MDS's are completed per RAI guidelines. Problems will be corrected at that time.

Management team will monitor that MDS's are completed in a timely manner and per RAI guidelines. Problems will be corrected as they are observed and further education will be provided as needed.

F 655:

This is my credible allegation of compliance to F 655. This allegation does not constitute guilt but that the facility is in compliance with F 655.

Resident 101 not longer resides in the facility.

Upon admission to the facility base line care plans are being completed per facility protocols

Staff were educated on 1/6/2022 on the importance of completing baseline care plans within the 48 hour time frame. This education also included that the resident/family need to be explained the baseline care plan and offered a copy of the baseline care plan. The discussion of the baseline care plan will be documented in the resident's record and if family was provided a copy.

New admissions will be audited for completion of the baseline care plan as part of the facility's Stand Up Meeting process. Problems will be corrected as they are observed.

Management team will monitor that audits occur and that appropriate corrective action took place. Problems will be corrected as they are observed

F 656:

This is my credible allegation to F 656. This allegation does not constitute guilt but that the facility is in compliance with F 656.

Resident 50's comprehensive care plan is up to date and current to assist in directing her care. Residents 2, 23, and 53 no longer reside in the facility.

Residents in the facility have comprehensive care plans in place to assist in directing care for them.

Staff were educated on 1/6/2022 on the importance of residents having a comprehensive care plan in place to assist in directing resident care. Education also included that comprehensive care plans need to be accurate to reflect the care needed and amount of staff support required.

The facilities Interdisciplinary Team will review care plans prior to and during care plan meetings to ensure up to date and reflect the resident care needs. Problems will be corrected as they are observed.

The facility's management team will monitor that reviews occur, and care plans are up to date and reflect the resident's care needs. Problems will be corrected as they are observed.

F 657:

This is my credible allegation of compliance to F 657. This allegation does not constitute guilt but that the facility is in compliance with F 657

Resident 47 no longer resides in the facility. Resident 5 and 46 are being invited to their scheduled care conferences as are their families/responsible parties.

Residents in the facility are being invited to their care conference meetings as are their families/responsible parties.

Staf was educated on 1/6/2022 of the importance of inviting residents and families/responsible parties to scheduled care conference meetings. SS will invite residents and their families/responsible parties to scheduled care conferences. Resident and family invitation will be documented in the resident's record.

Facility management will monitor that residents and families/responsible parties are invited to care conferences and invites are documented in resident records. Problems will be corrected as they are observed.

F 658:

This is my credible allegation of compliance to F658. This allegation does not constitute guilt but that the facility is in compliance with F 658.

Resident 32, 34, 3, 50, are receiving treatments/medications/services per their physician's orders. Residents 50, 46, and 31 have POS's signed and are current. Resident 23 no longer resides in the facility

Residents in the facility are receiving treatments/medications/services per their physician's orders and their orders have been reviewed and signed for by their physician.

Staff were educated on the importance of following physicians' orders and documenting the administration of medications/treatments as they are performed on 1/6/2022. Staff was also educated on 1/6/2022 of the requirements of 60-day physician review of current orders/plan of care (Physician Order Sheets). Nurse Management will audit MARs and TARs for appropriate documentation of treatment and med administration. Problems will be corrected as they are observed. Nurse Management will review POS's and log due dates to make sure physician's are current with their orders/plans of care. Problems will be corrected as they are observed. Staff will be audited for appropriate treatment/med administration techniques.

Facility's management team will monitor that MAR/TAR audits are completed with appropriate corrective action taken. Management team will also monitor that POS are sent and or reviewed every 60 day. Problems will be corrected as observed.

F 677:

This is my credible allegation of compliance to F 677. This allegation does not constitute guilt but that the facility is in compliance with F 677.

Residents 29 and 50 are receiving baths per the facility bath schedule. Resident 53 no longer resides in the facility.

Residents in the facility are getting their scheduled baths per facility protocols.

Staff were educated on 1/6/2022 on the importance of following the established bath schedule so that residents receive their scheduled baths. The facility's bath schedule was reviewed and updated on 1/6/2022 so residents will have 2 baths per week scheduled. Resident bath refusals will be documented to reflect that choice. Nurse management will audit baths/bath documentation to monitor that baths are being given and documented as given and or refused. Problems will be corrected as they are observed.

Management team will monitor that baths/bath documentation is audited and that bath refusals are not consistent. Problems will be corrected as they are observed.

F 678:

This is my credible allegation of compliance to F 678. This allegation of compliance does not constitute guilt but that the facility is in compliance with F 678

Appropriate facility staff have appropriate CPR certifications.

Staff were educated on the importance of keeping their CPR certification current on 1/6/2022_Staff attended CPR training on 1/6/2022 BOM will log and monitor CPR certifications for purposes of tracking certification dates and when certifications run out. New hires will be asked for CPR certifications upon hire and will be logged for when certifications run out.

Management team will monitor that CPR certifications are logged for expiration dates and that new hires CPR certifications are logged for expiration dates. Staff will be told 2 months in advance of CPR certification expiration date. Problems will be corrected as they are observed.

F 684

This is my credible allegation of compliance to F 684. This allegation does not constitute guilt but that the facility is in compliance with F 684.

Resident 101 no longer resides at the facility.

Residents in the facility are receiving appropriate wound care/wound assessments/diuretic care/weight monitoring/assessments as needed and physician notification of changes in condition.

Staff were educated on 1/6/2022 on the process for wound care/wound assessments/diuretic monitoring/insulin parameters/insulin administration/weight monitoring/physician notification of changes in condition. Facility is making wound rounds with Vohra Dr as well has having scheduled wound nurse for assessment purposes. Facility staff were educated on the importance of completing weights as scheduled on 1/6/2022 as weights play important role in meeting resident needs and health practices. Facility is screening weights that were taken and making sure were recorded properly and if not residents are re-weighed to obtain and accurate weight. Dietician will assist in monitoring weights and problems will be corrected as they are observed.

Nurse management is monitoring wound assessments/treatments/assessments/insulin needs/family and physician notifications and wound recommendations from wound rounds. Problems will be corrected as they are observed.

F 686:

Theis is my credible allegation of compliance to F 686. This allegation dose not constitute guilt but that the facility is in compliance with F 686.

Resident 53 is receiving proper wound care treatment and proper wound assessments per their physician's orders.

Residents with wounds are receiving proper wound care and proper wound assessments per their physician's orders.

Staff were educated on 1/6/2022 on the importance of wound care and following treatment orders and schedules. This education also included the importance of completing proper wound assessments per wound assessment schedules. Vohra wound care physician is making weekly rounds and facility is following up on physician wound care orders. Wounds are being assessed on a weekly basis with appropriate interventions in place for proper pressure prevention.

Nurse Management will monitor that wound treatments are provided per physician's orders and wound needs. Nurse management will audit wound assessments and treatments are performed per physician orders. Problems will be corrected as they are observed. Nurse Management will audit that proper pressure prevention interventions are in place and reflected on the resident plan of care.

Management will monitor that audits are completed and appropriate corrective actions were taken. Problems will be corrected as they are observed.

F 689:

Residents 2, 4, 40, and 23 no longer reside at the facility. Resident 10, 24, 33, 41, 42, and 48 are having their medications securely stored and doors are appropriately closed and alarmed where needed. Doors

are locked where needed/allowed. Resident 32 is having their wheelchair brakes locked and foot pedals applied when needed.

Residents' meds are being kept secure and facility doors are kept secure and alarmed per facility protocols. Resident are having their wheelchair brakes applied when needed and foot pedals are in place when being transported by staff.

Staff were educated on 1/6/2022 the protocols for proper storage of medications and proper securing of doors and checking for functioning alarms. Staff were educated on 1/6/2022 on the protocols for locking of wheelchair brakes and the use of wheelchair foot pedals. Staff will be audited on the use of wheelchair brakes and foot pedals on wheelchairs. Problems will be corrected as they are observed. Doors will be audited by maintenance for being properly secured and alarms functioning as part of their daily meeting requirements. Problems with doors will be corrected as they are observed. Medication storage will be audited by nurse management with problems corrected as they are observed.

Management team will monitor that audits are completed with appropriate corrective actions taken. Problems will be corrected as they are observed.

F 690:

Residents 31 and 32 are receiving direct cares/peri care per facility protocols.

Residents who require staff assistance with direct cares/peri care are receiving those cares per facility protocols.

Staff were educated on 1/6/2022 on the proper protocols for providing direct cares/peri care to avoid potential cross contamination. Nurse Management will audit staff while providing direct cares/peri cares to assist in ensuring performing proper cares to the residents. Problems will be corrected as they are observed and further education provided as needed.

Management Team will monitor that audits and appropriate corrective actions were taken. Problems will be corrected as they are observed.

F 692:

This is my credible allegation of compliance to F 692. This allegation does not constitute guilt but that the facility is in compliance with F 692.

Resident 102 not longer resides at the facility.

Residents who trigger for a significant weight loss are receiving appropriate nutritional interventions as a result of their weight loss to assist in maintaining a healthy weight.

Staff was educated on 1/6/2022 on the importance of obtaining an accurate weight. Education included obtaining weights via a consistent method so that weights would be more accurate. Weights that are off by 5 pounds will result in a re-weight to assist in obtaining more accurate weights. Dietician will continue to review residents with significant weight changes so that appropriate nutritional

interventions can be put into place to assist in preventing potential further weight changes. Dietary and nursing will continue to meet to discuss resident's weights and nutritional interventions to see if interventions are appropriate and effective. Nutritional interventions will be changed as needed to assist in meeting resident needs.

Management Team will monitor that resident weights are obtained on a consistent basis and that significant weight changes are reviewed by facility's dietician and for appropriate nutritional interventions were started. Problems will be corrected as they are observed.

F 693:

This is my credible allegation of compliance to F 693. This allegation does not constitute guilt but that the facility is in compliance with F 693.

Resident 31 is receiving her tube feeding per physician orders and Tube feeding tube is being connect to resident 31's G-tube appropriately per facility protocols.

Residents who receive supplemental feedings via a tube are receiving those services per facility protocols and tubing is being connected appropriately.

Staff were educated on 1/6/2022 on the proper protocols for the use of tube feeding supplies and the proper protocols for connecting tubing to G-tubes. Education also included dating of g-tube feeding supplies/tubing for when it was put into place. Staff will be audited for proper techniques when connecting feed tubes to resident's G-tube. Residents will be audited for proper dating of feeding tube supplies and tubing. Problems will be corrected at that time by nurse management and further education will be provided as needed.

Management team will monitor that audits occur and proper corrective actions were taken. Problems will be corrected as they are observed.

F 695:

This is my credible allegation of compliance to F 695. This allegation does not constitute guilt but that the facility is in compliance with F 695.

Resident 3 and 46 have appropriate physician's order for the use of their oxygen, their oxygen tubing is dated, and they are receiving the ordered amount of supplemental oxygen.

Resident who require the use of supplemental oxygen have appropriate physician's orders for their oxygen, their oxygen tubing is dated for when tubing was changed, and are receiving the amount of supplemental oxygen that their physician ordered.

Staff were educated on 1/6/2022 on the importance of changing O2 tubing per facility protocol, reviewing appropriate O2 flow rates for correct O2 flow of supplemental O2 for residents requiring O2, and that physician's orders are obtained for residents needing supplemental oxygen. Residents will be audited for appropriate physician's orders for supplemental oxygen, order will include appropriate flow rate. Residents will be audited for appropriate dating on O2 tubing to signify when the tubing was last

changed. Change dates will be reflected on the resident's TAR so staff know when next change date is. TAR will be audited to assist in ensuring tubing was documented as changed. Residents will be audited for proper flow rates. Problems will be corrected as they are observed. Furter education will be provided as needed.

Management team will monitor that audits occur and that appropriate corrective action was taken. Problems will be corrected as they are observed.

F 697:

This is my credible allegation of compliance to F 697. This allegation does not constitute guilt but that the facility is in compliance to F 697.

Resident 50 is receiving her pain med per her physician's orders. She is being assessed for pain and is receiving supplemental pain medication if she is in pain.

Residents are being assessed for pain and appropriate pain interventions are being implemented related to their pain and assessed for effectiveness for pain relief.

Staff were educated on the importance of assessments for pain and prompt and appropriate pain interventions on 1/6/2022 Staff were also educated on 1/6/2022 on the use of the facility's pharmacy and back up pharmacy for obtaining pain medications in a timely manner. If the facilities pharmacy does not contain the prescribed pain medication the back up pharmacy will be called and the ordered pain medication will be obtained ASAP and administered to the resident. Nurse management will audit pain assessments for where a resident's pain is at to see if an appropriate pain intervention was tried and if effective or not. Nurse Management will audit physician orders for pain medication to ensure that the pain medication was obtained in a timely manner and administered to the resident. Problems will be corrected as they are observed, and further education provided as needed.

Management Team will monitor that audits occurred and appropriate corrective action occurred when needed.

F 698

This is my credible allegation of compliance to F 698 this allegation does not constitute guilt but that the facility is in compliance with F 698.

Resident 2 no longer resides in the facility.

Residents who require dialysis are being weighed per their physician's order and are having Dialysis site assessed for bruit and thrill.

Staff were educated on 1/6/2022 on the importance of following physician orders on weighing dialysis residents. This education also informed staff of the facility protocols of assessing the resident's dialysis site pre and post dialysis and on non-dialysis days for bruit and thrill. Weights and dialysis assessments will be recorded in the resident's record. Nurse Management will audit that weights are obtained,

dialysis assessments are being performed, and physicians are being notified of any changes. Problems will be corrected as they are observed and further education provided as needed.

Management Team will monitor that audits are completed and appropriate corrective actions were taken. Problems will be corrected as they are observed.

F 725:

This is my credible allegation of compliance to F 725. This allegation does not constitute guilt but that the facility is in compliance with F 725.

Resident 11 is having her call light answered promptly and within the 15 minute guideline.

Residents are having their call lights answered promptly and within the 15 minute guideline.

Staff were educated on 1/6/2022 on the requirement of promptly answering call lights/requests for staff assistance. This education also included the 15 minute guideline for responding to resident call lights. The facility management will audit call light response times on different shifts to assist in ensuring call lights are answered within the 15 minute guideline. Problem will be corrected as they are observed.

Management team will monitor that audits are performed and appropriate corrective action was taken for observed problems. Further education will be provided as needed.

F 727:

This is my credible allegation of compliance to F 727. This allegation of compliance does not constitute guilt but that the facility is in compliance with 727.

The facility is maintaining 8 hours of RN coverage in a 24 hour period 7 days a week.

Facility continues to schedule 8 hours of RN coverage daily. Facility reviews schedule daily per their Department head meeting. The facility makes adjustments as needed to the schedule due to call-ins to maintain 8 hours of RN coverage on a daily basis. Schedules continue to be made out for a month so that RN coverage is planned for so that adjustments can be made in advance for requested days off and coverage of open RN shift can be covered.

The facility's management team continues to monitor for RN coverage and corrective actions are put into place when open RN shifts occur.

F 760:

This is my credible allegation of compliance to F 760. This allegation does not constitute guilt but that the facility is in compliance with F 760.

Resident 16 no longer resides in the facility. Resident 34 is receiving their medication per their physician's orders and has been free from significant medication errors.

Residents are receiving their medications per physician's order and have been free from significant med errors.

Staff were educated on 1/6/2022_on the importance of carrying out new physician orders. This included proper noting of orders so that the residents EMAR reflected the new orders. Staff was educated on the fact that they do have a back up pharmacy to call on ***insert correct date*** so that they can get medications if pharmacy does not carry that medication. They were also educated that over the counter meds could also be obtained by local retailer as well. Nurse Management will audit new orders and medications to see that new medications are delivered timely and residents receive their meds per physician orders. Problems will be corrected as observed.

Management Team will monitor that audits are completed and appropriate corrective actions took place. Problems will be corrected as they are observed.

F 761:

This is my credible allegation of compliance to F 761. This allegation does not constitute guilt but that the facility is in compliance with F 761.

Facility drugs are being stored appropriately. Refrigerators are being checked per facility protocols to monitor for appropriate temperatures.

Staff were educated on the importance of proper medication storage and monitoring refrigerator temperatures for proper medication storage. This education also included that medications will be administered from proper labeled cards and or containers, and will not be preset from unlabeled containers. Facility continues to have refrigerator logs in place for temperature checks. Nurse Management continues to monitor logs for temperature checks and verification of correct temperatures for medication storage. Problems are corrected as they are observed. Staff will be audited for correct medication administration techniques and problems will be corrected as they are observed.

Management staff will monitor that refrigerator temps are obtained and logged per facility protocols and that medication administration audits are completed and that appropriate corrective actions are taken.

F 804:

This is my credible allegation of compliance to F 804. This allegation does not constitute guilt but that the facility is in compliance to F 804.

Resident 40 is receiving their appropriate diet from the dietary department.

Facility residents who need a mechanically altered diets are receiving their meals served in a palatable and nutritious manner.

Staff were educated on 1/6/2022 of the importance of following pureed diet ingredients for food service and that liquid added to the food should be that of the same type of food being pureed such as broth and or gravy vs straight water. Pureed preparation will be audited to ensure proper liquid is being added

to achieve proper pureed food texture/consistency and maintaining food flavor and palatability. Problems will be corrected as they are observed.

Facility management will monitor that audits are completed and proper corrective actions were taken.

F 812:

This is my credible allegation of compliance to F 812. This allegation does not constitute guilt but that the facility is in compliance with F 812.

Facility dietary staff is properly sanitizing hands during food preparation and food service.

Staff were educated on 1/6/2022 on the proper hand sanitizing protocols for dietary. Staff will be audited on proper hand sanitation practices in the dietary department. Problems will be corrected as they are observed.

Management Team will monitor that audits are completed and proper corrective action were taken. Problems will be corrected as they are observed.

F 838:

This is my credible allegation of compliance to F 838. This allegation does not constitute guilt but that the facility is in compliance with F 838.

Facility's Assessment is current and up to date.

Facility was educated on 1/6/2022 on the importance of maintaining a current and accurate facility assessment. Facility reviewed and updated their facility assessment so that it reflects current information and data.

Facility Management will continue to monitor the facility assessment so that it contains current and accurate information and data.

F 842:

This is my credible allegation of compliance to F 842. This allegation of compliance does not constitute guilt but that the facility is in compliance with F 842.

Facility is storing medical records in a secure area that only facility management has access too.

Facility staff were educated on proper storage of medical records on 1/6/2022. Medical records was reorganized so that clinical records could be stored in a secure manner. Facility will audit that medical records are stored in a secure manner. Problems will be corrected as they are observed.

Management Team will monitor that audits are completed and proper corrective action were taken. Problems will be corrected as they are observed.

F 867:

This is my credible allegation of compliance to F 867. This allegation of compliance does not constitute guilt but that the facility is in compliance with F 867.

The facility has an active QAA/QAPI program.

The facility was educated on 1/6/2022. On the requirement of having an active QAA/QAPI program with in facility. The facility continues to work on issues within the facility using their QAA/QAPI program and establishing a root cause to the problem. The facility continues to implement proper interventions to problems to correct established problems.

The facility's management will monitor that an active QAA/QAPI programs continue and appropriate corrective actions are put into place for identified problems.

F 868:

This is my credible allegation of compliance to F 868. This allegation does not constitute guilt but that the facility is in compliance with F. 868.

The facility is having required quarterly QA meetings with required department heads, pharmacy, dietician, and Medical Director present.

Staff were educated on the importance of and the requirement of having a scheduled QA meeting with the appropriate staff present at the QA meeting. The facility has made out their schedule for 2022. Facility will maintain their established meeting and cover required areas of the meeting. Problems will be corrected as they are identified per the QA protocol.

Facility management will monitor that meetings occur with the appropriate staff members present. Problems will be corrected as they are observed.

F 880:

This is my credible allegation of compliance to F 880. This allegation of compliance does not constitute guilt but that the facility is in compliance with F 880.

Resident 53 no longer resided in the facility. Residents 30 and 50 are receiving proper care to their G tubes in a sanitary manner adhering to the facility's hand washing, glove usage, and G tube protocols to assist in preventing potential infections.

Staff were educated on 1/6/2022 on the facility protocols for hand washing, glove usage, catheter care/catheter emptying, and proper G-tube practices to maintain appropriate infection control. Staff will be audited for proper hand washing and glove usage techniques. Problems will be corrected as they are observed. Staff will be audited for proper care of a catheter and catheter drain bag as well as drain bag emptying. Problems will be corrected as they are observed. Staff will be audited for proper caring of

resident's g tubes and infection control practices with g tubes. Problems will be corrected as they are observed. Staff will watch the following videos: PPE lessons
https://www.youtube.com/watch?v=YYTATw9yav4&feature=youtu.be

Sparkling Surfaces:

https://www.youtube.com/watch?v=t7OH8ORr5Ig&feature=youtu.be

Clean Hands:

https://www.youtube.com/watch?v=xmYMUly7qiE&feature=youtu.be

Keep COVID OUT:

https://www.youtube.com/watch?v=7srwrF9MGdw&feature=youtu.be

Per root cause analysis the facility identified the root cause to be: Lack of education and education follow up to the problems of handwashing, glove usage, catheter care, catheter emptying, G tube techniques and handling of g tube supplies after prior administrator leaving her employment. Again facility is providing education to the staff on the above issues followed by staff auditing. Problems will be corrected as they are observed.

Management Staff will monitor that audits are completed, and that appropriate corrective actions were taken. Problems will be corrected as they are observed.

F 881:

This is my credible allegation of compliance to F 881. This allegation of compliance does not constitute guilt but that the facility is in compliance with F 881.

The facility has an active Antibiotic Stewardship program. They are tracking and logging infections within the facility per their facility protocols.

Staff was educated on 1/6/2022 of the importance of tracking and logging infections to assist in tracking infections and intervening for identified infections in common areas. Staff will continue to be educated on findings of infection tracking and types of infections so that they can assist in prevent of spreading infections. Infection patterns will discussed with staff so that they know of the infection patterns so that they can make adjustments and assist in infection prevention.

Management team will monitor that infections are tracked and logged appropriately so that infection patterns can be stopped and appropriate interventions implemented. Problems will be corrected as they are observed.

F 908:

This is my credible allegation of compliance to F 908. This allegation does not constitute guilt but that the facility is in compliance with F 908.

Facility freezers are in good repair and currently have NO ice build up present.

Staff were educated on 1/6/2022 on the importance of having freezers in good repair and free of ice buildup.

Facility purchased a new freezer on ***11/3/2021***. Facility monitors its freezers that they are in good operating order and free of ice buildup. Problems with freezers are corrected as they are observed.

Management Team will monitor that freezers are in good working order and that there is no ice build up in the freezers. Problems will be corrected as they are observed.

F 925:

This is my credible allegation of compliance to F 925. This allegation does not constitute guilt but that the facility is in compliance to F 925.

The facility continues to address pest control on a routine basis and per any concerns of pest sightings by staff and residents.

Facility continues to have their pest control company treat for pests on a 2 week basis. 2 week treatment is due to chemical buildup and keeping residents and staff safe from excessive chemicals. Pest sightings have decreased to almost zero. Facility will continue to this treatment plan and also have other pest control companies coming to look at facility and give bids or alternative treatment plans.

Management team will monitor that the every 2 week treatment plan continues and that alternative treatment companies are spoke to for potential alternative pest treatments plans.