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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 11/13/2024 |
| NAME OF PROVIDER OR SUPPLIER Greater Southside Health and Rehabilitation | | 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) |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44512</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to identify a hazard, and the facility did not take action to reduce the risk for further injuries. On 10/28/24, Resident #2 was identified to have a rectangular shaped red mark to the right forearm measuring 10.3cm x 5.6cm, with scattered blisters. Resident #2 reported to the staff that the water in the shower room caused the injury. On 10/31/24 the resident went to the Urgent Care and was found to have a 2nd degree burn on the right arm. The facility continued to give showers in the identified shower room. On 11/5/24, After 3 residents received showers, a Department of Inspection, Appeals and Licensing (DIAL) staff measured the water temperature to be 145.2 degrees Fahrenheit.</p> <p>The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of October 28, 2024 on November 5, 2024 at 4:55 p.m. The facility staff removed the Immediate Jeopardy on November 6, 2024 by implementing the following actions:</p> <ol style="list-style-type: none"> 1. Resident #2 had treatment in place of the area on the right arm. 2. The 3 residents that were given showers on the morning of 11/5/24 had complete head to toe skin assessments completed and were questioned about the temperature of water. 3. Weekly skin assessments are recorded in each resident's chart in Point Click Care (PCC), no residents voiced concerns about shower temperature, or any injuries noted from skin assessments. 4. All showers were put out of use immediately after DIL staff reported water temperature finding of 145.2 degrees. The high temperature had the potential to harm other residents in the facility that receive showers. 5. All showers are regulated to prevent water temperatures above 120 degrees. 6. 1-[NAME] Plumber services contacted on 11/5/24 to assess the current plumbing system with additional monitoring thermometer installed on the water heater. 1-[NAME] Plumber's report isolated an incident of sediment build up that was resolved by maintenance staff with no further interventions required for safe water temperatures. <p>(continued on next page)</p> |

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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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>7. Maintenance will check water temperature in each shower room daily beginning 11/5 for the next 7 days and then on a weekly basis as a part of weekly system checks through TELS. Weekly system checks have no end date.</p> <p>8. All nursing staff will be educated on how to monitor water temperature with a thermometer placed in the shower room by the end of day 11/6/24. If the water temperature is greater than 120 degrees, they are to cease the shower for the resident, and report to the administrator, maintenance or charge nurse and cease showers until the water temperature has been checked and deemed to be at a safe level.</p> <p>The scope lowered from J to D at the time of the Survey after ensuring the facility implemented staff education and procedures.</p> <p>The facility reported a census of 59 residents.</p> <p>The Minimum Data Set (MDS) for Resident #2 dated 8/9/24 revealed a diagnosis of quadriplegia (partial or complete paralysis of both arms and legs as a result of a spinal cord injury) and was dependent on staff for a shower. Resident had a Brief Interview for Mental Status (BIMS) score of 15 which suggested an intact cognition.</p> <p>The Care Plan for Resident #2 identified the need for total assistance with bathing and directed staff directed staff to offer a bath/shower 2 times a week and as needed.</p> <p>The Nursing progress notes for Resident #2 revealed:</p> <p>a. On 10/28/24 at 4:12 PM The nurse was notified by Physical Therapy (PT) of a skin alteration to resident's right arm. Upon assessment, the resident was noted with a rectangular shaped red mark to right forearm measured 10.3 centimeters (cm) x 5.6 cm with scattered blisters in the middle of the area. The resident stated this may have happened while in the shower earlier in the day. The area was cleansed, skin prep applied and family and provider notified.</p> <p>b. On 10/28/24 at 4:18 PM A change of condition: skin wound. The primary care provider was notified on 10/28/24 at 3 PM and the resident representative was notified at 3 PM.</p> <p>c. On 10/28/24 at 4:22 PM A condition follow-up: redness to right forearm with scattered blisters. An order for skin prep 2 times a day (BID) until healed.</p> <p>d. On 10/29/24 at 9:59 AM A condition follow-up: Staff J, Nurse Practitioner, was here to see the resident. Resident #2 complained of pain and burn on the site, skin looks red on surface. The treatment completed as ordered. No signs or symptoms of infection noted at this time.</p> <p>e. On 10/31/24 at 9:14 A condition follow-up: A new observation noted. The skin is still red, blisters are drained. A clear tape is covering the area. The resident complained of pain to the area.</p> <p>f. On 10/31/24 at 6:42 PM A condition follow-up: The arm was red with raised blisters, no signs or symptoms of infection.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>g. On 11/1/24 at 12:47 AM A condition follow-up: The area being monitored is from what resident stated was from water and then stating it was from the shower bar. The area is square in shape, has small intact blisters in the middle. The resident was out all day on Saturday and Sunday with friends and family and did not have a long sleeve shirt on when leaving facility. The resident stated it was sore. There was no bleeding or drainage noted.</p> <p>h. 11/1/24 at 7:45 AM Late entry: on 10/31/24 the resident and his friend came back with a note from Urgent care at Mercy.</p> <p>i. 11/1/24 at 6:26 PM Resident was seen by provider. A new order for a topical antibiotic (TAO) to be applied BID (2 times a day) and as needed (PRN), apply a non-adherent dressing and loosely wrap with Kerlix dressing. A voicemail was left for mother.</p> <p>During an interview on 11/5/24 at 1:09 PM, Resident #2 stated on 10/28/24, Staff B, Certified Nursing Assistant (CNA) assisted him to a shower chair and transported him to the upstairs shower room. Resident #2 stated when the water touched his forearm, he could feel the temperature and Staff B put the water on his right forearm. Resident #2 stated, She had to turn it down because it was scalding hot. Resident #2 stated he felt heat on his right (Rt) arm and felt discomfort when it was dried off with a towel. Resident #2 stated the CNA's that dressed him identified the reddened area and the therapist notified Staff D, Licensed Practical Nurse (LPN). Resident #2 stated Staff D assessed his arm and stated to leave it open. Resident #2 stated he notified his mother who came to the facility and was told it was a rash. Resident #2 stated his arm was painful, and was given Oxycodone for back pain but stated that did not relieve the burning pain. Resident #2 stated the facility provider assessed the reddened, blistered area on 12/29/24 who stated she was not sure what it was but the staff told her it was a rash and gave an order for skin prep to be applied. Resident #2 stated the blisters increased in size and he experienced prickly pain. Resident #2 stated he seen at the Urgent Care on 10/31/24 and treated for a 2nd degree burn to the right forearm.</p> <p>During an observation on 11/5/24 at 1:08 PM, Resident #2 had a reddened area to the right upper forearm/elbow area that revealed a dried, open, scared area inside the reddened skin. Resident #2's mother provided a picture of the affected area, verified by Resident #2, that was taken after a shower on 12/28/24 that revealed a reddened area with blisters in the center to the skin on his right forearm.</p> <p>A document titled Mercy One dated 10/31/24 revealed:</p> <p>a. History of present illness: Minor burn, patient notes a burn on right forearm and elbow. He notes that he lives in a home and was in the shower when he was burned. It is a second degree burn on his right arm at the elbow area.</p> <p>b. Assessment/Plan: 2nd degree burn. Keep clean and dry. Cover and use an antibiotic ointment on it, as needed, for the next 3-4 days until it is healing more and feeling better.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 10/4/24 at 2:58 PM The Director of Nursing (DON) stated Resident #2 was out of the facility over the weekend and received the shower that he said he received the burn on Monday 10/28/24. The DON stated the provider told her that the water in the shower may have exacerbated the area. The DON stated Resident #2 went to a clinic on his own. The DON stated she had followed up with the clinic staff who stated he was to put an antibiotic on the dressing, but they did not have an antibiotic order. The DON stated the facility provider was treating the area with skin prep to toughen up the blisters. The DON stated the maintenance supervisor keeps water logs and had tested water temperatures every day.</p> <p>During an interview on 11/5/24 at 9:52 AM, Staff K, CNA stated Resident #2 told her the shower water was too hot in the upstairs shower room. Staff K stated sometimes that shower room gets hot and they have to check it. Staff K reported giving 3 showers in that shower room this AM without incident. The metal grab bars could get hot if the water was turned all the way up and running straight down on to the bar. Staff K stated the water will get hot if turned all the way up.</p> <p>During an observation on 11/5/24 at 10:02 AM, in the shower room located in 100 Hall (identified as the upstairs shower room) the DIAL surveyor turned water on and tested the water temperature with her hand and the water was too hot to touch. A measurement was conducted with a thermometer that revealed 145.2 Fahrenheit. The Administrator was present for the test.</p> <p>During an observation on 11/5/24 at 10:37 AM, The administrator applied a sign onto the upstairs shower door that read out of order.</p> <p>During an interview on 11/5/24 at 11:25 AM, Staff I, CNA stated the shower room upstairs, if you turn it all the way up, potentially could burn your skin. Staff I stated, I don't turn it all the way up. I don't think anyone would turn it all the way up.</p> <p>During an interview on 11/5/24 at 3:02 PM Staff B, CNA stated she had assisted Resident #2 out of bed on 10/28/24 about 9 AM and into the shower room for the nurse to do bowel care before his shower. Staff B stated the entire time, the water was running, and she had tested the water. Staff B stated this was her first time to give Resident #2 a shower, he had a routine and would give instructions. Staff B stated Resident #2 let her know the water got cold and she had turned it up, then he could tell her if it was too hot. Staff B stated another aide took over after the shower. Staff B stated Staff E, LPN approached her when she was giving another shower, asked if she had seen anything red or raised on his arms and stated she did not see anything on Resident #2's right arm before or during the shower. Staff B stated she had given 4 showers before Resident #2 had his and the water was not overly hot.</p> <p>During an interview on 11/7/24 at 10:04 AM Staff E, LPN stated Resident #2 had lived in the facility about a year and was a typical [AGE] year old with an active social life. Staff E stated she had completed his bowel care and during that time, she did not visualize anything on his skin. Staff E stated after the shower, she was notified by therapy and assessed a red rectangular shape area with blisters to Resident #2's right arm. Staff E stated Resident #2 stated he was burned when the CNA ran water over his arm. Staff E stated she had notified the provider and received an order to apply skin prep and it was not normal to put skin prep on burns. Staff E stated she notified the mother, the DON and the Assistant Director of Nursing (ADON). Staff E stated she had questioned Staff B, CNA who denied having the water over his arm. Staff E stated that Resident #2 did not want to get the CNA into trouble.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>During an interview on 11/7/24 at 10:31 AM Staff M, CNA stated she had worked with Resident #2 on 10/28/24 and assisted his to undress for the shower. Staff M stated there was nothing, no redness to his arms and he did not have pain. Staff M stated she had assisted Resident #2 to the shower room then left the room. Staff M stated when Resident #2 returned from the shower, he had a red mark the size of her phone, with blisters to his right arm. Staff M stated she did not visualize the redness before the shower, but it was there after the shower.</p> <p>During an interview on 11/6/24 at 1:16 PM Staff L, Occupational Therapist (OT) stated on 10/28/24 he had entered Resident #2's room to assist in dressing after the shower. Resident #2 told Staff L that he had a burn to his right arm from hot water in the shower room upstairs. Staff L stated there was a red rectangular patch of redness to the upper forearm and lower humerus with small blisters in the center. Staff L stated he did not disagree with Resident #2 and notified the nurse.</p> <p>During an interview on 11/6/24 at 1:42 PM Staff C, CNA stated she was aware that the upstairs shower was pretty hot and stated she did not want to burn anyone. Staff C stated she was recently informed that there was a thermometer in the shower room and the staff were to measure the water to ensure it was not to rise above 120 degrees F.</p> <p>During an interview on 11/6/24 at 2:11 PM Staff F, CNA stated the water was too cold in the down stairs shower rooms, therefore Resident #2 would receive showers in the upstairs shower room. Staff F claimed the water was too hot to put her hand underneath it and would have to turn it down and test it before putting it on a resident.</p> <p>During an interview on 11/6/24 at 2:01 PM, Staff G, Certified Medication Aide (CMA) stated the water temperature in the upstairs shower room depended on how long it was on. Staff G stated she received a text message that read not to give showers until the problem was corrected.</p> <p>During an interview on 11/6/24 at 2:28 PM, Staff D, LPN stated Resident #2 told her on 10/29/24 that he received the injury in the shower room. Staff D stated she had not tested the water temperature, was not aware that the water was hot. Staff D stated, No one could figure out what it (the injury) was, I thought it was a spider bite because there was a blister on it.</p> <p>Document provided by the facility titled Test and Log the Hot Water Temperatures revealed:</p> <ol style="list-style-type: none"> a. Test the water at various locations throughout your facility. b. For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this temperature can still cause burns if exposure reaches five minutes. Many states have even stricter standards that can set maximum temperatures lower than 120 degrees Fahrenheit. Although 100 degrees Fahrenheit is considered a safe water temperature for bathing. c. Test temperature in shower areas. d. Check resident rooms at the end of each wing on a rotating basis or per facility policy. e. Note any discrepancies. f. Adjust water heater settings as required. <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>g. Retest as necessary.</p> <p>A document titled Logbook Water Temps revealed:</p> <p>a. Date 10/31/24</p> <p>8 Room's tested , room numbers not identified temp range 103 to 105F</p> <p>Laundry room and Kitchen 140F.</p> <p>Lacked testing of shower rooms. Signed by Staff H, Maintenance Supervisor.</p> <p>b. Date 10/25/24</p> <p>room [ROOM NUMBER]- T 104F, room [ROOM NUMBER]- T 104F, room [ROOM NUMBER]- T103, room [ROOM NUMBER]-T104F</p> <p>room [ROOM NUMBER]-T104F, room [ROOM NUMBER]- 104F, room [ROOM NUMBER]- T 103F, room [ROOM NUMBER]-T 104F</p> <p>Laundry room & Kitchen 140F. Lacked testing of shower rooms. Signed by Staff H.</p> <p>A document titled Logbook Documentation revealed:</p> <p>a. Dated Oct. 24-30 (no year) Side 1 shower pass 108.4, Side 2 east shower pass 104, Side 2 west shower pass 103.8. Comments: Side 1 a little higher than normal. Completed by lacking a signature.</p> <p>b. Dated [DATE]-[DATE] (no year) Side 1 shower pass 108.2, Side 2 east shower pass 103.8, Side 2 west shower pass 104. Comments: Side 1 still a little high than normal, still at passing temperature, I will keep checking it. Completed by lacking a signature.</p> <p>A review of the Journal of American Medical Association Studies of Thermal Injury revealed the time for a 3rd degree burn to occur for a water temperature of 148 degrees F. for 2 seconds, water temperature of 140 degrees F for 5 seconds and a safe water temperature for bathing 100 degrees F. Based upon the time of the exposure and the temperature of the water, the severity of the harm to the skin is identified by the degree of burn, as follows:</p> <p>a. First-degree burns involve the top layer of skin (e.g., minor sunburn). These may present as red and painful to touch, and the skin will show mild swelling.</p> <p>b. Second-degree burns involve the first two layers of skin. These may present as deep reddening of the skin, pain, blisters, glossy appearance from leaking fluid, and possible loss of some skin.</p> <p>c. Third-degree burns penetrate the entire thickness of the skin and permanently destroy tissue.</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37074</p> <p>Based on record review, hospital documentation review, resident, staff interviews and policy review the facility failed to assure that 1 of 1 resident (Resident #1) that received dialysis treatments, was provided with arrangements to and from the dialysis facility of his choice. The facility reported a census of 59 residents.</p> <p>Findings include:</p> <p>According to the Admission Minimum Data Set (MDS) assessment tool with a reference date of 7/16/24 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS listed the following diagnoses for him: end stage renal disease, atrial fibrillation, coronary artery disease, and diabetes mellitus.</p> <p>A Care Plan Focus Area with a revision date of 9/18/2024 documented Resident #1 needed dialysis related to his renal failure. Staff are instructed to encourage the resident to go for the scheduled dialysis appointments.</p> <p>The hospital provided a document titled Discharge Summary with an admitted [DATE] and discharge date of [DATE]. The summary included Resident #1's new dialysis center with appointments on Mondays, Wednesdays, and Fridays at 7:05 AM.</p> <p>The hospital provided a document titled Continuation of Care and Discharge Note with a date of service of 10/2/24. At 12:15 PM a call was placed to the facility and spoke with the Administrator. Discussed plan for resident to return today. Informed the Administrator that Resident #1 had completed his dialysis treatment this morning and that his dialysis treatment center has changed to a different location with appointments on Mondays, Wednesdays and Fridays at 7:05 AM, set to begin on Friday 10/4/24. The Administrator verbalized understanding. The document indicated he declined to receive dialysis treatments at the center he was going to prior to being admitted to the facility. He requested to go to a different dialysis center that was closer to the facility. The appointments were set up for Mondays, Wednesdays, and Fridays at 7:05 AM.</p> <p>The following progress notes were documented:</p> <p>a) On 10/3/24 at 8:39 PM on this date the Administrator and Director of Nursing (DON) were informed that Resident #1 had changed his dialysis location and time to 7:00 AM on Monday, Wednesday, and Friday. Resident #1 had previously been informed about transportation options when he first arrived at the facility, but stated he could arrange his own transportation and did not need the facility van. The DON and Administrator talked about his dialysis appointment at 7:00 AM on Friday, October 4, 2024 and reeducated him that transportation with the facility van was not available. He was asked if he could arrange for his own transportation if he wanted to keep the 7:00 AM appointment time. Resident #1 responded, he will have to check with his resources.</p> <p>(continued on next page)</p> | | |

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| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>b) On 10/4/24 at 8:24 AM received a call from a gentleman from the hospital asking why Resident #1 had not gone to his dialysis appointment today. This nurse asked if this was a staff member from the resident's previous dialysis center. The gentleman said it was with the hospital and stated this resident had changed his dialysis treatment location and time to 7:05 AM. Upon re-admission to the facility, it was agreed upon with this resident that they could not provide transportation at that time and would have to arrange for his own transportation to his dialysis treatment. Resident #1 was aware of these factors prior to being readmitted to the facility.</p> <p>On 11/5/24 at 12:27 AM Staff A Certified Medication Aide (CMA)/Driver stated she does transport residents to and from their appointments. Her working hours are 8:00 AM to 5:00 PM, but usually stays over depending on the appointments for that day. Staff A indicated the earliest she has come in to transport residents to their appointments is 6:30 AM for a 7:00 AM appointment. Staff A was asked if the facility had ever asked her to come in early to take Resident #1 to his dialysis appointment at 7:00 AM, she stated she vaguely remembers. She knew he had switched dialysis centers after one of his hospitalizations and she thought his appointment was at 6:00 AM. She added either way the Administration and Resident #1 got it figured out and he is back at his old dialysis center. Staff A stated if his appointment was at 7:00 AM she would have been able to come in early but not three days a week. She has kids that she has to help get ready for school and finding someone to help with that. But push come to shove, she would have done it. She indicated the Business Office Manager is able to drive the transport van as well.</p> <p>On 11/5/24 at 12:46 PM Resident #1 stated it has been problematic getting him to and from the dialysis center, on time. When asked what was going on, he stated they get him to his appointments late, he has missed days. Resident #1 stated he missed appointments because the facility could not take him; that's what they told him on those missed days. He acknowledged he did refuse to go to some of his treatment days, indicating he is an adult, can make his own decisions and manage his own care. There were some changes at his other dialysis center that he did not like. He spoke with his nephrologist and agreed to going to a different dialysis center. When it came time for his appointment at the new center, the facility told him they could not transport him there because they did not have staff on duty. Resident #1 denied being offered a taxi cab or uber ride to his appointment on 10/4/24. He added they did not tell him transportation was not available until after the appointment was set up. When asked if they could change his appointment times to a later time he indicated he likes to go earlier in the day so he has the rest of his day to get things done. When he would go in the afternoon, he would miss important calls.</p> <p>On 11/6/24 at 12:29 PM the Business Office Manager (BOM) stated prior to being promoted to BOM, she was mainly doing transportation and central supply. She added in the last three months she has helped with transportation at least one time. The BOM stated she would help if a resident needed to be at an appointment at 7:00 AM. She indicated when Resident #1 was initially admitted to the facility, she was taking him to his 11:50 AM dialysis appointments downtown. During one of his recent hospitalizations they changed his dialysis location and they were not aware until last minute. The BOM stated she would have not had any issues with taking Resident #1 to his early appointment time at the new location if they would have asked her to. When asked who was able to drive the transport van she stated herself, Staff A and the Administrator.</p> <p>(continued on next page)</p> | | |

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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 11/13/2024 |
| NAME OF PROVIDER OR SUPPLIER Greater Southside Health and Rehabilitation | | 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) | | |
| <p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/6/24 at 1:53 PM the Administrator stated Resident #1 can be non-compliant with his dialysis treatments, telling staff he knows his body better than they do. Resident #1 would tell staff he does not rely on them for transportation for his dialysis appointments. When he changed this appointment time to 7:00 AM at different dialysis center, they touched base with him on wanting to keep that time and he told them he would reach out to his resources for transportation. This was the day before his appointment. The morning of his appointment Resident #1 stated he did change the time of his treatment and they let him know they could not provide transportation because the driver was unable to accommodate for the earlier time. When asked about reaching out to additional transportation options he stated the company did not want to sign the HIPPA agreement, so the third-party option was not of help. When asked if he spoke with Staff A about accommodating, he indicated he told her they were waiting on a chair time change from the resident. He denied being told by Staff A that she could have taken him to the appointment if need be. When asked if the BOM could have taken Resident #1 to his dialysis appointment he stated she would have to do that 3 days a week but Resident #1 was trying to set up his own transportation. The Administrator stated it was working out fine with his 11:50 AM dialysis time, he was unsure what happened. The resident could have kept his 7:00 AM if they had additional resources. When the Administrator was questioned what a couple of options for transportation help between Staff A and the BOM, he stated the resident always would tell them they could not provide the care he needs. He told his staff to really start to document because the resident would have complaints but would refuse to do the things that were brought to him to help with his concerns. When asked if they could have called a Taxi or Uber for Resident #1's dialysis appointments he stated they can't depend on others to transfer him safely. When asked since the facility was given a two day notice about his change in appointment time, could they have arranged transportation for the appointment, the Administration stated the resident wanted to check with his resources. The Administrator indicated he is not under that facility's insurance policy to be a driver of the transportation van. The resident has gone back to his original dialysis center and time.</p> <p>Review of the facility's Admission Packet revealed the following: the facility will arrange for appropriate transportation of resident to other healthcare services provided outside of the facility in accordance with the attending physician's or the facility's Medical Director's orders and the facility's policies and procedures. If the resident's condition requires immediate medical attention, the facility will provide or secure transportation for the resident to the appropriate healthcare providers such as but not limited to physicians, dentists, physical therapists, or for treatment at renal dialysis facilities. In the Resident's Rights section with a subsection of medical care it stated: you have the right to be fully informed in advance about care and treatment and any changes in that care and treatment that may affect your well-being including the type of caregiver or professional who will provide that care. You have the right to be involved in the choice of your doctor and other healthcare providers subject to the provider's compliance with all applicable laws and reasonable rules and regulations of the facility.</p> | | |