Iowa Department of Inspections and Appeals

Health Facilities Division

Citation

Citation Numb	er:				Date:	
1024					8/11/2	1
Facility Name:			Survey D	ates:		
Genesis Senio	r Living Center		, May 3 –		2021	
Facility Addres	ss/City/State/Zip		, -	,,	- -	
5608 SW 9 th St						
Des Moines, IA	x 50315	JM				
Rule or				Fine A	mount	Correction
Code Section	Natur	e of Violation	Class			date
58.28(3)e	facility shall be responsimal maintenance of a safe of personnel. (III) 58.28(3) Resident safet e. Each resident shall protect against hazards the environment. (I, II, II) DESCRIPTION: Based on record review member and physician provide adequate super prevent hazards for 2 of (Residents #7 and #9).	receive adequate supervision to from self, others, or elements in II) a, and staff, resident family interviews, the facility failed to rvision and assistance to f 9 residents reviewed On 4/30/21, a nurse left ed on the commode in his	I	\$10,0	000	Upon Receipt

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	bathroom to obtain his wheelchair. When the nurse returned with the wheelchair, she found Resident #7 on the floor; he had fallen and sustained a laceration to the head due to striking his head on the floor when he fell. The facility sent the resident to the hospital Emergency Room (ER) and computed tomography (CT) scans showed bilateral (both sides of brain) subarachnoid hemorrhage (bleeding on the brain) and a subdural hematoma (bruising with concussion) of the left frontal lobe. Resident #7 died on 5/2/21 as a result of injuries sustained in the fall on 4/30/21. The facility reported a census of 50 residents. Findings include: 1. The 3/30/21 Minimum Data Set (MDS) Assessment tool revealed Resident #7 admitted to the facility 3/23/21 with diagnoses that included hemiplegia (paralysis on 1 side of the body), cerebrovascular accident (a stroke), aphasia (speech inability or difficulty) and atrial fibrillation (irregular heart beat).					

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	delirium, moderate difficaid used, had unclear sothers and could somet understood. The MDS arequired extensive assis surface transfers, bed nuse, bathing and persor incontinent of bowel and bladder. The MDS revestand or ambulate (walk revealed he had fallen vadmission and also sinc sustained injury. A risk for falls related to initiated 3/24/21 directed 3/23/21 - Anticipate resi	airment without symptoms of cultly hearing without hearing peech, usually understood imes make themselves also documented Resident #7 at of 2 staff for surface-to-nobility, dressing, eating, toilet hal hygiene, was always diffequently incontinent of aled the resident could not along the incomplete the admission without a history of falls care pland staff to:				

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	3/23/21 - Educate, provide supervision, and remind the resident to wear appropriate footwear. 3/24/21 - Scoop mattress to bed.					
Review of the incident reports revealed the following falls:						
	On 3/24/21 at 8:10 a.m., staff observed the resident transferring themselves from their wheel-chair to the bed in room and during the attempt to stand, the resident slid onto floor with his legs extending outward, and landed on his buttocks. The resident sustained a 3.5 centimeter (cm) "U" shaped skin tear on the upper right elbow that required a dressing. Staff then applied a scoop mattress to the bed.					
	On 4/15/21 at 3:15 a.m., a certified nursing assistant (CNA) answered the resident's bathroom call light and noted the resident sat on the floor in front of the toilet. The resident stated he took himself to the restroom, lost his balance, and slid to the floor. Staff identified					Page A of 3

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	no injuries and did not implement any new interventions. The record showed post fall vital signs and neurological assessments were initiated by Staff H, registered nurse (RN) and former assistant director of nursing (ADON) on 4/15/21 at 7:15 a.m. On 4/16/21 at 4:45 p.m., Staff H, RN and former ADON described the resident found lying on floor on right side with wheel chair tipped over him, the fall was unwitnessed. Noted blood on floor by resident's right arm. There was no documentation of post fall vital signs or neurological assessments in the resident's record. On 4/30/21 at 8:30 a.m., Staff I, licensed practical nurse (LPN), went into the room to check on Resident #7, assisted the resident to the commode, went to grab the wheel-chair from the bathroom, and when the nurse returned the resident lay on the floor bleeding from a laceration on the right side of the head. Staff then sent the resident to the hospital Emergency					Dave 5 of 2

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	Room (ER) and called 9	111 for ambulance transport.				
	Physical therapy notes to and 4/29/21 revealed the balance (position held in seconds) that ranged from a dynamic sitting balance movements of muscles from "did not tolerate" to resident had a fair station 4/29/21, and a poor shalance on 4/28/21. The hospital records reversident in the FR after resident in the FR after and 4/29/21 resident in the FR after and 4/29/21.					
	resulted in head trauma temple and below the ric tomography (CT) scans sides of brain) subarach the brain) and a subacu	revealed acute bilateral (both moid hemorrhage (bleeding on				
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	The facility's self-assessment submitted with their self-reported incident related to the resident's 4/30/21 fall revealed the following: On 4/30/21 at 8:00 a.m., Staff found the resident on his left side near his bed. The resident stated he attempted to transfer himself from the bed, lost his balance, and hit his head on the bed frame. The facility noted a laceration to the left side of the head and applied and maintained pressure until transport arrived. The facility concluded the resident's injury was caused by a fall and documented the resident passed away on 5/2/21. A progress note transcribed 4/30/21 at 3:17 p.m. by Staff N, facility social worker documented the hospital called and reported the resident admitted to the hospital and had orders for a neurological physician consult and palliative care.					Dave 7 of 2
	Staff N, facility social wo called and reported the hospital and had orders	orker documented the hospital resident admitted to the for a neurological physician				Page 7 o

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	Staff interviews revealed: 5/12/21 at 10:40 a.m., Staff I, LPN, stated she was currently employed by a sister-facility, no longer worked at the facility, the last day she worked at the facility was on 4/10/21. Staff I reported on the morning of 4/30/21, she received phone calls from Staff A, RN, and the facility's corporate nurse Staff G, RN, with requests for her to work at the facility that day due to staff call-ins. Staff I stated she arrived to the Side 2 unit of the facility at approximately 8:15 a.m., staff B, LPN was there, she didn't receive report on any of the residents and none of the morning medications had been administered to the residents she was responsible for. Shortly after she arrived, she was notified that the resident was scheduled for a family visit at 9:00 a.m. so she went to the resident's room to get him up and ready for the visit. When she entered his room the resident was awake and tried to climb out of the bed, she called for assistance, Staff B helped her transfer him from the bed to the commode, she got					Dago 9 of 2
						Page 8 of 2

If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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	assist with the transfer at the resident was on the fallen forward out of the on the floor, she didn't to transfer. The resident is head, she notified the morders to transfer to the ambulance. On 5/11/21 at 10:15 a.m morning of 4/30/21, she the resident to the commassist of 2 staff for transfer to the approximately 30 feet to B stated in less than a morning the resident was compared to the commassist of 2 staff for transfer to the approximately 30 feet to B stated in less than a morning the resident was compared to the resident was	oward the nurse's station. Staff ninute, Staff I called for help				

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high fall risk. Due to the r should not have been left or safely positioned in a comparison of nursing (DON), high fall risk, he was alway bladder and did not use the why staff would have transcommode but should not was positioned on the comproblems and impulsivened on 7/13/21 at 9:25 a.m., So falls, the nurse should alway post fall vital signs and net fall was unwitnessed or the when they fell.	5/11/21 at 10:47 a.m., Staff F, CNA, stated on 4/30/21,				
	5/11/21 at 10:47 a.m., Staff F, CNA, stated on 4/30/21, the resident was assigned to her and she saw the				

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	resident in bed between she checked on him. So tendency to lean forward to put his feet up in the his room.					
	7/1/21 at 10:42 a.m., Staff W, hospitalist physician stated she examined the resident in the ER on 4/30/21 for his head injury associated with a fall at the facility, he was extremely thin and dehydrated, appeared cachectic, his mouth was very dry and he had not received adequate oral hygiene care. In addition to emergent care for the resident's head injury, the resident also required emergent intravenous therapy to treat his dehydration. 7/1/21 at 12:45 p.m., Staff X, radiologist physician stated the small acute bilateral subarachnoid					
	hemorrhage was consis and the subacute left fro	tent with the injury on 4/30/21, ontal lobe subdural hematoma all on 4/30/21, but it possibly				Page 11 of 3

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	could be consistent with the unwitnessed falls that occurred 2 weeks prior. The left frontal lobe subdural hematoma was not present on a head CT scan completed in February, 2021 at the hospital, and likely developed from a fall after February as it was consistent with 1 or more weeks old. During an interview on 5/18/21 at 4:10 p.m., the resident's family member and responsible party (RP) stated the resident had a stroke that led to right side paralysis and problems with sitting balance. She stated they had seen him lean forward or to his right in the wheelchair sometimes when they saw him at scheduled facility visits. The RP stated the facility did not notify her of the 3/24/21 fall and on 4/15/21 the					
	facility notified them the fallen over on top of him the bathroom. On 4/30/2 at approximately 8:40 a facility visit when they rewho said the resident has				Page 12 of 2	

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	ordered a medication due to the results. Before they hung up they told her the resident had leaned forward when he reached for his oxygen tubing, fell out of his chair, and cut his head when it hit the floor so they were sending him to the ER. The RP stated they met the resident at the hospital and stayed with him, the nurses at the hospital and the ER doctor were very concerned about his injuries from the fall. The RP stated since the resident's death on 5/2/21, they had contacted the facility 3 different times to request copies of his records, and as of the time of the interview they still had not received them. The RP reported family elected for hospice care because the physician's explained he probably wouldn't have survived the surgery to relieve the bleeding on his brain, and so that meant the resident died as a result of the injuries from the fall. 2. Facility records revealed Resident #9 had diagnoses that included dementia with behavioral disturbance,					

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	inhalation of food/vomit, p.m. on 3/19/21, discha 3/20/21, admitted for sh p.m. on 4/29/21, and dis p.m. on 4/30/21. Progre 3/19/21 at 6:26 p.m., relation language, non-coand undressed self freq 3/20/21 at 6:26 a.m., reattempted self-transfers assigned to the resident resident safety. 3/20/21 at 12:00 p.m., Canalgesic) 5 milligrams restlessness, 1 to 1 stafe	y and pneumonia due to the resident admitted at 4:00 rged to family at 4:16 p.m. on ort-term Respite care at 12:36 scharged to family care at 6:00 ess note entries revealed: sident confused, spoke only ompliant with remaining in bed uently. sident removed clothing and from bed, Staff P, CNA, t for 1 to 1 supervision/care for Oxycodone (strong narcotic given per order for pain and f assignment continued.				Down 44 of 5

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	effective to reduce pain to 1 staff assignment for 4/29/21 at 12:36 p.m., a accompanied by spouse stay, resident believed hoctor appointment. 4/29/21 at 3:40 p.m., Who bracelet (an electronic or resident near an exit do due to wandering.	levice that alerts facility when or) placed on resident's ankle urse practitioner (NP) at facility				
	and authorized Ativan (a milligrams administered anxiousness. Resident room, ambulating with o hallway (restricted due t	an anti-anxiety medication) 0.5				Page 15 of 3

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	staff, hitting staff with his pulled the activity direct leave the facility and go 4/30/21 at 12:30 p.m., A anxiety and aggressive 4/30/21 at 5:00 p.m., reattempted to leave, sust abrasion on his right che	e front door several times by s cane, punched at staff and or's hair because he wanted to home with his spouse. Ativan 0.5 mg administered for behavior. Sident fell in facility foyer as he tained a 2.0 centimeter (cm) eek and a 0.2 cm abrasion on Ambulated resident back to his bed. Vital signs and				
	again, 3 cm by 3 cm hei	sident got out of bed and fell matoma (bruise) with scant ccipital area (back of the				

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	their request. An incident report related 4/30/21 at 5:00 p.m., conurse (RN), stated resid with abrasion to right chance the resident fell when he had been wearing glass frame. At 5:03 p.m. resident for by 3 cm mid-occipitation. The staffing schedule for was located, on 4/30/21 Staff A, RN, scheduled for the control of the staff and the control of the	or Side 1, where the resident				David 47 of 6

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	the 2:00 p.m. to 10:00 p	.m. shift (usually 3 CNA's).				
	The staffing schedule fo	or Side 2 on 4/30/21 revealed				
	the nurse assigned from	6:00 a.m. to 6:00 p.m. had not				
		taff interviews, the facility had a				
		ity come in at 8:15 a.m. and agency nurse that arrived at				
		re scheduled from 6:00 a.m. to				
	2:00 p.m., and 1 CNA s	cheduled from 2:00 p.m. to				
		by another CNA scheduled at				
	usually 3).	A for the area when there were				
	Staff interviews revealed	d:				
	5/6/21 at 9:50 a.m., Stat	ff A, RN, stated the resident				
		and didn't speak English.				
		eft when he was admitted he get up without assistance.				
		et up on his own, he was				
		't have the staff to make him a				
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Citation Number: 1024 Facility Name: Genesis Senior Living Center Facility Address/City/State/Zip 5608 SW 9th St. Des Moines, IA 50315 Rule or Code Section Nature of Violation Class Fine Amount Correction date Correction date 1 to 1 which is what he needed. The resident was looking for his family, tried to go out exit doors, he hit staff when they tried to redirect him away from the doors. Staff A was on the phone to notify the physician of the fall at 5:00 p.m. when the resident had another unwinessed fall in his room, again looking for his family. His family came and picked him up after that. 6/1/21 at 9:00 a.m., the facility administrator stated decisions about resident's accepted for admission were made by their management team that included herself, the director of nursing, social worker, activity director, dietary manager and maintenance supervisor (their inter-disciplinary team). During an interview on 5/11/21 at 2:11 p.m., the resident's family member stated they had contacted different staff at the facility at different times after the 4/30/21 discharge in attempts to get more information about the resident's falls and injuries, but the facility			,				
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Facility Administrator	Date

Citation Number	er:	<u> </u>			Date:		
1024					8/11/21		
Facility Name:			Survey D	ates:			
Genesis Senior Living Center			May 3 – July 27, 2021				
Facility Addres	ss/City/State/Zip		1				
5608 SW 9th St.							
Des Moines, IA	50315	JM					
Rule or				Fine Amount		Correction	
Code Section	Natur	e of Violation	Class			date	
		formation Theoretical	1	1	"		
	would not provide the information. They noticed bruising on the right side of his face, both knees, his right hand and left forearm, and a lump on his head when he was discharged on 4/30/21. The family member stated the resident had dementia which had impacted his memory and judgement, but he had not had physical behaviors when at home and had a calm demeanor prior to his admission to the facility. The family member expressed serious concern for the resident's injuries and the facility's refusal to explain how they had occurred. FACILITY RESPONSE:					Page 20 of 2 ′	
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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

Date

Facility Administrator

				_		
Citation Numb	er:				Date:	
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						Page 21 of 2

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