Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 04/19/2024
NAME OF PROVIDER OR SUPPLIER: Genesis Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 5608 SW 9th Street Des Moines, IA 50315	

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, staff interview, Nurse Practitioner (NP) interview, and Registered Nurse (RN)/Certified Wound Ostomy Continence Nurse (CWOCN) interview, Job Description forms and facility policy review, the facility failed to provide an assessment and interventions for a 2 of 3 residents who presented with a condition change. (Resident #2 and #3) The facility identified a census of 58 residents. On [DATE] at 2:30 p.m. the Iowa Department of Inspections, Appeals and Licensing (DIAL) staff contacted the facility staff to notify them the Department staff dtermined an Immediate Jeopardy (IJ) situation existed at the facility. The facility staff removed the immediacy on [DATE] after the facility staff completed the following: 1. NP/Designee Completed 100% Audit on All Residents; Change of Condition Evaluation in EMR/PCC on [DATE]. 2. 100% Care Plan Audit Completed; Interventions in Place for Residents with a Change in Condition on [DATE]. 3. DON/Designee Completed 100% Education w/Nursing Staff on the Following on [DATE]: Identifying Early Change in Condition; Completing Change in Condition Evaluation Utilizing SBAR/eInteract in EMR/PCC. Implementing Interventions with Change in Condition. Monitoring Change in Condition X72 Hours or Until Condition Improves; Utilizing Shift to Shift Reporting. DON/Designee will Incorporate Education on Change in Condition with New Hires as part of Orientation. 4. Facility will Monitor through Facility Audit Tool (5) Residents, X5/Week for X4 Weeks and then Monthly to ensure ongoing Compliance. Monitored Findings will be Reviewed during Monthly QAPI Meeting. The scope was lowered from and J to a G at the time of the survey. Findings include: (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. A Minimum Data Set (MDS) assessment form dated 3.1.24 indicated Resident #3 had diagnosis that included a cognitive communication deficit, Anemia, Atrial Fibrillation (AF), Hypertension (HTN), Renal Insufficiency, Diabetes Mellitus (DM), Respiratory Failure, morbid obesity, required assistance with personal care and muscle weakness. The assessment indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 (moderately impaired cognitive skills), an impairment of both sides of her lower extremities, dependent on staff with toileting hygiene, required substantial to maximum assistance of staff with rolling/repositioning and as always incontinent of her bowels and bladder. The assessment identified the resident as at risk for pressure ulcers however with no pressure ulcers and not on a turning/repositioning program. A Care Plan revealed the following Focus area and Interventions as dated: a. I/my responsible party requested a full code status. (initiated 2.25.22) 1. Staff to have called for an ambulance. (initiated 2.25.22) 2. Provision of emergency measures as appropriate. (initiated 2.25.22) b. A diagnosis of HTN. (initiated 3.8.22) 1. Staff to have monitored for and document any edema. (initiated 3.8.22) c. Anticoagulant medication use with a risk of abnormal bleeding, hemorrhage and/or increased/easy bruising related to (r/t) anticoagulant use of Coumadin/Warfarin. (initiated 2.16.23) d. The resident had a pressure ulcer to the left heel or potential for pressure ulcer development. (initiated 3.8.22) 1. Monitor/document/report any as needed (PRN) changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size and stage. (initiated 3.8.22) An email from Staff A, Assistant Director of Nursing (ADON) dated 4.5.24 at 9:59 a.m. to a NP revealed the following: Hey, the husband of Resident #3 made us send the resident to the hospital and we had no documentation related to (r/t) you having identified the resident as terminal or about the conversation you had with the resident's husband and etc. She requested a full code/CPR (cardiopulmonary) status so we really needed to be documenting everything on her. An email from the NP dated 4.5.24 at 3:50 p.m. revealed the following response to the above documented email: Sorry I have/had no right to say/write that someone is/was terminal until proven. I referred to Hospice because of the decline in health. I sent her to the hospital and they sent her back and the husband made the decision to refuse Hospice care. If her Husband is/was her Power of Attorney (POA), he had the right of decision to make her a Do Not Resuscitate (DNR) or FULL Code. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 4.10.24 at 3 p.m. the Director of Nursing (DON) confirmed the facility staff failed to properly assess the resident and they should have due to (d/t) her CPR status. Review of the resident's Progress Notes revealed the following as dated: a. 3.25.24 at 1:43 p.m. - A NP addressed the resident's code status as CPR. b. 3.25.24 at 1:49 p.m. - The resident experienced a change of condition r/t skin wounds and pressure ulcers. The blood pressure, pulse, respirations, temperature and pulse oximetry documented on this date revealed documentation from a 1.22.24 assessment. This assessment failed to identify the resident's current vital signs. c. 3.25.24 at 2:01 p.m. - Two (2) small scabbed areas to the resident's right 2nd toe and a small 0.5 centimeter (cm) x 0.5 cm scab to the top of the right end toe. Also noted to have a small scabbed area to her left third toe with no assessment provided. d. 3.26.24 and 3.27.24 - No assessment completed. e. 3.28.24 - The interdisciplinary team met to review the resident's changes in weight and overall decline in her physical health. No assessment completed. f. 3.28.24 at 11:05 a.m. - New order received on 3.27.24 which discontinued the treatment to the resident's right buttock. No assessment completed r/t skin issues and her overall decline in physical health. g. 3.29.24 thru 3.31.24 - No assessments completed r/t skin issues and her overall decline in physical health. h. 3.30.24 at 2:39 a.m. - PT/INR (prothrombin time and international normalized ratio) drawn with a reading of 7.3 (critically high). Order received for administration of 5 milligrams (mg) of Vitamin K and recheck PT/INR in the afternoon of 3.30.24. No further assessment completed. According to an email 4.23.24 at 10:25 a.m. the resident's therapeutic PT/INR range should have been 2.0 - 3.0 i. 3.30.24 at 2:45 a.m. - Order received to discontinue (DC) current Coumadin order with a plan for an establishment of new Coumadin dosing with the providers when the critical PT/INR of 7.3 had been resolved. No further assessment completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	q. 4.3.24 at 1:26 p.m. - No assessments completed by the facility nursing staff throughout the entire day. r. 4.4.24 at 10:54 a.m. - The resident alert without verbal responses to the nurse. The resident had been alert to self only. No further assessment completed. Review of the Hospital's ER report dated 4.5.24 indicated the resident arrived in the ER at 10:31 a.m. and was admitted at 10:35 a.m. A Certificate of Death form filed 4.10.24 indicated the resident passed away 4.5.24 at 3:30 p.m. from Sepsis. During an interview 4.11.24 at 3:54 p.m. Staff C, Certified Nursing Assistant (CNA) confirmed he found the area on the resident's gluteal region which he indicated it looked like a bruised, blistered area the size of a quarter. He reported the area to Staff A who assessed the area and applied a cream. The next time the staff member observed the ulcered area had been about another week and at that time he described the area as the size of an orange, the blister opened up as the skin flapped and drainage present in/on her brief. At that point the resident presented as coherent however the staff member kept saying staff needed to send her to the hospital. When the resident became really weak and made moaning noises the staff member called the resident's husband with a status report and the husband directed him to get her to the hospital Staff C state on 4.1.24 a Physician and Staff A came down to the resident's room and the staff member showed them new ulcered areas on her upper back and her thighs. The staff member offered that he felt like the facility management failed to take the direct care workers word/assessments seriously and they are the ones that saw everything. During an interview 4.11.24 at approximately. 12 p.m. a NP confirmed she observed the area on the resident's gluteal region on 3.25.24 and described it more like an unopened blister but not pressure of which the facility told her they thought the area presented as a [NAME] Ulcer. The NP confirmed once the blistered area presented itself staff should have assessed the area as a means to monitor the status. The NP indicated she had not observed the resident again until 4.1.24 when she was told in a meeting the resident had a swollen right arm. When she reviewed the Progress Notes there had been no assessment present so she had to assess the area herself but she expected staff to have assessed the area prior. Following the assessment she called the resident ' s husband who directed her to send the resident to the ER. The facility transferred the resident to the ER via the ambulance and after the hospital assessed and intervened they called her and told her they planned to send her back to the facility. The NP directed the hospital staff to wait as the resident ' s current condition had not been her baseline. The NP confirmed she expected staff to thoroughly assess a resident with a condition change on a regular basis and/or until resolved. (continued on next page)

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