

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48888</p> <p>Based on staff interview, clinical record review, and facility policy review, the facility failed to identify and report ongoing abnormal vital signs, outside of normal ranges, for 2 of 2 residents (Resident #1 and Resident #2). The facility further failed to complete respiratory assessment (Resident #1) when identified as short of breath on exertion for 5 out of 10 days reviewed. The facility reported a census of 68 residents.</p> <p>Findings include:</p> <p>1. The Admission Assessment, dated 4/11/25, revealed Resident #1 had been alert, confused, oriented to person and place on admission. Resident #1's apical pulse identified as regular in rhythm and resident denied cardiovascular concerns. Admission Assessment revealed Resident #1 had no pulmonary diagnoses, respirations were normal without shortness of breath. Resident #1 noted to have contractures and weakness of bilateral upper and lower extremities, and utilized a wheelchair for mobility.</p> <p>The Baseline Care Plan, initiated 4/12/25, revealed Resident #1 at risk for impaired cognitive function or impaired thought processes and at risk for falls. The Care Plan lacked identification of cardiovascular or respiratory system concerns.</p> <p>An Incident Report, dated 4/11/25 at 5:00 PM, revealed Resident #1 had an unwitnessed fall in room, found in front of the bed in a fetal position, no injuries observed. Resident #1 identified as alert and oriented to person, place, and time. Incident Report revealed Resident #1 was lifted off the floor and Neurological Assessments initiated. Incident Report lacked documentation of Resident #1's vital signs at time of fall.</p> <p>The Medication and Treatment Administration Record (MAR/TAR), dated April 2025, revealed an order, initiated 4/11/25, to monitor for signs and symptoms of shortness of breath every shift, as exhibited by the following number codes:</p> <p>0= None, 1= Shortness of breath on exertion, 2= Shortness of breath when sitting at rest, 3= Shortness of breath when lying flat. A code number 1 documented on the following dates: 4/14/25, 4/15/25, 4/16/25, 4/17/25, and 4/18/25.</p> <p>Review of Resident #1's Nursing Progress Notes revealed the following documentation:</p> <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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. On 4/15/25 at 9:24 PM, Blood pressure was 93/63 (normal range 100-120/60-90), heart rate 105 beats per minute (normal range 60-100), and temperature 99.8 degrees Fahrenheit (normal 98.6-99.6 degrees Fahrenheit). Documentation lacked physician notification of abnormal vital signs.</p> <p>2. On 4/20/25 at 8:20 AM, heart rate was recorded at 102 beats per minute. Documentation lacked physician notification of elevated heart rate.</p> <p>3. On 4/21/25 at 10:29 AM, Progress Note revealed that hospital was given report on Resident #1. Documentation lacked identification of incident leading to transfer or reason for Resident #1's transfer to Hospital.</p> <p>Facility document, titled Nursing Home to Hospital Transfer Form, indicated date of transfer 4/21/25 for loss of consciousness. Transfer Form revealed Resident #1's blood pressure was 77/58 and heart rate 101 beats per minute. Date of Transfer Form completion 4/22/25 at 6:16 am, after Resident #1's transfer to the hospital.</p> <p>On 4/23/25 at 3:55 PM, Staff A, Licensed Practical Nurse (LPN), stated during her shift on 4/21/25 it was reported to her that Resident #1 did not appear to be doing well and was not responding as usual. Staff A reported Resident #1 found to be sitting in a wheelchair in the dining room with irregular breathing and no verbal response. Staff A informed that a sternal rub was performed on Resident #1, without response, and noted his blood pressure had been low. Staff A revealed that due to Resident #1's lack of responsiveness, she decided to send him to the hospital. Staff A revealed paper work sent with Resident #1 included a Facesheet and a list of medications he was taking.</p> <p>On 4/23/25 at 4:00 PM, Staff B, Certified Nursing Assistant (CNA) stated she had assisted Resident #1 with morning cares on 4/21/25, and reported that he was fine at that time. Staff B revealed at baseline Resident #1 would be alert and verbally respond to staff. Staff B reported observation of Resident #1 in dining room during breakfast on 4/21/25, not lifting head, eyes unfocused, and breathing heavily.</p> <p>On 4/23/25 at 10:55 AM, Assistant Director of Nursing (ADON), revealed nurses were expected to notify physician for vital signs outside of normal range and any change of condition from a resident's baseline.</p> <p>On 4/24/25 at 3:30 PM, Director of Nursing (DON), revealed Unit Manager staff were expected to review and follow up with alerts that the Electronic Health Record (EHR) system provided when vital signs were recorded as outside of normal range, then recheck abnormal vital signs for accuracy, and notify the physician if vital signs remain off. DON revealed the expectation of nursing staff to notify physician for heart rates below 60 and above 100 beats per minute. DON unable to recall if shortness of breath was normal for Resident #1.</p> <p>2. The Minimum Data Set (MDS), dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating intact cognition. Diagnoses included Parkinson's Disease, Coronary Heart Disease, and hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan, initiated 9/23/24, revealed Resident #2 had hypertension related to stroke with interventions to check blood pressure and give anti-hypertensive medications as ordered. Intervention instructed staff to monitor for side effects of antihypertensive medication such as orthostatic hypotension and increased heart rate (tachycardia) and to report side effects to physician as necessary.</p> <p>The Medication Administration Record (MAR), dated April 2025 revealed an order, initiated 8/20/2022, for Losartan Potassium 25 milligrams (mg) with instructions to give one tablet by mouth in the morning for hypertension and to hold if systolic blood pressure is less than 100 or heart rate is less than 60 beats per minute. The MAR included Resident #2's daily blood pressure and heart rate reading.</p> <p>Review of Resident #2's Nursing Progress Notes revealed the following documentation:</p> <ul style="list-style-type: none"> -On 3/12/25 at 12:53 PM, heart rate was 56 beats per minute (bpm). -On 3/13/25 at 7:58 AM, Losartan Potassium 25mg was held for blood pressure result of 96/52. -On 3/18/25 at 7:36 AM, heart rate was 41 bpm, Losartan 25 mg held. -On 3/19/25 at 8:46 AM, Resident #2 presented with bradycardia (low heart rate) weak apical pulse of 46 bpm. Note indicated medications held for low pulse and a fax was sent to physician for further advice. -On 3/20/25 at 7:34 AM, heart rate was 38 bpm, Losartan 25mg was held. -On 3/20/25 at 3:02 PM, Resident #2's apical pulse was found to be weak and slow at 52 bpm. Note informed that a fax had been sent to the physician to update with medication list for further advice on low pulse rates. -On 3/21/25 at 5:07, heart rate was 48 bpm, Losartan 25mg held. -On 3/23/25 at 6:30 PM, Resident #2 had unwitnessed fall near restroom, found lying on top of walker after attempting to toilet self. Neurological Assessments initiated, heart rate 43 bpm. -On 3/24/25 at 3:20 AM, heart rate was 55 bpm, Losartan 25 mg held. -On 3/25/25 at 2:01 AM, heart rate was 47 bpm. Losartan 25 mg held. -On 3/26/25 at 4:07 AM, heart rate was 40 bpm. Losartan 25 mg held. -On 3/27/25 at 4:02 AM, heart rate was 40 bpm. Note informed that Resident #2 continued to have low heart rate. Progress Note lacked documentation of physician notification. -On 3/30/25 at 4:32 AM, heart rate was 46 bpm. Note informed that Resident #2 continued to have decreased pulse rate with no complaints of headache or lightheadedness. Progress Note lacked documentation of physician notification. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 4/03/25 at 3:42 PM, Resident #2 had an unwitnessed fall in room. Heart rate within normal range.</p> <p>-On 4/04/25 at 1:52 AM, heart rate was 45 bpm.</p> <p>-On 4/05/25 at 12:28 AM, heart rate was 58 bpm.</p> <p>-On 4/15/25 at 2:45 PM, Resident #2 had a witnessed fall during transfer in resident's room.</p> <p>-On 4/17/25 at 12:09 AM, Note informed that Resident #2 had increased weakness and required increased staff assistance with transfers.</p> <p>-On 4/17/25 at 2:57 PM, heart rate was 58. Labs and urinalysis specimen collected as ordered.</p> <p>-On 4/18/25 at 1:58 AM, heart rate was 55 bpm.</p> <p>-On 4/18/25 at 10:16 AM, Resident #2 noted to be soft spoken and lethargic for the first half of morning shift. Documentation lacked provider notification.</p> <p>-On 4/19/25 at 8:31 AM, Resident #2 urinalysis results reviewed by Provider, facility received order for Rocephin (antibiotic) 1 gram, with instructions to give intramuscularly daily for 5 days.</p> <p>-On 4/20/25 at 10:26 AM, Note revealed Resident #2 had episodes of unresponsiveness, jerking at times, and choking on breakfast. Oxygen saturation noted to be low at 60% (normal 90-100%) on room air. Family notified and decided to transfer Resident #2 to the hospital.</p> <p>-On 4/20/25 at 2:10 PM, Note revealed that the hospital called to notify facility Resident #2 had passed away.</p> <p>Review of Facimile (fax) sent to Provider on 3/19/25, revealed notification that Resident #2 presented with bradycardia, having a weak apical pulse at 46 beats per minute. Fax informed that medications had been held for low pulse. Fax informed that Resident #2's skin was intact without diaphoresis or pallor, no complaints of dizziness, chest/jaw/shoulder pain, and no fainting episodes. Provider responded they would see Resident #2 today, fax signed by Provider without date. Resident #2's Electronic Health Records (EHR) lacked additional fax communication to Provider related to low heart rates.</p> <p>A Provider Note, dated 3/24/25, revealed Resident #2 continued taking Losartan for hypertension. Review of Resident #2 cardiovascular system revealed normal heart sounds and a pulse of 50 beats per minute. Provider Note revealed chronic conditions were stable and instructed staff to administer medications as ordered and collect laboratory tests as ordered.</p> <p>A Transfer Assessment, dated 4/20/25, revealed Resident #2 had unplanned transfer to the hospital due to respiratory arrest. Vital signs recorded at time of transfer included blood pressure reading 153/98, heart rate 60 bpm, oxygen saturation at 90%.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/25 at 11:32 AM, Staff C Licensed Practical Nurse (LPN), confirmed working on 4/20/25 with Resident #2 and stated that it appeared Resident #2 was having some choking, vital signs were obtained and noted his oxygen saturation had been low. Staff C revealed that supplemental oxygen was placed on Resident #2, then physician and family were called. Staff C reported that family arrived to the facility shortly after call, and decided to send Resident #2 to the hospital. Staff C stated Resident #2 ' s pulse was always low and that this has been brought up to the physician. Staff C revealed communication with physician included calls, text messages, or faxes and stated that vital signs that were out of normal range would require a call to physician.</p> <p>On 4/24/25 at 1:20 PM, Staff E, Certified Medication Assistant (CMA) reported working at the facility for approximately 2 years. Staff E confirmed administering morning medications to Resident #2 on various dates throughout the month of April 2025. Staff E revealed Resident #2 required blood pressure and heart rate check every morning and reported that an electronic blood pressure machine was used to obtain results. Staff E denied noting any heart rate or blood pressure result concerns. Staff E was unable to recall if Resident #2 had any medication parameters related to blood pressure or heart rate readings. Staff E stated she would call the nurse if any resident vital signs were abnormal, and would notify nurse if Resident #2 ' s heart rate was less than 60 or greater than 100 beats per minute.</p> <p>On 4/24/25 at 3:30 PM, Director of Nursing (DON), revealed Resident #2 had been seen by a Provider on 4/18/25 with instructions to start Rocephin antibiotic for 5 days and if condition did not improve, to send to the hospital. DON revealed the expectation of nursing staff to notify medication aide staff of vital signs outside of normal limits when medications required hold parameters. The DON revealed Unit Manager staff were expected to review and follow up with alerts that the Electronic Health Record (EHR) system provided when vital signs were recorded as outside of normal range, then recheck abnormal vital signs for accuracy, and notify the physician if vital signs remain off. DON revealed the expectation of nursing staff to notify physician for heart rates below 60 and above 100 beats per minute.</p> <p>The facility policy titled, Care and Treatment: Change of Condition Reporting, dated 7/2017, revealed the expectation for all resident changes such as: life threatening changes, acute medical changes, or routine medical changes, be reported to physician prior to the end of assigned shift and all nursing actions, physician contacts, and resident assessment information would be documented in the Nursing Progress Notes.</p>		