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	10/27/2025

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 0600 Level of Harm - 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** Based on record review, policy review and staff interviews, the facility failed ensure residents were free from abuse for 2 of 3 residents reviewed (Residents #1 and #3). The facility reported a census of 71 residents. Findings include: 1. The 5-Day Assessment Minimum Data Set (MDS) dated [DATE] for Resident#1 (R#1) revealed a Brief Interview for Mental Status (BIMS) assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident did not speak, did not have behavioral symptoms and had diagnoses including quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk, and pelvis) and profound intellectual disabilities. The Care Plan initiated 8/28/25 for Resident #1 revealed the resident had an activities of daily living (ADL) deficit and required 2 staff with transfers via a mechanical lift. 2. The Quarterly MDS dated [DATE] for R#2 revealed a BIMS assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident had mumbled speech, had the ability to express ideas, usually understood others, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed toward others 1 to 3 days during the 7 day look back period. The resident had diagnoses including autistic disorder and profound intellectual disabilities. The Care Plan for R#2 revised 1/17/25 had an ADL self care performance deficit and revealed the resident was able to crawl in and out of his room independently. The Care Plan lacked interventions for sexual behavior prior to 10/19/25. During an interview on 10/21/25 at 10:09 AM Staff H, Certified Nurse Aide (CNA) revealed she was the one who witnessed the incident on 10/14/25 with R#1 and R#2. Reported around supper time she went to get R#1 for supper and found R#2 leaning into R#1's bed which had been in the low position masturbating and rubbing his hand on R#1's face. Staff H reported she observed R#1 who can't speak or move his body trying to cry and move his head away from R#2's hand. Staff H reported R#1's face was wet at the time she intervened. Staff H reported she immediately separated the two residents and reported the incident to Staff I, Licensed Practical Nurse (LPN). Staff H reported she had documented the incident between R#1 and R#2 on a piece of paper, signed and dated it and had Staff I sign and date it as well as she felt the incident was sexual exploitation and that R#1 could not defend himself and she needed to be his voice. Staff H stated when she went to remove R#1 from the situation, R#2 continued to masturbate and laugh. (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
	165175	A. Building B. Wing	10/27/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/21/25 at 1:35 PM, the Administrator revealed she had received a call from Staff I, LPN on 10/14/25 in regards to the incident between R#1 and R#2 and did not feel based on the information she received from Staff I that the incident rose to the level to report it to the Department of Inspections, Appeals and Licensing (DIAL). The Administrator reported she asked Staff I to document the information and she would discuss the incident in the morning meeting the next day. The Administrator stated she felt R#2 did not know what he was doing when he had been touching R#1 while masturbating. The Administrator revealed on the night she received the call from Staff I in regard to the incident, when R#2 started having sexual behaviors staff moved him out of the common area, his behaviors were not intentional, R#1 slept through the incident, he didn't have the ability to speak and R#1 was moved to a different room. The Administrator reported she told Staff I to document the incident, and notify the physician if R#2 was not able to be redirected. The Administrator revealed the next day staff had to again redirect R#2 due to his behavior. Stated Staff J, Nurse Practitioner (NP) was notified, and per R#2's Care Plan he had cycled with sexual behavior and he hadn't exhibited the behaviors in a while. Stated she had physician review R#2's medications and had her review the medications with a psychiatrist. Reported R#2's Care Plan was updated, he was redirected, it was not intentional and R#1 remained sleeping and the resident did not have signs or symptoms of distress following the incident. The Administrator confirmed an incident report and facility investigation had not been completed and DIAL had not been notified of the incident. During an interview on 10/22/25 at 10:08 AM, Staff I, LPN reported R#2 was pretty agitated and masturbating to stimulate himself in the common area on 10/14/25 when staff had gently covered him with a blanket and redirected him. Around 5:00 PM, Staff H, CNA reported to Staff I that she observed R#2 next to R#1's bed and petting R#1's face while masturbating and R#1 was screaming when it happened. Stated R#1 is non-verbal and they decided the two residents should no longer share a room so the CNAs and the oncoming nurse made the decision to move R#1 to a different room. Staff I reported she called the Administrator around 5:30 PM and the Administrator was supportive of keeping R#1 and R#2 separated. Stated she explained the incident to the Administrator like it had been explained to her that R#2 was petting R#1's face while masturbating. Staff I reported she would be upset if that had happened to one of her family members. Staff I reported R#1 is completely dependent on staff. Stated she felt like R#2 had been escalating with the sexual behaviors earlier in the day and she had called the physician to get a one time order for Ativan (sedative) and felt like they were winging it in regard to caring for R#2 and his behaviors. Stated Staff H, CNA documented a statement about the incident and Staff I, LPN signed it verifying what had been told to her in regard to what R#2 had been doing to R#1. During an interview on 10/22/25 at 6:45 PM, Staff D, LPN revealed on 10/14/25 at 6:00 PM she came into work and was getting report from Staff I, LPN when Staff H, CNA reported the concern about the interaction between R#1 and R#2. Staff L reported she directed the CNAs to move R#1 to a different room after R#2 had been found masturbating while touching R#1's face. Staff L reported she instructed one of the CNAs to do a 1:1 with R#2 as he hadn't been very redirectable. (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	10/27/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility policy titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised 8/2024 revealed 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. Residents must not be subjected to abuse by anyone, including but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, resident representatives, families, friends or other individuals. If there is an allegation or suspicion of abuse, the facility will make a report to the appropriate agencies as designated by State and Federal Law. 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: a. Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. b. Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. The Administrator of the Facility. b. The State Survey Agency. c. Adult Protective Services (as appropriate). 3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that the results of all investigations are reported within five (5) working days of the incident to: The Administrator and The State Survey Agency. Ensure that, if the alleged violation is verified, appropriate corrective action is taken. To assist the facility's staff members in recognizing incidents of abuse, the following definitions are provided: (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	10/27/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	a. Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. b. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. c. Mental Abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. d. Neglect is the failure of the Facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. e. Sexual abuse is non-consensual sexual contact of any type with a resident. Required to report per policy included: A resident who fondles or touches a person's sexual organs and the resident being touched indicates the touching is unwanted through verbal or non-verbal cues. Sexual activities where one resident indicates that the activity is unwanted through verbal or non-verbal cues. Sexual activity or fondling where one of the resident's capacity to consent to sexual activity is unknown. Sexual assault or battery (examples include rape, sodomy, coerced nudity). Forced observation of masturbation, or pornography. Forced, coerced or extorted sexual activity. Other unwanted actions for the purpose of sexual arousal or sexual gratification resulting in degradation or humiliation of another resident. 3. The Minimum Data Set (MDS) for R#3 dated 10/9/25 reflected admission to the facility from the hospital coded as an entry tracking record and documented basic demographics. (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	10/27/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	The Clinical Assessment List for R#3 documented a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed resident scored 13 out of 15 indicated is cognitively intact. The Electronic file lacked care plan documentation. A facility document titled, Self Report, 5 day summary relayed on 10/13/25 the Administrator received a phone call from R#3 who alleged abuse by Licensed Practical Nurse (LPN) Staff A. Staff A allegedly withheld medication and used profanities towards R#3. Findings noted, after the investigation was determined R#3 experienced poor services. Corrective action included all staff educated on reporting abuse. A statement (not dated) from Staff B, Certified Medication Aide (CMA) documented the following: On 10/10/25 Staff B heard LPN Staff A and R#3 yelling. R#3 said you do not control my medications. Staff A responded she followed the doctors orders so yes does control medications. Staff B reported she heard LPN Staff A verbalize as left the room, the way R#3 is acting, is not getting his fucking oxy, referred to oxycodone pain medication. A statement from CMA, Staff C dated 10/15/25 documented on 10/10/25 relayed Staff C asked by a Therapist, Staff L if R#3 could have pain medication. Replied yes and would be there when the current task finished. Staff L came back and informed R#3 is very upset. CMA, Staff C summoned the LPN, Staff A who entered R#3 room while CMA waited outside. Staff C relayed much yelling back and forth included LPN Staff A said, do not give him shit. CMA, Staff C reported much cussing back and forth, walked away as was instructed to do by Staff A . During an interview on 10/20/25 at 3:40 PM R#3 relayed while at the facility received only one time in the middle of the night pain medication and had a lot of pain, reported on 10/10/25 asked for the Administrator and Staff A responded, what do you want, I am all you got, was screaming back and forth. Staff F said don't give this mother f***r anything and left During an interview with LPN, Staff A on 10/21/25 at 1:50 PM relayed CMA ,Staff C asked for assistance on 10/10/21 sometime after 4:00 PM because CMA, Staff C was afraid of R3# due to his anger. R#3 complained is not getting pain medications. Relayed met with R#3 in his room, voices were raised, tired of R#3 repeated profanities, so just walked out. During an interview on 10/21/25 at 6:11 PM LPN Staff D relayed on 10/9/25 R#3 asked for pain medication, Staff D responded medications had not arrived from the pharmacy. Staff D reported left in the morning of 10/10/25 when the shift ended, still had not received the orders from the hospital. During an interview with the Administrator on 10/27/25 at 2:30 PM was relayed would have expected staff to inform her directly right away of verbal altercation and resident allegations of abuse that transpired on 10/10/25.

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	10/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review and staff interviews, the facility failed to report allegations of abuse to the Department of Inspections, Appeals and Licensing (DIAL) in a timely manner for 2 of 3 residents reviewed for abuse (Residents #1 and #3). The facility reported a census of 71 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for R#1 revealed a Brief Interview for Mental Status (BIMS) assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident did not speak, did not have behavioral symptoms and had diagnoses including quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk, and pelvis) and profound intellectual disabilities. The Care Plan initiated 8/28/25 for R#1 revealed the resident had an activities of daily living (ADL) deficit and required 2 staff with transfers via a mechanical lift. 2. The MDS dated [DATE] for R#2 revealed a BIMS assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident had mumbled speech, had the ability to express ideas, usually understood others, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed toward others 1 to 3 days during the 7 day look back period. The resident had diagnoses including autistic disorder and profound intellectual disabilities. The Care Plan for R#2 revised 1/17/25 had an ADL self care performance deficit and revealed the resident was able to crawl in and out of his room independently. During an interview on 10/21/25 at 10:09 AM Staff H, Certified Nurse Aide (CNA) revealed she witnessed the incident on 10/14/25 between R#1 and R#2. Reported around supper time she went to get R#1 for supper and found R#2 leaning into R#1's bed which had been in the low position masturbating and rubbing his hand on R#1's face. Staff H reported she observed R#1 who can't speak or move his body, trying to cry and move his head away from R#2's hand. Staff H reported R#1's face was wet at the time she intervened. Staff H reported she immediately separated the two residents and reported the incident to Staff I, Licensed Practical Nurse (LPN). Staff H reported she had written out the 10/14/25 incident between R#1 and R#2, signed and dated it and had Staff I sign and date it as well as she felt the incident was sexual exploitation. Staff H reported R#1 could not defend himself and she needed to be his voice and when she went to remove R#1 from the situation, R#2 continued to masturbate and laugh. During an interview on 10/21/25 at 1:35 PM, the Administrator revealed she had received a call from Staff I, LPN on 10/14/25 in regard to the incident between R#1 and R#2 and did not feel based on the information she received from Staff I that it rose to the level to report it to the DIAL. The Administrator reported she asked Staff I to document the information and she would discuss the incident in the morning meeting the next day. The Administrator stated she felt R#2 did not know what he was doing when he touched R#1 while masturbating. Stated the night she received the call from Staff I, R#1 was moved to a different room and when R#2 started to have sexual behaviors, staff moved him out of the common area, his behaviors were not intentional and R#1 was sleeping during the incident and wasn't able to speak. The Administrator confirmed the incident had not been reported to DIAL. (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	10/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/25 at 10:08 AM, Staff I, LPN reported R#2 was pretty agitated and masturbating to stimulate himself in the common area on 10/14/25 when they had gently covered him with a blanket and redirected him. Around 5:00 PM, Staff H, CNA reported to her that she observed R#2 next to R#1's bed and petting his face while masturbating and R#1 was screaming when it happened. Stated R#1 is non-verbal and they decided the two residents should no longer share a room so the CNAs and the oncoming nurse made the decision to move R#1 to a different room. Staff I reported she called the Administrator around 5:30 PM and the Administrator was supportive of keeping R#1 and R#2 separated. Stated she explained the incident to the Administrator like it had been explained to her that R#2 was petting R#1's face while masturbating. Staff I reported she would be upset if that had happened to one of her family members. Staff I reported R#1 is completely dependent on staff. Stated she felt like R#2 had been escalating with the sexual behaviors earlier in the day and she had called the physician to get a one time order for Ativan (sedative) and felt like they were winging it in regard to caring for R#2 and his behaviors. Stated Staff H, CNA wrote out a statement about the incident and Staff I, LPN signed it verifying what had been told to her in regard to the incident. During an interview on 10/22/25 at 6:45 PM, Staff L, LPN revealed on 10/14/25 at 6:00 PM she came into work and was getting report from Staff I, LPN when the Staff H, CNA reported the concern about the interaction between R#1 and R#2. Staff L reported she directed the CNAs to move R#1 to a different room after R#2 had been found masturbating while touching R#1's face. Staff L reported she instructed one of the CNAs to do a 1:1 with R#2 as he hadn't been very redirectable. Review of facility policy titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised 8/2024 revealed 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. 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: a. Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. b. Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. The Administrator of the Facility. b. The State Survey Agency. c. Adult Protective Services (as appropriate). (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	10/27/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that the results of all investigations are reported within five (5) working days of the incident to the Administrator and the State Survey Agency. During an interview on 10/23/25 at 1:45 PM, the Director of Nursing revealed any allegations of abuse needed to be reported to DIAL. 3. The Minimum Data Set (MDS) dated [DATE] reflected admission to the facility, from the hospital and documented basic demographics for R#3 coded as an entry tracking record. The Clinical Assessment List for R#3 documented a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed resident scored 13 out of 15 indicated is cognitively intact. The Electronic file lacked care plan documentation. A facility document, Self Report, 5 day summary relayed on 10/13/25 the Administrator received a phone call from R#3 alleging abuse by Licensed Practical Nurse (LPN) Staff A, alleged Staff A withheld medication and used profanities towards him. Findings noted, after the investigation was determined R#3 experienced poor services. Corrective action included all staff educated on reporting abuse. A statement (not dated) from Certified Medication Aide (CMA) Staff B documented on 10/10/25 heard LPN Staff A and R#3 yelling. R#3 said you do not control my medications. Staff A responded, followed the doctors orders so yes does control medications. Staff B heard Staff A verbalize as left the room, the way R#3 is acting, is not getting his fucking oxy , referred to oxycodone pain medication. A statement from CMA, Staff C dated 10/15/25 documented on 10/10/25 relayed Staff C asked by a therapy staff if R#3 could have pain medication. Replied yes and would be there when the current task finished. Therapy staff came back and informed R#3 is upset. CMA Staff C summoned the LPN, Staff A who entered R#3 room while CMA waited outside. Staff C relayed much yelling back and forth included LPN Staff A commented, do not give him shit. CMA Staff C reported much cussing back and forth so walked away. An interview with LPN, Staff A on 10/21/25 at 1:50 PM relayed CMA Staff C summoned her on 10/10/21 sometime after 4:00 PM to assist because Staff A was afraid of R3# who was angry, complaining is not getting pain medications. Relayed met with R#3 in his room yelled profanities in turn Staff A relayed did raise voice, tired of R#3 repeated profanities, so I just walked out. An interview with the Administrator on 10/27/25 at 2:30 PM Administrator relayed would have expected staff to inform her directly right away of verbal altercation and resident allegations on 10/10/25, instead heard from R#3 on 10/13/25. The Administrator relayed understood the obligation to report timely allegations of abuse.

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	10/27/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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	10/27/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interviews, the facility failed to complete a thorough investigation in regard to an allegation of sexual abuse in a timely manner for 1 of 3 residents reviewed for abuse (Residents #1). The facility reported a census of 71 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #1 revealed a Brief Interview for Mental Status (BIMS) assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident did not speak, did not have behavioral symptoms and had diagnoses including quadriplegia (weakness or paralysis leading to partial or total loss of function in the arms, legs, trunk, and pelvis) and profound intellectual disabilities. The Care Plan initiated 8/28/25 for Resident #1 revealed the resident had an activities of daily living (ADL) deficit and required 2 staff with transfers via a mechanical lift. 2. The MDS dated [DATE] for Resident #2 revealed a BIMS assessment was not conducted as the resident was rarely/never understood. The MDS further revealed the resident had mumbled speech, had the ability to express ideas, usually understood others, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed toward others 1 to 3 days during the 7 day look back period. The resident had diagnoses including autistic disorder and profound intellectual disabilities. The Care Plan for Resident #2 revised 1/17/25 had an ADL self care performance deficit and revealed the resident was able to crawl in and out of his room independently. During an interview on 10/21/25 at 10:09 AM Staff H, Certified Nurse Aide (CNA) revealed she witnessed the incident on 10/14/25 with Resident #1 and Resident #2. Reported when she went to get Resident #1 for supper and found Resident #2 leaning into Resident #1's bed which had been in the low position in the room they shared masturbating and rubbing his hand on Resident #1's face. Staff H reported she observed Resident #1 who can't speak or move his body trying to cry out and move his head away from Resident #2's hand. Staff H reported Resident #1's face was wet at the time she intervened. Staff H reported she immediately separated the two residents and reported the incident to Staff I, Licensed Practical Nurse (LPN). Staff H reported she had documented the incident between Resident #1 and Resident #2 that occurred on 10/14/25 on a piece of paper, signed and dated it and had Staff I sign and date it as well. Staff I reported she felt the incident was sexual exploitation towards Resident #1 who could not defend himself and she needed to be his voice. Staff H stated when she went to remove Resident #1 from the situation, Resident #2 continued to masturbate and laugh. During an interview on 10/22/25 at 10:08 AM, Staff I, LPN reported Resident #2 was pretty agitated and masturbating to stimulate himself in the common area on 10/14/25 when they had gently covered him with a blanket and redirected him. Around 5:00 PM, Staff H, CNA reported to her that she observed Resident #2 next to Resident #1's bed and petting his face while masturbating and Resident #1 was screaming when it happened. Stated Resident #1 is non-verbal and they decided the two residents should no longer share a room so the CNAs and the oncoming nurse made the decision to move Resident #1 to a different room. Staff I reported she called the Administrator around 5:30 PM and the Administrator was supportive of keeping Resident #1 and Resident #2 separated. Stated she explained the incident to the Administrator like it had been explained to her that Resident #2 was petting Resident #1's face while masturbating. Staff I reported she would be upset if that had happened to one of her family members. Staff I reported Resident #1 is completely dependent on staff. Stated she felt like Resident #2 had been escalating with the sexual behaviors earlier in the day and she had called the physician to get a one time order for Ativan (sedative) and felt like they were winging it in regard to caring for Resident #2 and his behaviors. Staff I revealed Staff H, CNA had written out a statement and Staff I stated she signed and dated it verifying what had been told to her by Staff H in regard to the incident. During an interview on 10/21/25 at 1:35 PM, the Administrator confirmed a facility investigation had not been completed in regard to the 10/14/25 incident involving Resident #1 and Resident #2. Review of the clinical record for Resident #1 lacked documentation regarding the 10/14/25 incident with Resident #2 including care plan updates, completion of an incident report and completion of a resident assessment. Review of the clinical record for Resident #2 lacked documentation regarding the 10/14/25 incident with Resident #1 including care plan updates related to hypersexual behavior until 10/19/25, completion of an incident report and completion of a resident assessment. Review of facility policy titled, Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised 8/2024 revealed 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

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	10/27/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. (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	10/27/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, resident interview and policy, the facility failed to ensure full admission orders for Resident #3 (R#3). The facility lacked medication orders, R#3 did not receive pertinent medication including insulin, cardiac, pain and psychotropic drugs. The facility reported a census of 71 residents. Findings included: The Minimum Data Set (MDS) for R#3 reflected admission to the facility on [DATE] from the hospital and documented basic demographics for R#3 coded as an entry tracking record. The Clinical Assessment List for R#3 documented a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed resident scored 13 out of 15 indicated is cognitively intact. An admission Record revealed R#3 admitted to the facility on [DATE], primary diagnosis of fracture of the right femur, acute kidney failure and chronic congestive heart failure. Additional diagnoses included leukemia in remission, diabetes, obesity, bipolar, anxiety disorder, high blood pressure, Chronic Obstructive Pulmonary disease (COPD refers to lung disease). An Electronically Mailed (email) statement from Licensed Practical Nurse (LPN) Staff A dated 10/14/25 at 4:02 PM documented on 10/10/25 sometime after 4:00 PM R#3 upset, swearing because did not receive pain medication earlier, said had been dealing with medication issues since arrived at the facility. Reported, R#3 used profanities said was getting the fuck out of here, called family who arrived, police arrived per R#3, requested to retrieve medications. LPN, Staff A relayed could not send medications, R#3 refused to reenter the facility and left with family. A Controlled Drug Receipt, Record, Disposition form documented thirty 5 milligram tabs of oxycodone was received on 10/9/25 directed to give 5-10 milligrams by mouth every four hours as needed for pain. It showed 10 milligrams were given at 4:45 AM on 10/10/25 and 10 milligrams was given at 10:46 AM on 10/10/25. No other medications documented as administered. The Medication/Treatment Administration Record entered by RN, Staff G on 10/10/25 included the following hospital discharge orders:a. Blood sugar check three times a day for diabetes.b. Insulin Glargine 50 units subcutaneously two times a day for diabetes.c. Aspirin 81 milligrams (mg) by mouth (PO) in the morning for heart disease.d. Cyclobenzaprine 10 mg PO three times a day for femur fracture .e. Lamictal 100 mg PO in the morning for bipolar disorder.f. Rosuvastatin Calcium 40 mg PO in the morning for high lipids (fat compound in blood).g. Sertraline 150 mg PO in the morning for bipolar disorder. h. Carvedilol 25 mg PO two times a day for chronic congestive heart failure.i. Pregabalin 50 mg PO two times a day for diabetes.j. Hydralazine 75 mg PO 3 times a day for heart failure.k. Trazodone 150 mg PO at bedtime related to bipolar disorder.l. Albuterol Sulfate, Inhalation, 2 puffs every 6 hours as needed for shortness of breath.m. Lorazepam 0.5 mg PO every 12 hours as needed for anxiety. n. Ondansetron 4 mg PO every 8 hours as needed for nausea.o. Oxycodone 5 mg oral every 4 hours as needed for pain related to femur fracture.p. Acetaminophen 1000 mg PO every 8 hours as needed for pain. During an interview on 10/20/25 at 3:40 PM R#3 relayed while at the facility received only one time in the middle of the night pain medication, did not receive any heart medication, no blood sugar checks, was repeatedly told by staff, you are not in the system and don't have any medications. R#3 relayed should have received insulin in the morning and at bed time and no staff checked his blood sugar or gave his usual medications while at the facility. R#3 relayed about 5:00 PM on Friday 10/10/25 demanded to see the Administrator or Social worker because had a lot of pain, acknowledged had a screaming match with the nurse and felt neglected. R#3 relayed called family and the police so could leave the facility. During an interview on 10/20/25 at 3:45 R#3's family confirmed R#3 left the facility because had not received necessary medications and had increased pain relating to the surgery. During an interview on 10/21/25 at 11:20 AM with LPN, Staff K relayed was working when R#3 arrived to the facility on [DATE]. Staff K was told when the job started, the floor nurses do not do the admission work, was not sure which of management staff was responsible for R#3 admission paperwork. Did not have a diet order but looked at a diagnosis list and decided to give a regular room tray. Staff K relayed shift ended at 7:30 PM and reported to next shift nurse, LPN Staff D of the new admission. During an interview on 10/21/25 at 6:11 PM LPN, Staff D stated the 10/9/25 shift began at 6:00 PM and was informed had a new admit. R#3 asked for pain medication about 6:00 PM, called the Director of Nursing for R#3 orders and was informed, Registered Nurse (RN) Staff G would be entering the orders into the system. Told R#3 the medications had not arrived from the pharmacy. Staff D relayed did have 4 medications that arrived earlier from the pharmacy included oxycodone for pain but did not have the physician orders. Called Staff G who instructed to give the medications that arrived from the pharmacy. Staff D relayed did not feel comfortable with no orders in the

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	10/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, resident interview and policy, the facility failed to provide appropriate pain medications for 2 of 3 residents reviewed for pain, Resident #3 (R#3) and Resident #4 (R#4).The facility reported a census of 71 residents. Findings included: 1. The Minimum Data Set (MDS) dated [DATE] reflected admission to the facility from the hospital and documented basic demographics for R#3 coded as an entry tracking record. The Clinical Assessment List for R#3 documented a Brief Interview for Mental Status (BIMS) assessment dated [DATE] revealed resident scored 13 out of 15 indicated is cognitively intact. The Electronic file lacked care plan documentation. A facility document titled, Self Report, 5 day summary relayed on 10/13/25 the Administrator received a phone call from R#3 alleging abuse by Licensed Practical Nurse (LPN) Staff A, alleged Staff A withheld medication and used profanities towards R#3. Findings noted, after the investigation was determined R#3 experienced poor services. Corrective action included all staff educated on reporting abuse. A statement from (CMA) Staff B undated documented on 10/10/25 heard LPN, Staff A and R#3 yelling. R#3 said you do not control my medications. Staff A responded, followed the doctors orders so yes does control medications. Staff B heard Staff A verbalize as left the room that R#3 is not getting his fucking oxy (referred to oxycodone pain medication). Staff B wrote R#3 family arrived just after and R#3 left the facility. A statement from CMA, Staff C dated 10/15/25 documented on 10/10/25 relayed Staff C asked by a Therapist, Staff L if R#3 could have pain medication. Replied yes and would be there when the current task finished. Staff L came back and informed R#3 is very upset. Staff C summoned the Staff A who entered R#3 room while Staff C waited outside. Staff C relayed much yelling back and forth included Staff A said, do not give him shit. Staff C reported much cussing back and forth, walked away as was instructed to do by Staff A. The Medication/Treatment Administration Record entered by RN, Staff G on 10/10/25 to direct pharmacy to send included the following orders for pain/anxiety: a. Cyclobenzaprine 10 mg PO three times a day for femur fracture. b. Pregabalin 50 mg PO two times a day for diabetes/neuropathy. c. Lorazepam 0.5 mg PO every 12 hours as needed for anxiety. d. Oxycodone 5 mg, 1-2 oral every 4 hours as needed for pain related to femur fracture. e. Acetaminophen 1000 mg PO every 8 hours as needed for pain. A Controlled Drug Receipt, Record, Disposition form documented thirty 5 milligram tabs of oxycodone was received on 10/9/25 directed to give 5-10 milligrams by mouth every four hours as needed for pain. (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	10/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.10 milligrams were given at 4:45 AM on 10/10/25 b. 10 milligrams was given at 10:46 AM on 10/10/25. No other medications documented as administered. During an interview on 10/20/25 at 3:40 PM R#3 stated while at the facility received only one time in the middle of the night pain medication and had a lot of pain. Stated on 10/10/25 asked for the Administrator and Staff A responded, what do you want, I am all you got, was screaming back and forth. Staff F said don't give this mother f***r anything and left. An interview on 10/21/25 at 11:04 AM with CMA Staff C reported gave R#3 a pain medication at 10:47 AM, R#3 scaled pain at an 8 or 9 out of 10 being most severe. R#3 asked again for pain medication about noon or 1:00 PM, and responded, to come back in two hours. Staff C relayed R#3 did not come back, thought perhaps resident left with family. Staff C relayed next time heard from R#3 was when the therapist reported R#3 was very angry about not getting pain medications, was demanding and yelled profanities at LPN, Staff A. An interview with LPN, Staff A on 10/21/25 at 1:50 PM relayed CMA Staff C was afraid of R3# and summoned her to go to R#3's room. Relayed R#3 screaming the F word. Staff A, stated, tried to explain orders were different from the hospital and were no longer scheduled and had to ask, voices were raised. Staff A relayed R#3 was offered three times to allow CMA to get the medication since it was now time. R#3 continued profanities and Staff A relayed got tired of it and walked out. Staff A reported R#3 went outside, told R#3 if would come back inside could get his pain medication, R#3 refused. Police arrived, Staff A told the police to inform R3# if came back in the building can get the medication, R#3 refused and left with family. An interview on 10/21/25 at 6:11 PM with LPN, Staff D relayed when arrived at about 6:00 PM on 10/9/25 and informed had a new admit, had no other information. R#3 asked for pain medication about 6:00 PM. Staff D responded the medications had not arrived from the pharmacy. Staff D relayed there was no information in the computer and was told RN, Staff G would be entering the orders into the system. About 11:00 PM called RN, Staff G who instructed to give the pain medication that arrived from the pharmacy. Staff D relayed did not have an order so was not comfortable doing that and instead called the on-call Nurse Practitioner (NP) Staff J and obtained an order for 10 milligrams of oxycodone. Confirmed the medication was not given to R#13 until 4:45 AM. Staff D relayed did contact the hospital and requested all orders to be faxed, left at end of shift and was not sure when the orders finally came, stated was not even sure the fax was working. During an interview on 10/23/25 at 9:25 AM the Corporate Registered Nurse (RN), Staff G relayed R#3 arrived at the facility between 3-4:00 PM on 10/9/35 and had agreed to enter the admission orders later and left the facility. Staff G received orders via e-mail from the Assistant Director of Nurses (ADON) Staff E, the orders did not include medication orders. Staff G confirmed Staff D called about 11:00 PM relayed R#3 lacked orders and R#3 requested medications for pain. Staff G instructed Staff D to give the oxycodone that arrived from the pharmacy and to get orders from the hospital. Staff G stated discovered the next morning when arrived to the facility that R#3 medication orders were not sent. Staff G agreed the delay in getting the admitting orders and medications caused R#3 unnecessary frustration. Confirmed R#3 did not receive medications that included pain, muscle relaxant and psychotropic medications. (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	10/27/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Pharmacist, Staff F on 10/27/25 at 9:56 AM confirmed received admission orders from the facility system on 10/10/25 for R#3 who admitted on [DATE]. Pharmacist, Staff F relayed would have expected a call from the facility if there were any concerns regarding medications. Staff F relayed the facility has an emergency kit of medications to use or could call the pharmacy 24 hour on call option. Staff F relayed a concern with the process was evident regarding R#3 admission. A Policy titled: Nursing Administration, Subject: Pain documented, The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by screening, assessing, identifying circumstances and by developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals. Staff directed to document, monitor, treat and consult with the physician to evaluate and revise as indicated. 2. The MDS dated [DATE] revealed R#4 had a BIMS of 14 indicating intact cognition. The MDS further revealed the resident had diagnoses including acute osteomyelitis (inflammation of bone) in the right ankle and foot, pain in the right and left knee and required scheduled pain medication regimen in addition to as needed pain medication. The Care Plan initiated 8/24/25 revealed R#4 had acute/chronic pain and directed staff to administer analgesia medication per orders and half an hour before treatments or care. Clinical census for R#4 revealed an admission date of 8/22/25. Review of Encounter Note dated 8/29/25 completed by Staff J, Nurse Practitioner (NP) revealed R#4 reported pain to be 10/10. Staff J documented an order to restart Oxycodone 5 milligrams (mg) every 6 hours as needed. During an interview 10/22/25 at 11:40 AM, Staff J, NP revealed a nurse had called her the week of 9/2/25 reporting they did not have an as needed order for R#4's Oxycodone. Staff J reported she was upset someone had not called her over the weekend as she would have given a verbal order for the Oxycodone. Staff J verified she had originally re-ordered the Oxycodone on 8/29/25 after a visit with R#4 and the information was documented in her notes. Review of Clinical Physician Orders for R#4 revealed the order for Oxycodone 5 mg every 6 hours as needed was initiated 9/4/25. During an interview 10/22/25 at 12:50 PM, R#4 revealed when he first arrived at the facility his hip pain was unbearable and he didn't get much help with pain control except Tylenol. Stated he got an order for more pain medication from the NP and the pain control improved. During an interview 10/22/25 at 3:25 PM, the Director of Nursing (DON) revealed the as needed Oxycodone should have been transcribed when it was received. The DON revealed he was not sure when the breakdown happened but is looking at improving the process.