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	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. 47079 Based on clinical record review, resident, family, and staff interview, and policy review the facility failed to ensure the resident's representative rights were met for 1 of 3 residents reviewed. (Resident#10). The facility identified a census of 67 residents. Findings include: The Quarterly Minimum Data Set (MDS) for Resident #10 dated 9/12/24 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained but indicated the resident was rarely or never understood. It included diagnoses of anemia, hyponatremia (low blood sodium), non-Alzheimer's Dementia, Transient Ischemic Attack (TIA-brief blockage of blood flow to the brain), metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood), and electrolyte imbalances. It revealed the resident was usually understood with difficulty communicating some words or finishing thoughts and was dependent for all levels of Activities of Daily Living (ADLs). The Care Plan indicated the resident desired to be a full-code and was dependent on staff for cognitive stimulation. It also directed staff to engage the resident in simple, structured activities and revealed her family preferred her to be included in activities even if she is not participating in them. The Electronic Health Record (EHR) revealed monthly labs were collected on 9/19/24 and sent to the lab. On 9/26/24 at 1:06 pm, the resident's relative stated she entered the resident's room and came back out after noting the resident's continued declined condition and notified the nurse the resident's mouth was dry and reminded them the resident needed to be hospitalized . She stated she informed the nurse every time the resident exhibited these signs, it was due to a urinary tract infection (UTI) and she had to be hospitalized . On 9/26/24 at 3:50 pm, Staff J, Licensed Practical Nurse (LPN) stated Resident #10 appeared more tired than usual on 9/19/24 and her white blood cell (WBC) count was a little high at 20 cells/microliter. She also stated she didn't recall the resident's relative visiting on Thursday (9/19/24) during her 12-hour shift (6 a-6p) and Saturday (9/21/24) was the first recollection she noticed the resident's level of consciousness (LOC) had declined since Thursday (9/19/24). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 1:43 pm, the resident's relative stated she didn't insist or stay until the facility contacted medical provider to send the resident to the hospital because she was told the facility was going to contact the physician. She stated she told the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and Staff J, LPN on 9/21/24 the resident needed to be sent to the hospital. On 9/30/24 at 2:18 pm, Resident #12 stated Resident #10 appeared more sluggish than her normal on Thursday (9/19/24) and Friday (9/20/24). She also stated the staff assigned to the resident said they would have the doctor come look at Resident #10. She further stated Resident #10's relative told the assigned nurse on Friday (9/20/24) she still wanted Resident #10 to be sent to the hospital to which the nurse replied they would get a hold of the doctor and see what he wants to do. The MDS for Resident #12 dated 8/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and depression and revealed her hearing and ability to understand others were intact and she used corrective lenses. On 9/21/24 at 11:34 am, the DON documented a change of condition for Resident #10 due to an elevated heart rate of 110. At 11:40 am, a follow-up documented change of condition included dry mouth, increased lethargy (tiredness), and increased WBC count. The documentation indicated the resident's relative was notified. On 9/30/24 at 2:35 pm, Staff J stated she was unable to recollect details of any conversation with Resident #10's daughter. She stated she didn't remember the daughter requesting the resident be sent to the hospital. On 9/30/24 at 3:48 pm, the DON stated she didn't recall the resident's daughter saying anything else after she was notified of the change of condition on 9/21/24. The EHR indicated the resident went unresponsive on 9/22/24 at 10:30 am and staff obtained orders from the medical provider to send the resident to the hospital. On 10/01/24 at 8:50 am, the medical provider reported she was not notified Resident #10's relative requested her to be sent to the hospital. A document titled Resident Rights amended 7/13/17 indicated the resident be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option the resident prefer and has the right to request, refuse, and/ or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. In an email, the Administrator indicated if the request is in the best interest of the resident AND is considered appropriate, then the response will depend on that as well as the area of request, which if appropriate, would be directed/provided to the HCP (healthcare provider) responsible for that scope to carry out. In most situations, it should be carried out.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on clinical record review, family and staff interview, and policy review the facility failed to notify a resident family/representative of a medication change for 1 of 3 residents reviewed (Resident #1). The facility reported a census of 67 residents. Findings Include: The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 carried the diagnoses of congestive heart failure, diabetes, mitral and aortic valve stenosis and venous insufficiency. The MDS indicated the resident's Brief Interview for Mental Status (BIMS) score was 99 indicating the resident was unable to complete the interview and had severely impaired decision making. Resident #1 was dependent on staff for toileting, bathing, personal hygiene and transfers and required set up assistance with eating. The resident received anti anxiety, antidepressant, diuretic, opioid, and hypoglycemic medications during the observation period. She received oxygen therapy and was under hospice care. The Care Plan dated 8/5/24 indicated Resident #1 was at risk for falls and included an intervention for staff to educate the resident/family/caregivers. Res #1 had a fall on 8/7/24 and the scheduled Lorazepam was discontinued at that time. Review of the physician orders for Resident #1 indicated the resident had the following orders for Lorazepam: Lorazepam Oral Tablet 0.5 milligrams (MG). Give 1 tablet by mouth every 4 hours as needed for anxiety, shortness of breath, or restlessness. It had an order date of 08/05/2024 and a discontinue date of 08/06/2024 Lorazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for anxiety, shortness of breath, or restlessness. It had an order date of 08/06/2024 and a discontinue date of 08/07/2024 Lorazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth four times a day for anxiety. It had an order date of 08/06/2024 and a discontinue date of 08/07/2024 Lorazepam Oral Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for anxiety, shortness of breath, or restlessness. It had an order date of 08/07/2024 and a discontinue date of 08/20/2024. The residents medical record lacked notification to the family/decision maker of Resident#1 of the 8/07/24 Lorazepam order. The Progress Notes dated 8/6/24 at 11:30 AM indicated the resident was seen by the nurse practitioner and an order was received for Lorazepam 0.5 MG four times a day and pro re nata (PRN) (as needed). It further indicated the family would be notified by Staff I, Licensed Practical Nurse (LPN). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 12:39 PM a call was placed to Staff I, LPN to inquire if she completed the family notification on 8/6/24 as she documented she would related to the resident's new order for Lorazepam 0.5 MG four times a day due to increased anxiety. The number was no longer in service and Staff I, LPN was no longer employed at the facility. A Progress Note dated 8/10/24 at 12:38 PM by the Director of Nursing (DON) indicated the resident was extremely anxious. Lorazepam was scheduled due to being so anxious. The resident normally did not take Lorazepam often. Due to her experiencing a fall, the Lorazepam was switched back to PRN only. Family was understanding and preferred it to be PRN only. Family and provider were aware. On 9/26/24 at 1:48 PM an email from the facility nurse practitioner stated she did not speak to the family/representative related to the order for scheduled Lorazepam. She stated the hospice Registered Nurse (RN) or facility nurses were the ones to notify families/representatives of medication changes In a facility provided policy titled Notification, Physician or Responsible Party revised 8/2024 stated the facility staff was to promptly notify the resident, his/her attending physician, and/or family/representative of changes in the resident's condition and/or status. The family/representative were to be notified when there was a significant change in the resident's physical, mental, or psychosocial status or there was a need to alter the resident's treatment significantly. In an interview on 10/1/24 at 4:28 PM, the DON stated it was the expectation that if a resident's family member/representative was involved, staff were to call them with any changes in condition or medication changes and make sure it was documented.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44972 Based on observations, record review, staff interview and policy review, the facility failed to ensure physician orders were followed and documented appropriately and accurately for 2 of 4 residents reviewed (Resident #2 and #8). The facility reported a census of 67 residents. Findings include: 1. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented Resident #8 had diagnoses including chronic obstructive pulmonary disease, acute and chronic respiratory failure, obstructive sleep apnea, schizoaffective disorder, anxiety and morbid obesity. The MDS indicated the resident's Brief Interview for Mental Status (BIMS) score was 10 which indicated moderate cognitive impairment. The resident required set up or clean up assistance with eating, toileting, and personal hygiene, moderate staff assistance with bathing and was independent with transfers. Resident #8 experienced shortness of breath with exertion, when sitting at rest and when lying flat and utilized oxygen therapy. The Medication Administration Record for Resident#8 dated 10/01/24 to 10/31/24 documented the following physician order with start date of 8/02/24; Oxygen at 2 litters via nasal cannula continuous every morning and at bedtime related to acute and chronic respiratory failure with shortness of breath. O 9/24/24/ at 12:45 PM, Resident #8's oxygen concentrator was noted to be unplugged and against the wall in her room and an oxygen tank was in the corner of the room and not being used. Resident #8 did not have oxygen on at the time. On 9/24/24 at 4:07 PM, Resident #8 was lying in bed with her eyes closed and no oxygen on. On 9/25/24 at 9:56 AM, Resident #8 was sat on the bed with no oxygen on at that time. The concentrator was still along the wall and unplugged. The oxygen tank was next to it and turned off. Resident #8 stated she had not used the oxygen in several days. She denied being short of breath. She stated the concentrator had been unplugged for several days because the staff had moved the concentrator from under the window to along the wall and never plugged it back in. In an interview on 9/25/24 at 10:59 AM, Resident #8 reported she was able to put the oxygen on herself but she had been unable to do it for the previous 3-4 days, since staff moved the concentrator and never plugged it in. She stated she had not experienced any shortness of breath during that time but did prefer to wear the oxygen at night for sleeping. On 9/26/24 at 1:25 PM, Resident #8 sat in her room in her wheelchair. She did not have oxygen on at that time. The oxygen concentrator was sitting along the wall and not plugged in. On 9/30/24 at 9:05 AM, Resident #8 sat in her room in her wheelchair and the concentrator was located along the wall and not plugged in. The oxygen tank was sitting next to it and turned off. The resident was not wearing oxygen at that time. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/2/24 at 10:20 AM, Resident #8 was sitting in her room in her wheelchair. The oxygen concentrator and oxygen tank were both sitting along her wall and the concentrator was not plugged in. The resident was not using oxygen at that time. Review of the oxygen saturations documented in the electronic health record (EHR) under the Weight/Vitals tab revealed the staff documented the resident oxygen saturations with the method being oxygen on via nasal cannula on the following dates and times: 9/23/24 at 12:33 AM as 96% with Oxygen via Nasal Cannula 9/24/24 at 12:47 AM as 96% with Oxygen via Nasal Cannula 9/24/24 at 7:57 AM as 94% with Oxygen via Nasal Cannula 9/26/24 at 2:37 AM at 94% with Oxygen via Nasal Cannula 10/1/24 at 2:45 AM at 96% with Oxygen via Nasal Cannula 10/1/24 at 11:45 PM at 92% with Oxygen via Nasal Cannula The resident had not used oxygen at all during this time frame as the concentrator was unplugged in her room and the oxygen tank remained turned off and next to the concentrator. In an interview on 10/1/24 at 4:30 PM, the Director of Nursing (DON) stated it was the expectation that if the resident was supposed to be using oxygen and they were checking the oxygen saturation and the resident did not have oxygen on but the oxygen saturation was normal, the staff should re-evaluate the need for the oxygen and contact the provider. If the oxygen saturation was checked and the resident did not have oxygen on, it was to be documented as room air and not with oxygen on. 50471 #2 On 9/24/24 at 3:45 PM observation revealed in the medication cart, the Resident #2 Acetaminophen 325 mg two tablets in a package dated 9/23/24 PM. The Staff I, Registered Nurse (RN), stated that is the Resident #2 Acetaminophen for 9/23/24, to be given at PM. The Staff I stated that we are to give what is in the package, there is no stock medications for the Resident #2. On 9/24/24 at 4:00 PM The Resident #2 clinical record revealed that the Staff D, RN documented on the Electronic Medication Administration Record (EMAR) administered Acetaminophen 325 mg gave two tablet by mouth on 9/23/24 at PM. In an interview on 10/1/24 at 3:57 PM the Director of Nursing (DON) stated if she was auditing documentation of the residents and seen an area that was documented and that did not occur she would address it with that nurse, verify if they accidentally documented it or if they meant to document. Medication related, she would investigate, currently they have daily package, so they should realize what has been given and what has not, documentation should follow. The DON stated if it is a legit error then steps would be followed for medication error. (continued on next page)

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Documentation and Charting Policy revised 7/23 instructed staff documentation must be accurate to the best of the writer's abilities based upon the information available to them.

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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. 47079 Based on clinical record review, staff interview, and policy review the facility failed to ensure physician's orders were followed for 2 of 3 residents reviewed (#2, #10). The facility identified a census of 67 residents. Findings include: 1) The Quarterly Minimum Data Set (MDS) for Resident #10 dated 9/12/24 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained but indicated the resident was rarely or never understood. It included diagnoses of anemia, hyponatremia (low blood sodium), non-Alzheimer's Dementia, Transient Ischemic Attack (TIA-brief blockage of blood flow to the brain), metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood), and electrolyte imbalances. It revealed the resident was usually understood with difficulty communicating some words or finishing thoughts and was dependent for all levels of Activities of Daily Living (ADLs). The Care Plan indicated the resident desired to be a full-code and was dependent on staff for cognitive stimulation. It also directed staff to engage the resident in simple, structured activities and revealed her family preferred her to be included in activities even if she is not participating in them. On 9/21/24 at 5:14 pm, the Assistant Director of Nursing (ADON) entered a Progress Note dated 9/20/24 that indicated the medical provider saw the resident and gave new orders for a urinalysis (UA) with culture and sensitivity (C&S) as indicated, increase gastric tube flushes to 250 mL every 6 hrs, monitor for signs and symptoms of infection, and to recheck complete blood count (CBC) and basic metabolic panel (BMP) in 2 weeks. The Electronic Health Record (EHR) did not include an order for a UA. On 9/26/24 at 1:06 pm, the resident's relative stated she entered the resident's room and came back out after noting the resident's continued declined condition and notified the nurse the resident's mouth was dry and reminded them the resident needed to be hospitalized . She stated she informed the nurse every time the resident exhibited these signs, it was due to a urinary tract infection (UTI) and she had to be hospitalized . On 9/30/24 at 2:35 pm, Staff J, Licensed Practical Nurse (LPN) stated she was made aware on 9/21/24 in report a UA was ordered for the resident but it wasn't collected by the time she began her 9/21/24 AM shift. She stated she was expected to get it if she could but said another nurse said she would get it because she had more time. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 3:31 pm, the ADON stated he received the UA order from the provider via an email and was responsible for entering the order into the EHR. He also indicated the Director of Nursing (DON) usually verified his order entries were correct but he didn't believe she had an opportunity to verify it. He also revealed he didn't enter the UA order into the EHR because he thought the resident would need to be straight catheterized. He stated he was waiting to get further clarification because some staff wouldn't think to straight catheterize the resident if they were unsuccessful at collecting a urine sample. On 10/01/24 at 8:50 am, the medical provider stated she was not notified that the UA had not been collected. A policy titled Notification, Physician or Responsible Party revised 8/2024 indicated the nurse supervisor will notify the resident ' s attending physician when there is a need to alter the resident's treatment significantly and when deemed necessary or appropriate in the best interest of the resident. On 10/01/24 at 4:17 pm, the DON stated the order should have been placed in the computer on Friday 9/20/24. She also stated on Saturday 9/21/24, an order to cancel the urine sample should've been obtained. She further added if staff are unsuccessful in executing an order, they should call the DON to get assistance or guidance or utilize another nurse as a resource. 50471 #2 On 9/24/24 at 3:45 PM The Resident #2 medication was reviewed in the medication cart, found pain relief 325mg two tablets in a package dated 9/23/24 PM. The Staff I, Registered Nurse (RN), stated that is the Resident #2 pain relief for 9/23/24, to be given at PM. The Staff I stated that we are to give what is in the package, there is no stock medications for the Resident #2. On 9/24/24 at 4:00 PM The Resident #2 clinical record revealed that the Staff D, RN documented on the Electronic Medication Administration Record (EMAR) administered Acetaminophen 325mg gave two tablet by mouth on 9/23/24 at PM. In an interview on 10/1/24 at 3:57 PM the Director of Nursing (DON) stated if the nursing staff finds an error or commits an error, the staff should notify the doctor, file an Incident Report or Risk assessment, notify the family, monitor-change of condition for every shift for 72 hours. The staff should be trained at orientation about documentation error and how to handle the situation. The future plan is for the staff to have monthly meetings for education. The facility policy titled Medication Errors and Adverse Reactions reviewed 8/24 instructed the staff that medication errors and adverse drug reactions must be reported to the resident's attending physician, medication error means the observed or identified preparation or administration of medications-the prescriber's order, nursing services must immediately implement and follow the physician's orders. The resident's condition must be closely monitored for seventy-two (72) hours or as may directed, Documentation of the resident's condition and response to treatment must be recorded during the monitoring period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration revised 5/07 instructed staff to read resident's medication sheet and select appropriate drugs from the unit dose drawer, open unit dose pills into souff cup, give medications, document administration of medication.

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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 0684 Level of Harm - Actual harm 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** 47079 Based on clinical record review, staff interviews, and policy review, the facility failed to provide assessment and intervention for the necessary care and services for 4 of 4 residents reviewed (#4, #8, #9, & #10). This resulted in harm to Resident #10 due to delayed interventions and resulted in an emergent transfer to a higher level of care. The facility reported a census of 67 residents. Findings include: 1) The Quarterly Minimum Data Set (MDS) for Resident #10 dated 9/12/24 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained but indicated the resident was rarely or never understood. It included diagnoses of anemia, hyponatremia (low blood sodium), non-Alzheimer's Dementia, Transient Ischemic Attack (TIA-brief blockage of blood flow to the brain), metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood), and electrolyte imbalances. It revealed the resident was usually understood with difficulty communicating some words or finishing thoughts and was dependent for all levels of Activities of Daily Living (ADLs). The Care Plan indicated the resident desired to be a full-code and was dependent on staff for cognitive stimulation. It also directed staff to engage the resident in simple, structured activities and revealed her family preferred her to be included in activities even if she is not participating in them. The Electronic Health Record (EHR) revealed monthly labs were collected on 9/19/24 and sent to the lab. On 9/26/24 at 1:06 pm, the resident's relative stated she entered the resident's room and came back out after noting the resident's continued declined condition and notified the nurse the resident's mouth was dry and reminded them the resident needed to be hospitalized . She stated she informed the nurse every time the resident exhibited these signs, it was due to a urinary tract infection (UTI) and she had to be hospitalized . On 9/26/24 at 3:50 pm, Staff J, Licensed Practical Nurse (LPN) stated Resident #10 appeared more tired than usual on 9/19/24 and her white blood cell (WBC) count was a little high at 20 cells/microliter. She also stated Saturday (9/21/24) was the first recollection she noticed the resident's level of consciousness (LOC) had declined since Thursday (9/19/24). On 9/30/24 at 2:18 pm, Resident #12 stated Resident #10 appeared more sluggish than her normal on Thursday (9/19/24) and Friday (9/20/24). She also stated the staff assigned to the resident said they would have the doctor come look at Resident #10. The MDS for Resident #12 dated 8/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of anxiety and depression and revealed her hearing and ability to understand others were intact and she used corrective lenses. (continued on next page)

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	165175	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/30/24 at 1:23 pm, the resident's relative stated Staff J informed her on 9/21/24 via telephone the resident's vital signs were normal. She added that when she arrived to the facility, she checked the resident's pulse and respiratory rate and had to locate the nurse and notify her of the elevated vital signs. On 9/30/24 at 2:35 pm, Staff J stated she did not work on 9/20/24 but worked on 9/21/24 and 9/22/24. When shown resident documentation she signed on 9/20/24, she stated she forgot she worked that day. She was unable to provide any details of an interaction with the resident's daughter on 9/20/24. She also stated she was made aware on 9/21/24 in report a UA was ordered for the resident but it wasn't collected by the time she began her 9/21/24 AM shift. She stated she was expected to get it if she could but said another nurse said she would get it because she had more time. On 9/30/24 at 3:31 pm, the Assistant Director of Nursing (ADON) stated he received the UA order from the provider via an email on 9/20/24 and was responsible for entering the order into the EHR. He also indicated the Director of Nursing (DON) usually verified his order entries were correct but he didn't believe she had an opportunity to verify it. He also revealed he didn't enter the UA order into the EHR because he thought the resident would need to be straight catheterized. He stated he was waiting to get further clarification because some staff wouldn't think to straight catheterize the resident if they were unsuccessful at collecting a urine sample. On 9/30/24 at 3:48 pm, the DON stated she documented a change of condition on 9/21/24 for Resident #10 because Staff J notified her that the resident's heart rate was elevated at a rate of 110 bpm. She stated the follow-up documented change of condition on 9/21/24 at 11:40 am included dry mouth, increased lethargy (tiredness), and increased WBC count. She stated she did not contact the medical provider about the additional assessment information. The EHR progress notes indicated the resident went unresponsive on 9/22/24 at 10:30 am and staff obtained orders from the medical provider to send the resident to the hospital. On 10/01/24 at 8:50 am, the medical provider stated she was not made aware of the resident's relative's request to send the resident to the hospital nor about the additional change of condition assessment findings on 9/21/24. She also stated she was not notified the UA had not been collected. She added the resident would have been sent to the Emergency Department and would have had more resource options had she been informed of this information. She also stated she felt the resident's outcome would not have changed. A policy titled Resident assessment dated ,d+[DATE] directed staff to complete a nursing assessment with a significant change in the resident's condition. 2) On 9/24/24 at 9:17 am, Resident #4's negative pressure wound therapy (NPWT = wound vac) machine was audibly beeping while the resident slept. At 9:28 am, Staff K, Certified Nurse Aide (CNA) entered the room and removed the breakfast trays for both residents. The resident's wound vac alarm was audibly beeping. At 9:42 am, Staff L, Occupational Therapist (OT) entered the resident's room and to confirm therapy attendance. Resident #4's wound vac alarm was still audibly beeping. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	At 9:44 am, Staff M, CNA entered the room to fill ice cups and exited at 9:53 am. The wound vac alarm was still audibly beeping. At 10:13 am, Staff K and Staff M entered the resident's room and the wound vac alarm was no longer audible. The wound vac screen was dark and was not plugged in to the power outlet. The Minimum Data Set (MDS) for Resident #4 dated 8/05/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of neurogenic bladder (uncontrolled bladder due to nerve damage), hip and other fractures, traumatic brain injury (TBI), and a pressure ulcer. It also revealed the resident required setup assistance with eating, supervision with oral and personal hygiene, moderate assistance with upper body dressing, and was dependent with all other activities of daily living (ADLs). It further indicated he received nonsurgical dressings. The Care Plan dated 9/08/24 directed staff to change the wound vac to the right ischium (the lower back part of the hip) on Monday, Wednesday, and Friday and as needed (PRN) for contamination or dislodgement. On 10/01/24 at 4:15 pm, the DON stated staff should report alarms to the assigned nurse. On 10/02/24 at 1:16 pm, the Administrator indicated the facility did not have a policy specific to staff responding to alarms as it is a standard of practice. 44972 3) The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 carried diagnoses of chronic obstructive pulmonary disease, acute and chronic respiratory failure, obstructive sleep apnea, schizoaffective disorder, anxiety and morbid obesity. The MDS indicated the resident's Brief Interview for Mental Status (BIMS) score was 10 indicating moderate cognitive impairment. The resident required set up or clean up assistance with eating, toileting, and personal hygiene, moderate staff assistance with bathing and was independent with transfers. Resident #8 experienced shortness of breath with exertion, when sitting at rest and when lying flat and utilized oxygen therapy. The care plan dated 8/1/24 revealed a focus area for Resident #8 having emphysema, and chronic obstructive pulmonary disease related to smoking. Interventions included: to give aerosol or bronchodilators as ordered and to give oxygen therapy as ordered by the physician at 2 liters per nasal cannula continuous. The Medication Administration Record for Resident#8 dated 10/01/24 to 10/31/24 documented the following physician order with start date of 8/02/24; Oxygen at 2 liters via nasal cannula continuous every morning and at bedtime related to acute and chronic respiratory failure with shortness of breath. In an observation on 9/24/24/ at 12:45 PM, Resident #8's oxygen concentrator was noted to be unplugged and against the wall in her room and an oxygen tank was in the corner of the room and not being used. Resident #8 did not have oxygen on at the time. On 9/24/24 at 4:07 PM, Resident #8 was lying in bed with her eyes closed and no oxygen on. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 9/25/24 at 9:56 AM, Resident #8 sat on the side of the bed with no oxygen on at that time. The concentrator was along the wall and unplugged. The oxygen tank was next to it and turned off. Resident #8 stated she had not used the oxygen in several days. She denied being short of breath. She stated the concentrator had been unplugged for several days because the staff had moved the concentrator from under the window to along the wall and never plugged it back in. In an interview on 9/25/24 at 10:59 AM, Resident #8 reported she had not refused or told staff she did not want to wear the oxygen. She stated she was able to put the oxygen on herself but she had been unable to do it for the previous 3-4 days, since staff moved the concentrator and never plugged it in. She stated she had not experienced any shortness of breath during that time but did prefer to wear the oxygen at night for sleeping. On 9/26/24 at 1:25 PM, Resident #8 sat in her room in her wheelchair. She did not have oxygen on at that time. The oxygen concentrator was sitting along the wall and not plugged in. On 9/30/24 at 9:05 AM, Resident #8 sat in her room in her wheelchair and the concentrator was located along the wall and not plugged in. The oxygen tank was sitting next to it and turned off. The resident was not wearing oxygen at that time. On 10/2/24 at 10:20 AM, Resident #8 satin her room in her wheelchair. The oxygen concentrator and oxygen tank were both sitting along her wall and the concentrator was not plugged in. The resident was not using oxygen at that time. In an interview on 10/1/24 at 4:41 PM, the Director of Nursing (DON) stated it was the expectation that if a resident was supposed to be using oxygen and they were checking the oxygen saturations when the resident was not wearing oxygen and the oxygen saturations were normal, they should re-evaluate the need for oxygen and contact the provider. The staff should document the resident was not using the oxygen and then follow up with the provider for further evaluation. In an interview on 10/2/24 at 12:42 PM, the Marketing Director stated the facility did not have a policy relating to following physician orders as it was considered a standard of practice. 50471 4) Observation on 9/26/24 at 2:40 PM revealed the Resident #9 resting in wheelchair in lounge, no date on tubing, portable oxygen tank noted completely empty and on 3 liters. The Staff E, Certified Medication Aide (CMA) assessed the pulse ox-noted 85-89%-oxygen tank is empty, checked the nasal cannula for air flow-none noted, looked at the gauge on the portable oxygen tank, noted the tank is empty, asked staff to get a portable oxygen tank, the Assistant Director of Nursing (ADON) obtained the portable oxygen tank, noted the oxygen tank empty, and proceed to switch the tanks, and assessed the pulse ox-noted 95% on 3 liters. Observation on 9/30/24 at 11:26 AM revealed the Resident #9 sitting in wheelchair with visitor in lounge, noted portable oxygen tank gauge at beginning of red-revealed need for refill tank, and showed the Resident #9 on 2 liters. In an interview on 9/26/24 at 2:23 PM the ADON stated the Resident #9 is to be on 3 liters nasal cannula continuously. The Resident #9 current order for oxygen is 4 liters continuous. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 9/30/24 at 11:26 AM The ADON stated the nurses look at the orders to verify what liters of oxygen the residents are on. The Resident #9 is on 3 liters of oxygen continuous. The Resident #9 current order is 4 liters continuous. Clinical Physician Orders directed staff as follows; Oxygen at 4 liters via nasal cannula continuously with revision date of 2/9/24. The facility policy titled Physician Orders revised 8/24 instructed the staff that drugs shall be administered only upon the written order of a person duly licensed and authorized to prescribe such drugs, no drugs or biologicals shall be administered except upon the order of a person lawfully authorized to prescribe for and treat human illnesses, and drug and biological orders must be recorded on the physician's order sheet in the resident's chart.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, clinical record review, staff interview, and policy review, the facility failed to provide treatment and services to promote the healing of a pressure ulcer for 1 of 3 residents reviewed (#4). The facility reported a census of 67 residents. Findings include: The Minimum Data Set (MDS) for Resident #4 dated 8/05/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of neurogenic bladder (uncontrolled bladder due to nerve damage), hip and other fractures, traumatic brain injury (TBI), and a pressure ulcer. It also revealed the resident required setup assistance with eating, supervision with oral and personal hygiene, moderate assistance with upper body dressing, and was dependent with all other activities of daily living (ADLs). It further indicated he received nonsurgical dressings. The Care Plan dated 9/08/24 directed staff to change the wound vac to the right ischium (the lower back part of the hip) on Monday, Wednesday, and Friday and as needed (PRN) for contamination or dislodgement. A grievance form dated 9/16/24 indicated weekend staff on 9/14/24 and 9/15/24 did not provide wound vac care because the nurses stated they did not know how to do wound vacs. The Director of Nursing (DON) documented on 9/18/24 that staff received education and the wound vac treatment days were changed to Tuesday, Thursday, and Saturday. On 9/24/24 at 9:17 am, Resident #4's negative pressure wound therapy (NPWT = wound vac) machine was audibly beeping while the resident slept. On 9/24/24 between 9:28 am and 9:53 am, two (2) Certified Nursing Assistants (CNAs) and an Occupational Therapist (OT) entered the resident's room and did not respond to the wound vac alarm. On 9/24/24 at 10:13 am, two (2) CNAs entered the resident's room and the wound vac alarm was no longer audible. The wound vac screen was dark and was noted to not be unplugged from the power supply cord and no longer audibly providing negative pressure suction. On 9/24/24 at 11:05 am, the Assistant Director of Nursing (ADON) entered the resident's room to perform his wound vac care. He left at 11:06 am to verify the order and the wound vac was noted to still be disconnected from the power supply cord and no longer audibly providing negative pressure suction. On 9/24/24 at 11:14 am, the ADON disconnected the wound vac tubing and changed the resident's wound vac dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 11:29 am, the ADON finished the wound vac change and pressed the power button on the wound vac pump. The screen illuminated and he connected the pump to the power cord connector hung on the resident's bedframe. When he turned on the wound vac pump, a yellow, oval message battery critical was observed on the pump screen. He then directed a CNA to connect the power supply cord to the AC adapter and to plug the receptacle into the wall. He turned on the wound vac pump and secured it beside the resident on his bed. On 9/24/24 at 11:37 am, the resident reported it had happened in the past that the battery has wound down while he was in bed and alarmed. On 9/30/24 at 2:42 pm, Resident #4 was observed in his wheelchair in the hall without his wound vac. He stated he had it off on Friday to go to a festival. He stated he returned from the festival Sunday at 2:00 pm and was expecting the wound vac to be reapplied at that time. It was reapplied after 3:00 pm on Monday 9/30/24. On 9/30/24 at 2:46 pm, Staff J, Licensed Practical Nurse (LPN) stated the ADON changes Resident #4's wound vac and she would go ask him what's the plan. An undated document titled Wound Vacuum Assisted Healing Device indicated negative pressure should be applied to the wound at least 22 hours per day. On 10/01/24 at 4:04 pm, the Director of Nursing (DON) stated if he (the resident) refused to apply the wound vac, staff should have called [NAME] and obtained an order for a wet-to-dry dressing or call the on-call nurse and received guidance.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44972 Based on observation, record review, staff interview and policy review, the facility failed to ensure oxygen was available to a resident requiring the use of oxygen for 1 of 3 residents reviewed (Resident #9). The facility reported a census of 67 residents. Findings include: 1) Observation on 9/26/24 at 2:40 PM revealed the Resident #9 resting in wheelchair in lounge, no date on tubing, portable oxygen tank noted completely empty and on 3 liters. The Staff E, Certified Medication Aide (CMA) assessed the pulse ox-noted 85-89%-oxygen tank is empty, checked the nasal cannula for air flow-none noted, looked at the gauge on the portable oxygen tank, noted the tank is empty, asked staff to get a portable oxygen tank, the Assistant Director of Nursing (ADON) obtained the portable oxygen tank, noted the oxygen tank empty, and proceed to switch the tanks, and assessed the pulse ox-noted 95% on 3 liters. Observation on 9/30/24 at 11:26 AM revealed the Resident #9 sitting in wheelchair with visitor in lounge, noted portable oxygen tank gauge at beginning of red-revealed need for refill tank, and showed the Resident #9 on 2 liters. In an interview on 9/26/24 at 2:23 PM the ADON stated the Resident #9 is to be on 3 liters nasal cannula continuously. The ADON did not know how long the Resident #9 sat in lounge with oxygen tank empty. The ADON stated the oxygen tubing is changed every Wednesday and the staff place a piece of tape on the oxygen tubing. In an interview on 9/30/24 at 11:26 AM The ADON stated the nurses look at the orders to verify what liters of oxygen the residents are on and there is no place that staff document portable oxygen tanks are checked for amount remaining. The ADON stated the Resident #9 is on 3 liters of oxygen continuous. A Physician's Order with revision date of 2/9/24 directed staff as follows; Oxygen at 4 liters via nasal cannula continuously. The facility policy titled Oxygen Administration revised 8/24 instructed the staff that oxygen therapy is administered, as ordered by the physician, obtain appropriate physician's order, assemble the oxygen unit and flowmeter, making sure all connections are secure, reassess oxygen flowmeter for correct liter flow, and document all appropriate information in medical record.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on resident and family interviews, staff interviews, record review, and policy review, the facility failed to maintain competent staff to appropriately perform an enema on a resident (#5) and provide wound vacuum care for 1 resident (#4). The facility reported a census of 67 residents. Findings include: 1) On 9/23/24 at 12:30 pm, Resident #10 reported Staff F, Licensed Practical Nurse (LPN) performed his bowel enema roughly on 9/18/24 and he experienced rectal bleeding afterward. On 9/23/24 at 1:30 pm, the Assistant Director of Nursing (ADON) performed the resident's enema. He was observed providing digital anal stimulation prior to inserting the enema wand into the resident's rectum. On 9/23/24 at 2:00 pm, the resident's relative stated she informed Staff F that she was performing the procedure incorrectly when she noticed Staff F attempted to insert the enema wand into Resident #10's rectum without the resident properly positioned in the shower chair and no visual confirmation of rectum location. The Minimum Data Set (MDS) dated [DATE] for Resident #10 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of Neurogenic bladder (loss of bladder control due to damaged nerves), quadriplegia, anxiety, depression, Post-Traumatic Stress Disorder (PTSD), and constipation. It also revealed the resident required maximum assistance with eating, oral hygiene, and personal hygiene and was dependent in all other aspects of Activities of Daily Living (ADLs). The Electronic Health Record (EHR) included a physician's order dated 3/13/24 for Lactulose enema: mix 300 ml of Enulose with 700 ml of water or normal saline and administer rectally three times per week on Monday, Wednesday, and Friday (M-W-F) with bowel care. A subsequent order created 9/16/24 with a 9/18/24 start date directed staff to provide a Lactulose Enema: Mix 300 ml of Enulose with 700 ml of water or normal saline and administer rectally three times per week on M-W-F. The nurse must digitally remove stool before and after enema. The Care Plan dated 8/01/24 revealed the resident had specific bowel cares done on Mondays, Wednesdays, and Fridays. On 9/23/24 at 4:25 pm, Staff G, Certified Nurse Aide (CNA) stated she assisted Staff F with Resident #10's enema on 9/18/24. She stated Staff F had difficulty seeing the resident's anus while she tried to insert the enema wand into his rectum. Staff F asked Staff G to lean the resident forward. Staff G stated Staff F indicated she was able to see the resident's anus then instructed Staff G to put the resident back down. Staff G stated blood was noted on the enema wand when the resident was lowered. (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 1:10 pm, Staff H, CNA stated she was present with Resident #10's shower on 9/18/24. She put him in the shower chair for Staff F, Licensed Practical Nurse (LPN) to perform his bowel care. She stated Staff F shoved the enema wand into Resident #10's anus a little roughly. Staff H stated Resident #10 asked Staff F if she was going to do the digital stimulation to which she replied no. Staff H stated Staff F said the digital stimulation was discontinued and Resident #10 didn't need anyone playing with his butt. Staff F, LPN, put the enema wand in and out several times but left without checking for efficacy. Staff H went to check to see if Staff F was coming back and stated Staff F stated she was done with him. Staff H stated the resident's family member instructed Staff F to stop because she was doing it too roughly. Staff H stated Staff F instructed the family member the resident required the procedure. Staff H stated the resident's family member performed the digital stimulation with a large, bloody, bowel movement. On 9/24/24 at 2:08 pm, Staff F, LPN stated she performed Resident #10's enema on 9/18/24. She stated when she tried to initiate the enema, she believed the stool was close to the anus because the wand couldn't be inserted too far. She said she initially experienced resistance and presumed there was stool at the anus so she pushed the wand into the anus. She stated she did not perform a digital stimulation because the digital stimulation order was discontinued. She stated the resident asked her during the procedure if she was she fu*@ing him with the probe. She stated she did not come back to the resident afterwards because the procedure was completed. On 9/24/24 at 3:00 pm, the Assistant Director of Nursing (ADON) stated the enema order changed on 9/16/24 because two orders confused the nurses. He stated the digital stimulation component was added to the order. He also stated the facility felt nurses may not have known to include it as he felt may not be familiar with the procedure. On 10/01/24 at 4:04 pm, the Director of Nursing (DON) stated if staff were unable to visualize the resident's anus during the procedure, he or she should have informed the resident and relative that the resident needed to be repositioned lying down to perform the task effectively. She also stated staff should've followed the doctor's order or recruited assistance from another nurse if she felt uncomfortable with further procedure requirements. Two undated documents titled Enema (Retention) and Enema (Cleansing) both describe positioning the resident so the anus can be visualized prior to inserting the enema and require staff to return after the enema solution has been inserted into the resident's rectum. 2) A grievance form dated 9/16/24 indicated weekend staff on 9/14/24 and 9/15/24 did not provide wound vac care for Resident #4 because the nurses stated they did not know how to do wound vacs. The Director of Nursing (DON) documented on 9/18/24 that staff received education and the wound vac treatment days were changed to Tuesday, Thursday, and Saturday. The Minimum Data Set (MDS) for Resident #4 dated 8/05/24 indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of neurogenic bladder (uncontrolled bladder due to nerve damage), hip and other fractures, traumatic brain injury (TBI), and a pressure ulcer. It also revealed the resident required setup assistance with eating, supervision with oral and personal hygiene, moderate assistance with upper body dressing, and was dependent with all other activities of daily living (ADLs). It further indicated he received nonsurgical dressings. (continued on next page)

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	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 9/08/24 directed staff to change the wound vac to the right ischium (the lower back part of the hip) on Monday, Wednesday, and Friday. The Electronic Health Record (EHR) included an order which indicated vac to be removed for assessment and reapplied 3 times per week and as needed (PRN) for contamination or dislodgement. An undated document titled Wound Vacuum Assisted Healing Device included procedure directions and indicated negative pressure should be applied to the wound at least 22 hours per day. On 10/01/24 at 4:04 pm, the Director of Nursing (DON) stated if he (the resident) refused to apply the wound vac, staff should have called [NAME] and obtained an order for a wet-to-dry dressing or call the on-call nurse and received guidance. On 10/02/24, the Market Leader (ML) stated the facility did not have completed competency checklists for staff but have implemented one that will be used in their annual skills fair.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079 Based on observations, staff interviews, and policy review, the facility failed to properly secure medications from unauthorized access for two of two medication carts observed. The facility reported a census of 67 residents. Findings include: 1) On 9/24/24 at 9:10 am, the Side 2 (200 resident hall) medication cart was observed unlocked with no staff present. Staff A, Certified Medication Aide (CMA) stated he left the cart unlocked by mistake. 2) On 9/24/24 at 12:08 PM, the Side 1 (100 resident hall) medication cart was observed unlocked. There were 8 residents sitting in the dining room and no medication authorized staff was present. Staff B, Certified Medication Aide (CMA) stated it is not customary to leave the medication cart unlocked when staff are away from the cart. A policy titled Medication & Treatment Carts revised 8/01/24 indicated the medication and treatment carts are to be locked at all times when not in use. It also directed staff the cart must remain in line of sight when it is not locked and to not leave the medication or treatment cart unlocked or unattended in the resident care areas. On 10/01/24 at 4:04 PM, the Director of Nursing (DON) stated if staff leaves the cart, they should lock it. 44972 3. On 9/24/24 at 11:15 AM, the Side 2 (200 resident hall) medication cart was observed unlocked in the hall and no medication authorized staff was present. Staff A, CMA left the medication cart unattended as he entered room [ROOM NUMBER] and the cart was stationed across the hall outside room [ROOM NUMBER] and out of his sight.

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	165175	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47079 Based on observations, staff interviews, and policy review, the facility failed to properly protect resident information from unauthorized access for two of two laptops reviewed in common areas. The facility reported a census of 67 residents. Findings include: On 9/23/24 at 9:10 am, the Side 2 (200 resident hall) medication cart was observed unlocked and resident information was visible on the laptop screen. There was no staff present. Staff A, Certified Medication Aide (CMA) stated he left the cart unlocked and the laptop open by mistake. On 9/24/24 at 12:08 PM, a medication cart was observed unlocked and 12 residents ' information was visible on the laptop screen. There were 8 residents sitting in the dining room and no medication authorized staff was present. Staff B, Certified Medication Aide (CMA) stated it is not customary to leave the laptop with resident information and the medication cart unlocked when staff are away from the cart. A document titled Safeguards for PHI (Protected Health Information) dated January 2017 directed staff to store all documents containing PHI in a secure, locked location with limited access to authorized workforce members. On 10/01/24 at 4:04 PM, the Director of Nursing (DON) stated staff should activate the lock feature on the screen prior to walking away.