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	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Genesis Senior Living	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35434 Based on clinical record review, policy review, and staff and resident interview, the facility failed to notify the family of a resident's change in condition for 1 of 3 residents reviewed for assessment(Resident #1). The facility reported a census of 59 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 4/16/24, listed diagnoses for Resident #1 (R#1) which included acute respiratory failure with hypoxia (a low amount of oxygen in the blood), heart failure, and diabetes (a disease which caused abnormal blood sugars). The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. A 4/16/24 11:12 a.m. Nurses Note stated the resident reported that yesterday he bumped his shoulder while out on transport and was now having pain in his right shoulder. The facility lacked documentation of resident representative notification of the incident. On 5/30/24 at 8:29 a.m., via phone, the resident's representative stated R#1 was in the van and the driver stopped suddenly, and the brake did not work so R#1 went forward suddenly because he was not properly secured. On 6/3/24 at 1:57 p.m. Staff B Certified Nursing Assistant (CNA) stated she had Resident #1 in her van and they hit a bump and his wheelchair moved. She stated he was strapped into the van but his brakes were not secure so his wheelchair moved and he hit his shoulder on the gate. She stated his shoulder now hurt and he had a Magnetic Resonance Imaging (MRI) scheduled because of this. She stated on a previous trip about 2 weeks prior, the resident's brakes were not working and she reported this and was told by Staff C, Maintenance Supervisor (MS) that the brakes were fixed but they were not. She stated since the brakes were not secure, the chair moved. On 6/3/24 at 1:36 p.m., Staff C, MS stated he fixed the brakes on Resident #1's chair but the problem ended up not being the brake. He stated it would lock tight but the second they put weight in the chair, it would not lock so they switched chairs out. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 3:54 p.m., the Director of Nursing (DON) stated she would want wheelchair brakes to work. She stated she was not sure what happened but the resident hit his shoulder and she informed the Nurse Practitioner (NP). She stated she was under the impression the resident's representative was aware of the incident. The undated facility policy Van and Bus Safety directed staff to lock wheelchair brakes after loading. The facility policy Notification of a Change in Condition reviewed 4/26/23, directed staff to notify the resident representative of an accident or incident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on observation, policy review, and staff interview, the facility failed to ensure bathroom surfaces were clean and tile in good repair for 4 of 4 resident bathrooms observed. The facility reported a census of 59 residents. Findings include: Observation of sampled resident bathrooms revealed the following concerns: On 5/30/24 at 9:03 a.m. the bathroom of room [ROOM NUMBER], occupied by Resident #3, was missing a tile on the back wall and had a black substance covering the edges of the tiles. On 5/30/24 at 9:10 a.m., the bathroom of room [ROOM NUMBER], occupied by Resident's #4 and #6, had a missing tile on the back wall with a black substance on the walls and built-up in the corners of the room. On 5/30/24 at 9:30 a.m., the bathroom of room [ROOM NUMBER], occupied by Resident #1 had a brown substance on the hinges of the toilet seat and on the outside of the toilet. On 6/3/24 at 3:54 p.m., the Director of Nursing stated bathrooms should be free of black substances and tiles should be in good shape. On 6/3/24 at 4:45 p.m., the bathroom of room [ROOM NUMBER], occupied by Resident #10 and Resident #11 was missing 2 tiles on one side of the toilet and broken pieces of tile sat on the floor toward the wall. The facility policy Room Cleaning, dated 10/2022, directed staff to clean under the toilet bowl, spot clean walls, and, mop the floor. The policy directed staff to carry out a maintenance check for repairs.

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(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. 35434 Based on clinical record review, policy review, and staff and resident interview, the facility failed to follow professional standards by failing to carry out leg wraps as ordered, failing to ensure a resident received a meal in a timely manner after receiving insulin (an injectable medication used to treat diabetes), and failing to ensure the provision of audiology (the medical specialty which treated disorders of the ear) services for 1 of 3 residents reviewed for professional standards (Resident #1). The facility reported a census of 59 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool, dated 4/16/24, listed diagnoses for Resident #1 which included acute respiratory failure with hypoxia (a low amount of oxygen in the blood), heart failure, and diabetes (a disease which caused alterations in blood sugars). The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. a. An 11/27/23 Care Plan entry stated the resident had the potential for impaired circulation and dependent edema(swelling which occurred when the legs were in a position lower than the heart). The May 2024 Treatment Administration Record(TAR) listed the following 2/1/24 order: apply Dermaphor(a cream used to prevent skin irritations and protect skin) to bilateral lower extremities(BLE) first thing in the morning, don Tubigrips(a wrap which prevented swelling) do not double it over at the top, only fold over at the bottom by the toes. Next apply foam layer. Apply 8 centimeter(cm) elastic bandage then 10 cm elastic bandage to both legs. Every day. Sleep with them on, take them off in the morning and reapply the treatment, one time per day for lymphedema(swelling caused by the accumulation of fluid). On 5/30/24 at 10:12 a.m. the entry for the above treatment had the initials of Staff A Licensed Practical Nurse(LPN) to indicate the completion of the treatment at 7:00 a.m. on 5/30/24. The entries for the following dates in May also contained Staff A's initials: 5/8/24, 5/10/24, 5/14/24, 5/16/24, 5/24/24, 5/25/24, 5/28/24. On 5/30/24 at 10:16 a.m. the resident stated staff did not wrap his legs yet today. On 5/30/24 at 1:15 p.m., Staff A stated she did not apply his wraps today because they were already on. She stated staff wrapped his legs every other morning. On 5/30/24 at 4:09 p.m. the Director of Nursing(DON) stated staff should follow the orders on the TAR. On 6/3/24 at 3:54 p.m., the DON stated staff should apply the cream and wraps every day and stated Staff A did not understand the order so they separated it out to make it clearer. The facility policy Physician Orders, dated 9/28/22, stated staff would implement orders in accordance with professional standards. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Care Plan entries, dated 11/27/23, stated the resident had diabetes and would be free of any signs and symptoms of hypoglycemia(low blood sugar). The entries directed staff to administer the medication as ordered by the physician. The May 2024 Registered Nurse(RN)/Licensed Practical Nurse(LPN) Administration Record listed an order for Novolog(a rapid-acting insulin, used to lower blood sugar) 15 units via subcutaneous(injected into the tissue under the skin) route, before meals for diabetes. The 5/29/24 7:00 a.m. entry contained staff initials to indicate the resident received the dose. The Meal Intake flow sheet for May 2024 was blank for the 5/29/24 breakfast entry. On 5/30/24 at 8:29 a.m., via phone, the resident's representative stated yesterday the resident did not receive breakfast but received his insulin. She stated he told the nurse but one and a half hours elapsed. She stated at 11:00 a.m., the kitchen manager came in, dropped the tray on the table, stated to him here's your breakfast, and left. She stated there were multiple times when he missed meals. On 6/3/24 at 1:57 p.m. Staff B Certified Nursing Assistant(CNA) stated there were times when resident's did not get breakfast and they had to go back to the kitchen and request one. She stated Resident #1 did not get breakfast until 10:00 a.m. or 11:00 a.m. and stated it happened on a few occasions where residents did not get a tray. On 6/3/24 at 2:39 p.m., the Dietary Manager stated she was here the day that Resident #1 did not get a tray and stated it was around 8:00 a.m. or 9:00 a.m. when someone said he did not get a tray. She stated he did receive breakfast a little bit before 10:00 a.m. She stated she didn't think staff completed their rounds to make sure everyone received a tray. She stated the dietary staff and CNAs should do rounds to make sure everyone received a meal. On 6/3/24 at 3:54 p.m., the DON stated nurses should ensure residents ate after they received insulin. On 6/3/24 at 5:51 p.m., via email, the DON stated the facility utilized the manufacturer guidelines with regard to insulin administration and meal times. The Novolog Prescribing Information, revised 2/2023 and retrieved from https://www.novo-pi.com/novolog.pdf on 6/4/24 stated residents should eat a meal within 5-10 minutes after administration. The facility policy Meals and Snacks reviewed 3/31/21, stated the facility provided breakfast at 7:30 a.m. and stated Nutritional Services was responsible for delivering meals to residents. c. A 3/19/24 Nurses Note stated the resident's representative inquired about an audiology appointment for the resident and stated the writer of the note would check on the appointment tomorrow and call her with an update. The facility lacked further documentation regarding an audiology appointment from 3/19/24-6/3/24. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 at 3:54 p.m., the Director of Nursing stated she was not aware the resident's representative wished for the resident to see the audiologist and stated they were coming to the building within a couple of weeks and she would follow up. She stated in general if there was a desire to see a specialist, the facility would carry this out.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35434 Based on clinical record review, policy review, and staff and resident interview, the facility failed to ensure a resident was secured in a van during transport causing the resident to bump his shoulder during the ride for 1 of 3 resident's reviewed for supervision(Resident #1). The facility reported a census of 59 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment tool, dated 4/16/24, listed diagnoses for Resident #1 which included acute respiratory failure with hypoxia (a low amount of oxygen in the blood), heart failure, and diabetes (a disease which caused abnormal blood sugars). The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. A 4/16/24 Nurses Note stated the resident reported that yesterday he bumped his shoulder while out on transport and was now having pain in his right shoulder. On 5/30/24 at 8:29 a.m., via phone, the resident's representative stated he was in the van and the driver stopped suddenly and the brake did not work so he went forward suddenly because he was not properly secured. On 6/3/24 at 1:57 p.m. Staff B Certified Nursing Assistant (CNA) stated she had Resident #1 in her van and they hit a bump and his wheelchair moved. She stated he was strapped into the van but his brakes were not secure so his wheelchair moved and he hit his shoulder on the gate. She stated his shoulder now hurt and he had a MRI scheduled because of this. She stated on a previous trip about 2 weeks prior, the resident's brakes were not working and she reported this and was told by Staff C, Maintenance Supervisor that the brakes were fixed but they were not. She stated since the brakes were not secure, the chair moved. On 6/3/24 at 1:36 p.m., Staff C Maintenance Supervisor stated he fixed the brakes on Resident #1's chair but the problem ended up not being the brake. He stated it would lock tight but the second they put weight in the chair, it would not lock so they switched chairs out. On 6/3/24 at 3:54 p.m., the Director of Nursing (DON) stated she would want wheelchair brakes to work. She stated she was not sure what happened but the resident hit his shoulder and she informed the Nurse Practitioner (NP). She stated she was under the impression the resident's representative was aware of the incident. The undated facility policy Van and Bus Safety directed staff to lock wheelchair brakes after loading.