STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Jewish Senior Life Center	900 Polk Boulevard Des Moines, IA 50312

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 40905 Based on observation, record review and staff interview, the facility failed to meet professional standards by not observing a resident take their medications for 1of 8 residents (Resident #18) reviewed. The facility reported a census of 51 residents. Findings include: A Minimum Data Set (MDS) for Resident #18, dated 3/12/24, included diagnoses of heart failure, anxiety, and depression. The MDS documented the resident had a Brief Interview for Mental Status score of 15, indicating no cognitive impairment. Observation on 4/15/24 at 12:05 PM, resident in room and holding medication cup with several pills in the cup. Resident stated they always leave them for me, they know I will take them as they are good for me. Review of the resident's Medication Administration Record dated 4/1/24 - 4/30/24, documented the following medications ordered and administered at noon: a. ascorbic acid (supplement) b. aspirin c. buspirone (anti-anxiety) d. cholecalciferol (supplement) e. ditiazem (high blood pressure) f. duloxetine (anti-depressant) g. ferrous gluconate (iron supplement) h. furosemide (diuretic for fluid retention) i. L-Lysine (canker sore) (continued on next page)

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. metoprolol (high blood pressure) k. Tylenol l. Zyrtec (allergies) Interview on 4/17/24 at 11:36 AM, Staff B, Licensed Practical Nurse (LPN) stated she always stays with residents until they take their medication and does not leave medications with any residents. Interview on 4/17/24 at 12:08 PM, Staff C, LPN stated she always stays with residents until they take and swallow their medication, the protocol is to stay with the resident and no residents are able to self-administer their medications. Facility policy titled Administration of Medication, dated 6/28/2023, directed staff to remain with the resident to ensure that the medication is swallowed. Interview on 4/17/24 at 2:47 PM, the Director of Nursing stated she expects staff to remain with the residents until the medication is swallowed and recently provided education to the staff regarding this.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46873 Based on clinical record review, family and staff interview and policy review, the facility failed to prevent a significant medication error for 1 of 11 residents reviewed (Resident #155). The facility reported a census of 51 residents. Findings Include: The Baseline Care Plan of Resident #155 reflected a date of 4/10/24. The Care Plan documented the resident unable to easily communicate with staff, and to be vision and hearing impaired. The Admit/Readmit Summary, dated 4/10/24 at 7:35 pm, documented the resident admitted to the facility on [DATE], was oriented to self and to place, not to time. The Summary also documented the resident to have moderately impaired vision and moderate difficulty hearing. The Health Status Note, dated 4/13/24 at 7:20 am, documented the resident to be very confused and anxious and not able to follow direction. The Health Status Note, dated 4/13/24 at 11:22 am, documented Resident #155 was in a wheelchair in the dining room when approached by a medication aide and called by a name other than her own. Per the note, the resident responded to the other name and then given 650 mg of Tylenol and 0.25 milliliters of morphine intended for the other resident. After administering the medication, per the note, the medication aide then went to Resident #155's room for medication pass and then realized her error and notified the nurse on duty. The physician, family member of the resident, and nurse manager were informed of the error and the resident monitored. The Order Note, dated 4/13/24 at 5:56 pm, documented the resident's daughter chose to send the resident to the emergency room for evaluation. On 4/15/24 at 4:26 pm, a family member of Resident #155 stated the resident had blood work done upon arrival to the facility, prior to the medication error, which showed high potassium and high creatinine levels. She stated the medical director had made some medication changes due to the abnormal laboratory values. She stated when the resident arrived at the hospital, she had a CT scan (computed tomography, a test to obtain internal images of the body) which showed no concerns and she tested negative for having a urinary tract infection. She stated the hospital did not appear concerned the mental status change was related to the morphine error. The lab work collected on 4/13/24 at 5:45 pm reflected a potassium level of 5.9 (normal values 3.5-5.1). and a Creatinine of 1.6 (normal values 0.6-1.1). The History and Physical from the hospital also noted the resident was abruptly taken off of tramadol after 4 years of chronic use and documented may need to add back tramadol and slowly taper off if necessary to avoid acute detox. Hospital notes reflected mental status change likely related to hyperkalemia (high potassium) which was present prior to morphine administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/24 at 12:56 pm, Staff D, Certified Medication Aide stated she had been employed at the facility since 2018. She stated when she arrived to work on 4/13/24, she was scheduled to work the floor in the memory care unit, which is not where resident #155 resided. She stated the nurse in the part of the facility where Resident #155 resided had been busy and the nurse needed assistance to complete the morning medications. She voiced once she got all of her residents up and dressed on the memory care unit, she was asked to go help in the other portion of the building. She said she always works in the memory care unit and had never met either of the residents who she got mixed up with the medication error. She stated she pulled up Electronic Health Record of Resident #157, looked at her photo, looked at Resident #155 sitting in the dining room and thought that Resident #155 was actually Resident #157. She stated she walked over to Resident #155 and asked her if she was (first name of Resident #157) and the resident replied yes. She said she told her she had pills for her and Resident #155 said ok and she took them. She stated again she had never met either resident. The Medication Error/Omission Report, dated 4/13/24, documented How this error could have been prevented Have identification on any wheelchair used by residents out of room. Ask resident name and date of birth before giving meds - 5 rights (The five rights of medication administration) The facility form Medication Error Process documented Why did this occur? Resident was not ID'd correctly. She answered to (other resident's name) and was in a wheelchair with no ID. Was not asked her name. The facility policy Administration of Medication, revision date of 6/28/23 documented the Standard of: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46873 Based on observations, clinical record review, staff interview and policy review, the facility failed to maintain infection control standards due to lack of hand hygiene when providing cares and assisting residents to dine for 2 of 23 residents (Resident #15, and Resident #24). The facility reported a census of 51 residents. Findings include: 1. On 4/15/24 at 12:18 pm, dining room observation began for the 200 and 300 hallway of the facility. On 4/15/24 at 12:26 pm, Staff A, Certified Medication Aide (CMA) sat down at a table wearing single use disposable gloves. Resident #15 was to her right and Resident #24 was to her left. Staff A provided set up assistance to Resident #24, removing covers from food and cutting up food. On 4/15/24 at 12:33 pm, Staff A stood up, keeping her gloves on, walked across the dining room to speak to a dietary staff member and then returned to the table. Using her left hand, she picked up the built up silverware for Resident #15 and began to feed him. She alternated, using her right hand to offer assistance to Resident #24. After alternating between feeding the two residents, Staff A picked up the dinner roll off of Resident #15's plate using her hands, still wearing the same gloves, breaking the dinner roll into two pieces. With her gloves remaining in place, she continued offering both food and fluids to both residents. On 4/15/24 at 12:38 pm, Resident #15 had small pieces of food falling from his mouth. Staff A reached up and removed the food from the resident's chin with her gloved hand. On 4/15/24 at 12:39 pm, Staff A reached and picked up the menu of Resident #24, read it and then placed it back on the table. On 4/15/24 at 12:40 pm, Staff A stood up, and offered a drink of fluid to Resident #24, then alternated to offering foods and fluids to Resident #15 while standing. On 4/15/24 at 12:41 pm, Staff A sat back down, and offered more bites of food to Resident #15. She then placed both of her arms on the dining table, with her right hand seen touching her shirt sleeve of her left arm. On 4/15/24 at 12:44 pm, Staff A stood up, placing her gloved hands on the arm rest of the chair to stand. She adjusted the position of Resident #15 who was leaning to one side. She then removed her gloves and threw them in the trash, performed hand hygiene and donned new gloves. On 4/15/24 at 12:45 pm, dietary staff delivered a peanut butter and jelly sandwich for Resident #15 due to him not eating very much of the planned menu. Staff A picked up the sandwich with her gloved hands and cut the sandwich into four pieces. She offered a bite to Resident #15, kept the same gloves on, and turned to offer a bite of food to Resident #24. She used both hands to pick up silverware of Resident #24 and cut some more of his food. She offered sips of fluid to Resident #24. After giving verbal cues to Resident #15 to continue eating, she picked up a portion of the sandwich and brought it to his mouth. Resident #15 then took the sandwich from her and took a couple of more bites. On 4/15/24 at 12:50 pm, Staff A was again observed touching Resident #15's sandwich with her gloved hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 12:50 pm, a dietary aide began to distribute Thrive ice cream (a nutritional supplement) to residents with orders for nutritional supplements. Staff A, still wearing the same gloves, picked up the ice cream to remove the cover from the top. She then picked up the sandwich again. Staff A used both hands to hold the sandwich, trying to get Resident #15 to eat. She then placed her left hand on the tablecloth before using that hand to again pick up the sandwich. On 4/15/24 at 12:53 pm, Staff A was observed changing her gloves but no hand hygiene was observed. She picked up the silverware of Resident #24 to offer him bites of food as she was standing. She then sat and placed her right hand on the arm of the chair to scoot herself closer to resident #15 to continue to offer him food. On 4/15/24 at 12:57 pm, she again alternated to feeding Resident #24. During the observation, Staff A was seen repeatedly alternating between touching the silverware and the cups of both residents, touching the table, touching the chair and touching the food of the resident, failing to maintain infection control standards. On 4/18/24 at 12:24 pm, The Director of Nursing stated if staff need to wear gloves due to assisting a resident who drools or has secretions, her expectation would be to feed just the one resident to avoid cross contamination. She also stated her expectation is for staff not to touch other surfaces or to complete hand hygiene in between. The facility policy Feeding Residents, revision date 6/28/23 directs: Gloves should be worn anytime you may come in contact with contaminated objects or when feeding a resident who spits or drools. If you are going to come in contact with the resident's food, don gloves, complete task, then remove gloves and perform hand hygiene. 40905 2. A Minimum Data Set (MDS) for Resident #24, dated 3/12/24, included diagnoses of renal insufficiency and Alzheimer's. The MDS documented the resident had an indwelling catheter, and a Brief Interview for Mental Status score of 5 out of 15, indicating severe cognitive impairment. Observation on 4/16/24 1:40 PM, with Director of Nursing (DON) in attendance, Staff E, Certified Nursing Aide (CNA) entered Resident #24's room and washed her hands, applied gown and gloves. Staff E then, with her gloved hands, picked up a floor mat, touched a cabinet door and touched a dirty garbage bag. Staff E, with the same gloves on, proceeded to place a barrier and graduated cylinder on the bed beside the resident and with the same gloved hands cleansed the tip of the catheter tube, drained urine from the bag, and cleansed tubing again with an alcohol swab. Staff E emptied and rinsed the cylinder, gathered the trash and placed in red bag, and removed gloves and gown and then washed hands. Facility policy titled Emptying Catheter Drainage Bag, dated 6/28/23, directed if you soil your gloves, or touch objects while gathering supplies to perform cares, remove gloves and perform hand hygiene and don new gloves and continue with completing cares. Interview on 4/16/24 at 3:10 PM, the DON confirmed she observed Staff E touch the floor mat, garbage bag, and other items and with the same gloves emptied the catheter. DON stated the expectation is to perform hand hygiene and put on new gloves after touching items and before performing catheter care.