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	03/20/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on record review, observations, resident interview, visitor interview, staff interview, and policy review the facility to treat residents in a dignified, respectful manner by entering resident rooms without announcement or knocking and by not ensuring clothing appropriate to the weather conditions for 3 of 10 residents reviewed. (R#1, R #2, R#4). The facility reported a census of 70. Findings include: 1. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #2 listed diagnoses of heart disease, cancer, and end stage renal disease depression. The MDS documented the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The Care Plan focus initiated 11/27/24 documented resident #2 wishes to be long term placement, in addition Resident #2 had self-care deficits. Interventions included to allow resident to make decisions about treatment regime and to provide sense of control. On 3/18/25 at 9:50 AM observed Activity Department, (AD) Staff A knocked and walked into Resident #2 room simultaneously, did not wait for resident to respond to the knocking. On 3/18/25 at 9:53 AM resident #2 relayed it is not ok and expected courtesy from staff. On 3/18/25 at 10:00 AM Visitor present in the facility relayed staff just come right in, happens a lot. I have seen it many times. 2. The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #4 listed diagnoses of traumatic spinal cord dysfunction, quadriplegic, anxiety, depression and post-traumatic stress disorder. The MDS documented the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The Care Plan initiated 12/15/24 for Resident #4 documented self-care performance deficit and immobility, intervention added to encourage resident to discuss feelings about self-care deficits. On 3/18/25 at 12:10 PM Resident #4 in private conversation with room door closed. CNA, Staff B walked into the room, did not knock. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 AT 12:10 PM CNA, Staff B voiced after entering Resident #4 room, was sorry and should have knocked. During an interview on 3/18/25 at 1:10 PM the Administrator relayed all staff receive orientation at hire and training, included, to knock and introduce self before entering a resident's room and is the expectation. 3. The Annual Minimum Data Set (MDS) for Resident #1 dated 12/12/24 listed diagnoses included traumatic brain dysfunction, renal disease, diabetes, acquired absence of right and left leg above knees. The MDS section for Brief Interview of Mental Status (BIMS) scored 15 out of 15 indicated intact cognition. The Care Plan focus dated 9/4/24 for Resident #1 documented self-care performance deficit. Intervention for dressing included, required assist of one with lower and upper body dressing, putting on and taking off. On 3/19/25 at 9:57 AM Resident #1 sitting in wheel chair waiting to go outside for usual supervised smoking, wore a short-sleeved cotton shirt at chest level with large abdomen exposed revealing varies types of psoriatic rashes. Resident wore shorts on upper thighs, both legs had been amputated and the leg stumps were exposed. Approximately seven other residents waiting in the hall to go outside, most with coats and/or blankets due to the start of rain and windy conditions. Resident #1 exited with staff for the outside break. On 3/19/25 at 10:07 AM Resident #1 back in the facility from outside smoke break, queried if wanted more clothing on when going outside with the changing weather conditions. Resident #1 relayed most everything is in the laundry. Facility Policy/Procedure, Section titled Resident Rights, Subject, Dignity and Respect documented staff members shall knock before entering the resident's room and included residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and be well groomed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47582 Based on clinical record review, facility document review, personnel file review, resident interview, staff interview, and facility policy review, the facility failed to protect 1 of 3 residents (Resident #3) reviewed from financial abuse. The facility reported a census of 70 residents. Findings include: Resident #3's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 12 which indicated moderate cognitive impairment. The MDS reflected Resident #3 diagnosis Parkinson's disease without dyskinesia, dysphagia, atherosclerotic heart disease, hyperlipidemia, essential hypertension, abnormal gait and mobility, muscle wasting and atrophy, and weakness. The MDS further documented Resident #3 required staff assistance for performing most activities of daily living. A facility reported incident dated 1/20/25 documented the following: on January 20, 2025, at approximately 2:45 PM, the facility was alerted to an isolated incident regarding the misappropriation of property belonging to Resident #3. This concern was raised by Resident's #3 family member, who had installed a camera in his father's room. The footage, recorded on January 17, 2025, showed Staff F, Certified Nurses Aide (CNA) accessing a secured drawer containing Resident's #3 money, resulting in a report of $55 missing. The personnel file for Staff F included a certificate dated 3/3/24 certifying she completed the course for Dependent Adult Abuse. The Counseling/Disciplinary form for Staff F dated 1/20/25 documented discharge (last day worked) 1/20/25, the decision to terminate employment was based on the employee's involvement in the misappropriation of resident property, which represented a serious breach of trust and violation of the facility's policies. Such behavior was unacceptable in any professional setting, particularly in a skilled nursing facility where the safety and well-being of residents was paramount. In an interview with Resident #3 on 3/18/25 at 12:50 pm he recalled event on 1/20/25 about missing money and how his son was able to review the video footage and see that Staff F went into his room while he was asleep, got into his locked drawer and took the money, $55 cash. Resident #3 stated the facility repaid the missing cash back right away and he hasn't had any issues since. No prior incidents of missing cash or any other personal items. Resident #3 stated he had a video camera in his room that his son installed a while ago. In an interview on 3/18/25 at 9:45 am Staff F confirmed she was in Resident #3 room on the alleged date, 1/20/25, but denied taking money from Resident's #3 locked drawer. Staff F also revealed she was not aware Resident #3 had a video camera in his room and she was recorded. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/17/25 at 3:00 pm the Administrator confirmed he watched the video on Resident's #3 son's cellphone and it was evident Staff F unlocked the resident's dresser keypadded drawer with a key, picked up something and then put it in her pocket. She told him the resident asked her to put his wallet in the drawer but the resident denied asking her to do that. The Administrator further explained this event occurred around 2 am while the resident was asleep and Staff F should not have gone through his personal belongings. The Administrator notified Staff F via phone call she was terminated for violating the facility's zero-tolerance policy regarding the misappropriation of resident property. The facility provided policy titled Abuse: Prevention of and Prohibition Against revised 12.2023, documented It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. It is also the policy of this Facility to recognize the resident right to personal privacy and confidentiality of their physical body, personal care, and personal space or accommodations. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, exploitation, or use of technology that would infringe on the resident's right to personal privacy. To assist the Facility's staff members in recognizing incidents of possible abuse, neglect, misappropriation of resident property, or exploitation, the following definitions are provided: Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Mistreatment means inappropriate treatment or exploitation of a resident.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, staff interview, resident interview and policy review, the facility failed to ensure before and after dialysis assessments were completed for 1 of 1 resident reviewed on dialysis (Resident #2). The facility reported a census of 70 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 revealed diagnosis of end stage renal disease and received dialysis. The Brief Interview for Mental Status (BIMS) scored 15 out of 15 indicating no cognitive impairment. The Care Plan for Resident #2 initiated 9/18/24 documented Resident #2 needed dialysis related to renal failure. Staff directed to encourage resident to go for the scheduled dialysis appointments, to check the fistula (site for dialysis) daily, to obtain vital signs and weight, report significant changes in pulse, respirations and blood pressure immediately, to monitor, document and report to the provider signs any symptoms of renal insufficiency. During an interview on 3/17/25 at 2:20 PM Resident #2 queried about dialysis assessments, Resident #2 relayed staff do not always check vital signs prior to leaving for the appointments and do not always assess when returned from dialysis. Resident #2 reported recollection of day in January was feeling very ill after a dialysis appointment and felt dismissed. During an interview on 3/18/25 at 3:15 PM with Licensed Practical Nurse (LPN) Staff E relayed assessments were completed in the treatment record and there was a recent change, now a form is completed before the resident leaves for dialysis which included vital signs and is also completed after the dialysis. Staff E relayed the form should be uploaded in residents record. Electronic record review look back February 1, 2025 to March 12, 2025 revealed the following Forms titled: Dialysis Communication Transfer Form a. 2/12/25 - included assessment prior to dialysis, no documentation after dialysis b. 2/14/25 - dialysis scheduled, no assessment found c. 2/19/25 - dialysis scheduled, no assessment found d. 2/21/25 - dialysis scheduled, no assessment found e. 2/24/25 - dialysis scheduled, no assessment found f. 2/26/25 - dialysis scheduled, no assessment found g. 2/28/25- included assessment prior to dialysis, no documentation after dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. March 2025 - dialysis assessments completed 3/5/25 and 3/12/25 - no other assessments in March located During an interview on 3/19/25 at 10:30 AM The Director of Nurses (DON) relayed did look at the facility dialysis assessment process and several assessments were not completed or could not be located for Resident #2. DON relayed had a work in progress to improve systems to ensure are completed. Facility Policy, Subject: Dialysis (Renal) Pre and Post Care, last reviewed 3/2023 included directives for dialysis care as follows: Pre-dialysis care: 1. Assess resident's blood pressure (in non-shunt arm) prior to being transported to the dialysis unit. 2. Medications will be administered as prescribed by the medical provider 3. Any staff concerns that may influence the dialysis treatment should be addressed prior to leaving facility. 4. Any staff concerns that may influence the dialysis treatment should be addressed prior to l leaving f facility verbally communicated to the dialysis unit if warranted. Post-dialysis care: 1. Dialysis access should be assessed upon return to the facility for patency, and any unusual redness or swelling. 2. Post dialysis shunt access care as ordered. 3. Any problems with a resident's access should be addressed timely. 4. Report any significant change in the resident will be reported to the provider and dialysis center 5. Any significant change in medical condition should be reported immediately. 6. Notify Registered dietician of any dietary concerns. 7. Contact Social Services staff to help resident deal with adjustment issues as needed. 8. Contact Activity staff to help resident deal with leisure needs as needed. 9. Collect dialysis run sheet from dialysis unit, report any needed changes to the provider for further orders and file.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46513 Based on observation, staff interviews, resident interviews and policy review, the facility failed to provide a proper functioning call system to allow resident to staff communication for 1 of 5 residents reviewed. (Resident #1). The facility reported a census of 70. Findings include: The Annual Minimum Data Set (MDS) for Resident #1 dated 12/12/24 listed diagnoses included traumatic brain injury, heart disease, respiratory failure, diabetes, renal disease, depression, schizophrenia, acquired absence of right and left leg above knees. The resident was coded needed substantial/maximus assistance with transferring from bed or chair, for dressing lower body bathing and putting footwear. MDS section for Brief Interview of Mental Status (BIMS) scored 15 out of 15 which indicated intact cognition. The Care Plan initiated 8/2/24 for Resident #1 documented self-care performance deficit with intervention to encourage to use bell to call for assistance. On 3/18/25 at 10:30 AM Resident #1 relayed had pulled cord was waiting for staff, not sure how long ago had pulled the call card. Resident #1 agreed and pulled the cord again to test if the light outside of the door would go on. An Observation on 3/18/25 at 10:33 revealed the call light above Resident #1 door was not on. On 3/18/25 at 10:40 AM The Business office Manager (BOM), Staff D standing outside of Resident #1 door reported the call light went on and it was the light for the resident that resided on the opposite side of Resident #1. The call light then observed to go off. Staff D could not explain why it went on then off and relayed the resident would not be able to get up to turn it off, no other person visiting in the room. On 3/18/25 at 10:41 AM Certified Nursing Staff #C arrived and tested Resident #1 call light by pulling the call cord. The call light did not go on. Staff C relayed was not aware Resident #1 call light did not work but, did know the resident on the other side of the room had a call cord that did not work and was given a button to press that will sound at the nurse's station. Staff C voiced Resident #1 may also need the same type of call button since also is not working. On 3/18/25 at 10:50 AM the Administrator arrived and joined outside Resident #1 door. The Administrator relayed awareness of call light concerns and reported there are plans in place for changing the entire call light system but was delayed. The Administrator reported did recognize some call light concerns and when one is found not working, the resident will be given a button that alerts the nurses station. The facility policy Call Light/Bell documented the facility to provide the resident a means of communication with staff.