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	09/03/2025

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** Based on clinical record review, observation, staff interview, and policy review the facility failed to ensure a resident's buttocks was appropriately covered in order to maintain the resident's dignity for one of sixteen residents sampled (Residents #15). The facility reported a census of 70 residents.Findings include:The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had diagnoses of severe intellectual disability and schizoaffective disorder. The MDS recorded the resident had a Brief Interview for Mental Status Score of 9, indicating moderately impaired cognition. The MDS indicated the resident required partial to moderate assistance for lower body dressing. The Care Plan revised 5/22/25 revealed the resident required assistance with Activities of Daily Living (ADL's). The Care Plan directed staff to provide assistance of one for dressing. During observation on 8/25/25 at 12:04 PM, Resident #15 sat in a chair by a table in the upper dining room with her buttocks fully exposed. At the time, nine other residents were in the same dining room. One male resident sat at a table facing Resident #15's backside. At 12:08 PM, four staff were lined up by the kitchen waiting for food to be plated and in order to deliver plates of food to the residents in the upper dining room. Staff walked back and forth between the kitchen and the upper level dining hall, and walked past Resident #15. At 12:12 PM, Staff B, Certified Medication Aide, placed a blanket between Resident 15's back and the chair to cover the resident's exposed buttocks. In an interview 9/2/25 at 4:05 PM, the Administrator reported sometimes a resident would expose their body but he expected the staff to ensure the resident's backside was appropriately covered. A Dignity and Privacy policy revised 10/2024 revealed all residents treated with dignity and privacy. Residents will be appropriately dressed in a manner that maintains the privacy of their body.

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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F 0684 Level of Harm - Minimal harm or potential for 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** Based on observation, clinical record review, staff interview, and policy review the facility failed to administer treatments and perform dressing changes as ordered by the physician for one of four residents reviewed (Resident #11). The facility reported a census of 70 residents.Findings include: The Significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 had a Stage 3 pressure ulcer on the left ankle, one Stage 1 pressure ulcer and one unstageable pressure ulcer. The MDS recorded the resident required application of nonsurgical dressings and medications for skin treatments. The Care Plan revised 5/23/25 revealed the resident had impaired skin integrity related to wounds on her left inner ankle and coccyx, and also had a history of infections. The care plan directed staff to administer treatments as ordered. The Care Plan lacked information about a wound to the right foot. The Order Summary Report dated 8/27/25 revealed an order to cleanse the right lateral foot wound with cleanser of choice, apply calcium alginate to the wound bed, cover the wound with a silicone absorbent dressing daily and as needed for wound care with order date of 8/21/25.The Treatment Administration Record dated 8/1/25 to 8/31/25 revealed a wound treatment and dressing change to the right lateral foot documented on the day and the night shift 8/24/25 to 8/26/25.During observation on 8/27/25 at 10:10 AM, Staff D, Licensed Practical Nurse (LPN) and Staff E, Wound Nurse Practitioner, were in the room with Resident #11. Staff D removed the foam boots on the resident's feet while the resident was lying in bed. A dressing was observed to the right lateral foot dated 8/24/25. Staff D removed the dressing over the right lateral foot. Staff E took a scalpel and debrided the wounds to the right lateral foot and left inner ankle. Staff D cleansed the wound areas and applied calcium alginate and a silicone foam dressing. Staff D then placed a piece of tape labeled 8/27 and her initials. In an interview 8/28/25 at 10:15 AM, the Director of Nursing (DON) reported he expected staff date and initial the dressing whenever a resident's dressing had been changed. The DON explained if a treatment or dressing change was ordered more than once a day, the dressing should be labeled with the date and the staff's initials. The DON reported he would be able to tell who completed the dressing change and when the dressing was changed by checking the date and the staff's initials on the dressing. A Physician's Order policy reviewed 8/2024 revealed the facility accurately implemented orders in addition to treatment orders in accordance with the resident's plan of care.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on confidential resident interviews, family interviews, staff interviews, clinical record review, and facility policy review, the facility failed to provide appropriate staffing to meet residents needs. The facility reported a census of 70. Findings include: During a confidential resident interview on 8/25/25 at 11:30 AM, the resident reported he had noticed staff were not getting residents who sat at the assist table up for supper. During the supper meal, only one or two residents were at the assist table, but during the breakfast and lunch meals there were more residents seated at the assist table. The resident reported staff came into the room and shut the call light off, and staff got mad at the resident if he pressed the call light again. The resident reported there had been times when there were only one CNA working upstairs and one CNA working downstairs, which isn't enough to care for all of the residents at the facility. According the the MDS, the resident had a documented BIMS of 15, indicating intact cognition. In an interview 8/25/25 at 8:08 AM, Staff F, LPN, reported the facility only staffed with two CNA's and one nurse downstairs and two CNA's and one nurse upstairs about 50 % of the time. During a confidential interview 8/25/25 at 3:15 PM, a family member expressed concern it took 40-47 minutes for staff to respond to call lights. Staff came in the room, shut the call light off and say they will be back, which took even longer for the resident to get assistance. Staff also brought the resident's food tray in but it took staff 45 minutes to return and feed the resident. In a confidential family interview on 8/27/25 at 11:10 AM, a family member reported the facility was short-handed. The family member expressed concern about the resident not getting changed properly during the night due to the staffing ratio. There were not enough staff to feed the residents that needed assistance with eating. The family member expressed he had concerns about staff coming into the room and shutting the call light off before the resident's needs were addressed. The family member reported residents and family members had expressed concerns about reporting their concerns about call lights and staffing due to they feared retaliation. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A confidential resident interview on 08/27/2025 at 09:31 AM with a Resident they stated the facility just does not have enough staff. They stated call lights have been taking a long time, but they was worried about speaking out further for fear of getting in trouble. A review of the Residents Minimum Data Set (MDS) documented they had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A confidential resident interview on 08/27/2025 at 02:02 PM with a Resident they stated the facility is under staffed. They stated they mostly notice it at night. They stated they have missed wound dressing changes as a result of the low staffing, and are often left in their wheelchair well past their desired 9pm bed time. They stated they have been left up in their wheelchair due to staffing until at least 11pm, with a few occasions having gone even later. They stated they have openly communicated with the facility about this, but worry about reprisal should they continue to self-advocate. A review of the Residents Minimum Data Set (MDS) documented they had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. A confidential resident interview on 08/28/2025 at 01:59 PM with a Resident they said the facility has staffing concerns. They stated call lights, often during the evening shift, can take longer than 25 minutes to get assistance. There are times their call light is answered but their issue is not addressed, their call light is turned off, and they have to press their light again. A review of the Residents MDS documented they had a BIMS score of 15, indicating intact cognition. An interview on 09/02/2025 at 10:27 AM with Staff G, Certified Nurse Aide (CNA), she stated there are only some days she feels they have enough CNAs. She stated she knows the facility has been working on it, but it is still difficult and has led to not everything getting done. An interview on 09/02/2025 at 10:27 AM with Staff H, Licensed Practical Nurse (LPN), he stated that while staffing has gotten better, they can still improve. An interview on 09/02/2025 at 10:32 Am with Staff A, CNA, she stated the facility still struggles with staffing. At least once a week they are so short staffed that it is difficult to get everything done. A review of time card data from 07/28/2025, 08/04/2025, and 08/22/2025 failed to document the required number of CNAs on several shifts. It also documented the Director of Nursing (DON) worked the floor from 10pm-6am on 07/28/2025. Review of Resident Council Notes dated 8/22/25 documented facility call light times were still out of parameters (greater than 15 minutes) and that beds were still not getting made. Review of the Facility Assessment from 2025, it documented there are to be at least 5 CNAs on day and evening shifts, and 4 or more on the overnight shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, staff interview, and facility policy review, the facility failed to provide appropriate infection control practices in the form of enhanced barrier precautions when required for 3 of 5 individual reviewed (Resident's #9, #11, #14). The facility reported a census of 70. Findings include: 1. The Quarterly Minimum Data Set (MDS) for Resident #14, dated 07/17/2025, documented the residents Brief Interview for Mental Status (BIMS) score as 15, indicating intact cognition. It documented the following relevant diagnoses: Septicemia (Blood infection), Hip fracture, Cerebrovascular Accident (Stroke), Paraplegia (Paralysis of the legs), Traumatic Brain Injury, Need for Assistance with personal Cares, Pressure ulcer of the right ankle. The MDS documented that the resident was dependent on staff for toileting hygiene, personal hygiene, lower body dressing, and putting on/taking off footwear.The Care Plan for Resident #14, last revised 08/14/2025, documented the resident's need for assistance with personal cares due to his paraplegia, as well as warned staff that he had alterations to the right lateral lower leg's skin due to trauma. The Care Plan instructed staff to follow Enhanced Barrier Precautions (EBP). During a direct observation on 08/28/2025 at 09:26 AM with Staff I, Licensed Practical Nurse (LPN), and Staff J, Certified Nurse Aide (CNA) where they were performing wound care for Resident #14's ankle pressure wound. During the observation, Staff I, LPN, donned gloves and a disposable gown, but Staff J, CNA, did not wear a gown while assisting with cares and directly handling the resident. Also during the observation, Staff I touched the incontinence pad and the residents skin and buttocks with gloved hands, then used the same gloves to cleanse the wound bed. In an interview on 09/02/2025 at 10:27 AM with Staff G, CNA, she stated staff members are required to wear Personal Protective Equipment (PPE) when they are handling a resident that has a qualifying condition such as open wound or catheters. She stated she has to wear PPE even when she is not directly providing those cares. In an interview on 09/02/2025 at 10:32 AM with Staff A, CNA, she stated PPE has to be worn by all members of the care team when caring for a resident who requires enhanced barrier precautions. She noted PPE consists of a gown and gloves in this case. She stated the PPE should be donned as soon as they enter the room. In an interview on 09/02/2025 at 10:44 AM with Staff K, CNA, she stated everyone in the room who is touching or might touch a resident who requires enhanced barrier precautions requires PPE. In an interview on 09/02/2025 at 10:20 AM with Staff H, LPN, he stated that all people assisting with cares on a resident who requires enhanced barrier precautions should be wearing PPE as you do not know when you will be required to touch a resident. In an interview on 09/02/2025 at 12:20 PM with the Director of Nursing (DON), he stated that all parts of the care team are expected to wear PPE when required by enhanced barrier precautions standards, which include open wounds and catheters. He stated you should never clean a wound bed after touching potentially contaminated surfaces such as an incontinence pad or a residents skin. 2. The Significant Change in Status MDS assessment dated [DATE] revealed Resident #11 had a Stage 3 pressure ulcer on the left ankle, one Stage 1 pressure ulcer and one unstageable pressure ulcer. The MDS recorded the resident had application of nonsurgical dressings and medications for skin treatments. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan revised 5/23/25 revealed the resident had impaired skin integrity related to wounds on her left inner ankle and coccyx, and had a history of infections. The Care Plan directed staff to administer treatments as ordered. The Care Plan directed staff to use a gown and gloves for Enhanced Barrier Precautions (EBP) during high resident contact care activities due to wounds. The Order Summary Report dated 8/27/25 revealed an order to cleanse the right lateral foot wound with cleanser of choice, apply calcium alginate to the wound bed, cover the wound with a silicone super absorbent dressing daily and as needed for wound care. During observation on 8/27/25 at 10:10 AM, Staff D, LPN, and Staff E, Nurse Practitioner, were in the room with Resident #11. Resident lying in bed. Staff D removed the foam boots on the resident's feet. A dressing was observed to the right lateral foot dated 8/24/25. Staff D removed the dressing over the right lateral foot. Staff E took a scapel and debrided the wounds to the right lateral food and left inner ankle. Staff D cleansed the wound areas and applied calcium alginate and a silicone foam dressing. Staff D placed a piece of table labeled 8/27 and initials KW. Staff did not wear a gown while performing treatment or the dressing change on the resident's wound. 3. The Quarterly MDS assessment dated [DATE] revealed Resident #9 had diagnoses of quadriplegia. The MDS recorded the resident had no skin conditions such as a pressure ulcer present. The Care Plan revised 1/10/25 revealed the resident had impaired skin integrity. The Care Plan directed staff to provide treatments per the physician's orders and use enhanced barrier precautions. The Order Summary Report dated 8/2025 revealed an order for EBP's with start date of 5/14/25. EBP's indicated due to wound and indwelling medical device. Use of a gown and gloves required for high contact care activities. During observation on 8/27/25 at 11:35 AM, Staff D obtained supplies from a treatment cart, then took the supplies to Resident #9's room. Staff D sanitized her hands and donned a pair of gloves. Staff D took a gauze soaked in Vashe wound cleanser and cleansed the resident's left and right heels. Staff D applied betadine, an ABD (large) dressing, and kerlix to each wound. Staff D did not wear a gown during the procedure, and did not change gloves or sanitize hands when going from a dirty to clean task. In an interview 8/28/25 at 11:30 AM, Staff A, Certified Nursing Assistant (CNA) reported EBP used whenever wound care or catheter care performed, or if a resident had an infection. EBP entailed wearing a gown and gloves during high contact activities. In an interview 8/28/25 at 10:15 AM, the Director of Nursing (DON) reported he expected EBP implemented anytime staff took care of a resident who had a catheter or a wound. Staff should wear PPE gown and gloves for EBP. The DON reported he also expected gloves changed whenever staff removed a dressing and anytime going between steps or a clean area. Staff should change gloves and sanitize their hands, then put a clean dressing on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Infection Control Standard and Transmission-Based Precautions policy reviewed 8/2024 revealed infection control measures implemented to prevent the spread of diseases and conditions. Section 3 revealed EBP's used in conjunction with standard precautions and expanded the use of gown and gloves during high-contact resident care activities (for example when cared for residents with wounds and indwelling medical devices due to the high risk of acquisition and colonization of Mulit-Drug Resistant Organisms (MDRO's). Personal Protective Equipment (PPE) donned upon room entry, then doffed and properly discarded, and hand hygiene performed before exiting the room to contain pathogens.