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	04/09/2026

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, staff interviews and policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections, Appeals and Licensing (DIAL) within two (2) hours for one of three residents reviewed for potential abuse (Resident #2). The facility reported a census of 66 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 had diagnoses of metabolic encephalopathy (disorder where medical problems such as blood infections or liver or kidney failure cause brain damage), anemia (lack of red blood cells to help transport oxygen from the lungs to the organs) and sepsis (blood poisoning) (the body's response to a life-threatening infection that damages vital organs). The MDS recorded the resident had a Brief Interview for Mental Status score of 13 indicating cognition intact. The Care Plan revised 10/28/25 revealed the resident had a risk for impaired cognitive function/ dementia related to respiratory failure with hypoxia (low oxygen to the body tissues). The Progress Notes revealed: a. On 12/2/25 at 11:45 PM, Resident #2 became agitated and started yelling at the CNA (certified nursing assistant). The CNA left the room and reported that the resident was upset and calling her names. Two CNA's then went down to the resident's room. The resident became angry with both CNA's. The resident called the CNA's bitches and said you guys don't know how to do anything, get the hell outta my room. The CNA's reported that the resident refused to have the CNA's change him. Staff J, Licensed Practical Nurse (LPN), went to the resident's room and asked him what had happened. Resident #2 stated they broke his bed. Staff J pushed the buttons on the remote and showed the resident that the bed was not broken. b. On 12/2/25 at 11:45 PM Resident #2 called 911 to report that he was being attacked. Staff J went to check the resident and asked if he felt safe at the facility. Resident #2 responded no, not with those two girls here. When asked to describe the girls, the resident stated that one was a white, big girl, and the other a black girl with something wrong with the skin on her face. An assessment of the exposed skin on arms and legs revealed no redness, new discolorations developing, no fresh scratches or abrasions observed. The on-call provider was notified and an order was received for a UA (urine specimen) when the resident would allow for a catheter change. c. On 12/3/25 at 12:48 AM, received a call from the police department. The resident had called and stated that he was being attacked and to send help. The police asked if staff could check on the resident and call them back to let them know if the resident was okay. Staff went down to see if resident was okay. The resident allowed staff to change him.Review of a facility Self Report to DIAL on 12/3/25 at 1:06 PM regarding Resident #2 revealed an allegation of abuse with staff to resident. The incident occurred on 12/2/25 at 12:45 AM. The original incident summary was reported to the DIAL hotline number on 12/3/25 at approximately 1:33 AM. In an interview on 4/9/26 at 10:08 AM, Staff J, LPN, reported Resident #2 was always septic due to a UTI (urinary tract infection) from his catheter. She reached out to the on-call physician (Dr) to see if she could send the resident out. The On-call Dr did not want the resident sent out and gave an order to give Ativan (an antianxiety medication). The CNA went to check on the resident and he was resistive or swinging. The CNA came out and told her about it. She told the CNA to go in with two staff. Staff L, CNA, took another CNA (Staff K) in and they came (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back and told her they could not get him changed. He accused them of being rough with him. He described there was a white fat gal and black gal with something wrong with her face. She called and reported it to Staff I, the former Administrator. She also talked to Staff M, former Director of Nursing (DON). The description of each CNA matched the description of what the resident told her about. In an interview on 4/9/26 at 10:25 AM, Staff K, CNA, recalled Resident #2 said he thought staff were attacking him. She and Staff L went in to change his brief. He became threatening and lashed out at them. He was yelling and screaming and was very confused. She went and reported it to the nurse. Staff K reported she had not seen anybody be rough or unkind to residents. She would report to the nurse right away, let the DON know, write a statement, and call the State if she witnessed any type of abuse. In an interview on 4/9/26 at 10:42 AM, Staff L, CNA, reported she recalled she went to help Resident #2 change his brief. Resident #2 called the police and said that staff were beating him up. She told the nurse about it. The nurse told her not to go in by herself, so Staff L took another CNA in to help her. Staff L reported when she took care of Resident #2 the day before he was not like that, so it surprised her when he started attacking them that night. On 4/9/26 at 11:11 AM, a DIAL Intake Specialist verified the facility called in an allegation of abuse to the DIAL hotline about Resident #2 on 12/3/26 at 1:33 AM by Staff I. In an interview on 4/9/26 at 1:30 PM, the Clinical Resource Nurse reported she expected staff report any kind of allegation of abuse within 2 hours to the facility Administrator. In an interview on 4/9/26 at 1:38 PM, the Administrator reported anytime there was a suspicion of abuse, he expected staff separate the resident and ensure the resident was safe, then contact the Administrator. The Administrator would report the allegation of abuse to DIAL right away or within 2 hours of the allegation. The facility's Freedom from Abuse, Neglect, Exploitation policy revised 8/2024 revealed the facility reported to the appropriate agencies as designated by State and Federal laws if there is an allegation or suspicion of abuse. All allegations of abuse are reported immediately but not later than two hours after the allegation is made if the events that cause the allegation involves abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to update and revise the care plan to reflect changes in the plan of care for 1 of 10 residents reviewed for smoking and/or vaping (Residents #7). The facility reported a census of 66.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #7 had diagnoses of traumatic spinal cord dysfunction, quadriplegia C5-C7 complete and Post Traumatic Stress Disorder (PTSD). It also indicated that he had a Brief Interview for Mental Status (BIMS) score of 15 meaning he was cognitively intact.The Electronic Health Record (EHR) indicated on 10/9/25 that management had taken Resident #7's vape from him as he was not following the smoking policy. It also indicated that he had a diagnosis of vaping-related disorder and vaped daily.The Care Plan initiated on 8/1/24 indicated that Resident #7 had a potential for injury related to vaping and directed staff to provide 1:1 observation while smoking cigarettes or vape due to not being able to hold it. It also directed staff to maintain his smoking materials at the nurses' station or other designated area. It indicated that he was often non-compliant with the smoking policy by keeping his vape in his room. It lacked documentation that he could have his vape in a locked box in his room or that he only used it to chew on.During an observation on 4/7/26 at 1:33 PM Resident #7 had a purple vape to the left side of his neck. When asked if it was a vape, he did not say anything for a while. After asking again, he stated that it was a vape and that his mom gets them for him. He stated he usually keeps them in a lock box in his room.In an interview on 4/7/26 at 2:30 PM Staff A, CMA stated that Resident #7 had a vape in his room and was able to have it. Most of the staff were aware of the vape. She was not aware of where he got them or what kind they were.In an interview on 4/8/26 at 9:15 the Administrator stated, Resident #7 could have his vape locked in his room against the current policy since he is not actually using it but is simply chewing on it for PTSD. The decision to be able to have it in his room but, not use it was decided in his quarter 3 care conference on 10/13/25. Resident #7 and his mom both agreed he would not use it except to chew on unless he was with his mom, or in the designated smoking area. The Administrator stated that this change should have been on the care plan.In a document titled Policy/Procedure - Nursing Administration under Section: Care and Treatment and Subject: Care Planning revised 4/2025 it indicated that it was the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The Care Plan would be revised as needed, and interventions would be implemented. It also indicated that in the event that a resident refused certain services posing a risk to resident's health and safety, the comprehensive care plan would identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews, and policy review, the facility failed to monitor and supervise a resident with access to a vape for 1 of 10 residents reviewed for smoking and/or vaping (Resident #7). The facility reported a census of 66.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #7 had diagnoses of traumatic spinal cord dysfunction, quadriplegia C5-C7 complete and Post Traumatic Stress Disorder (PTSD). It also indicated that he had a Brief Interview for Mental Status (BIMS) score of 15 meaning he was cognitively intact.The Electronic Health Record (EHR) indicated on 10/9/25 that management had taken Resident #7's vape from him as he was not following the smoking policy. It also indicated that he had a diagnosis of vaping-related disorder and vapes daily.The Care Plan initiated on 8/1/24 indicated that Resident #7 had a potential for injury related to vaping and directed staff to provide 1:1 observation while smoking cigarettes or vape due to not being able to hold it. It also directed staff to maintain his smoking materials at the nurses' station or other designated area. It indicated that he was often non-compliant with the smoking policy by keeping his vape in his room.The Interdisciplinary Team Care Plan Review dated 10/13/25 lacked documentation on Resident #7 being able to have a vape in his room only to chew on. It indicated that a risk assessment for smoking safety evaluation was discussed and smoking and vaping instructions and expectations with facility protocol and smoking policy were reviewed.During an observation on 4/7/26 at 1:33 PM Resident #7 had a purple vape to the left side of his neck. When asked if it was a vape, he did not say anything for a while. After asking again, he stated that it was a vape and that his mom gets them for him. He stated he usually keeps them in a lock box in his room.During a continuous observation of Resident #7's room on 4/7/26 starting at 2:51 PM:At 2:51 PM Staff C, Assisted Director of Nursing (ADON) did not go into Resident #7's room after the interview with the surveyor but went into the Director of Nursing's (DON) office where the Administrator was at. At 2:57 Resident #7's mother and another woman entered his room with sacks in hand. Mom immediately came back out. At 2:57 Staff D, Certified Nurses Aide (CNA) went into the room and left the room at 3:04 PM. At 2:59 Resident #7's mother returned with utensils and told another resident that she needed to feed Resident #7. At 3:00 PM Resident #7's call light came on. At 3:02 PM Staff D, CNA went in briefly and the light went off. At 3:03 PM Staff C, ADON approached the surveyor in the hall, and then returned to the DON office at 3:10 PM.At 3:30 PM the continuous observation was completed.In an interview on 4/7/26 at 2:30 PM Staff A, Certified Medication Aid (CMA) stated that Resident #7 had a vape in his room and was able to have it. Most of the staff were aware of the vape. She was not aware of where he got them or what kind they were.In an interview on 4/7/26 at 2:32 PM Staff B, CNA stated he had not been in Resident #7's room as he will not allow men to help him. Resident #7 is not supposed to have a vape. He used to have one in his room but not anymore.In an interview on 4/7/26 at 2:42 PM Staff C, ADON stated that Resident #7 was not supposed to have a vape. If he had a vape, staff should ask if they could remove it and let him go out at the designated smoke times. If he won't let them have it they can reach out to his mom. If that doesn't work she didn't know what to do but she would get back to the surveyor. The surveyor informed her that the resident currently had a vape to the left side of his neck. She stated she was not aware that he had a vape but now that she was aware, she would ask him for it after the conversation. If an independent smoker smokes or vapes in their room, they would lose independent smoking privileges if they signed the smoking agreement on admission. She was not sure what they would do if they did not sign the smoking agreement one admission. She was not sure what kind of vape he had. If a family brings in vapes or cigarettes they should bring them to the nurse's station to be locked away. Independent smokers had their own lock box in their room. She was not sure if they have lock boxes yet. She was not sure how he was getting the vape to his neck or who was giving it (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to him but she would find out.In an interview on 4/7/26 at 2:54 PM Staff D, CNA stated that she saw Resident #7's vape when she was in his room. She did not know how he got the vape to his neck but she did not do it. She stated that the resident had told her in the past that he will do what he wants. She reported to the nurse all the time but nothing changed. She had not reported it today but she would after the conversation.In an interview on 4/7/26 at 3:03 PM Staff C, ADON stated that they don't look at the vapes to see what kind of vapes they are, they just put them in the lock box. If they were to find out about a tetrahydrocannabinol (THC) vape, they would call law enforcement.In an interview on 4/7/26 at 3:40 PM the Administrator stated that Resident #7 was not using his vape currently but did have it in his room so he can chew on it to calm him due to PTSD. When he first arrived, he had it in a lock box but that didn't work. Then his mom was going to keep it and take him out to smoke. That didn't work, so he agreed to get up and go outside during smoking times. That was working then he backed off as he didn't like the times. His mom gives it to him now, not the staff. He doesn't smoke it but puts it in his mouth to chew for PTSD. When asked how he knew Resident #7 was not smoking it, he simply said yes that is true. They can't keep it from him as independent smokers can have smoking supplies in their rooms. They are new to the independent smoker thing and they are trying to figure out what to do with him. The surveyor advised that he is not an independent smoker. He then said they would have to catch him with the smell or smoke noted. When asked if they have tried other things to chew on besides a vape or make sure he could not use the vape, he did not answer the question. He stated they have to believe Resident #7 and his mom have the best intentions. When asked if Resident #7 could actually take a hit of the vape he kept in his room, he said that he could. When the surveyor asked if he knew that none of this information was on the care plan, he did not answer.In an interview on 4/8/26 at 5:56 AM Staff E, Licensed Practical Nursing (LPN) stated that Resident #7 had a vape in his room that he kept in a lock box. His mother comes in daily and gives it to him. She stated he can use his right hand to put it in his mouth. She had not seen him use it.In an interview on 4/8/26 at 6:10 AM Staff F, CNA stated she was aware that Resident #7 had a vape that he keeps locked in a locked drawer. She stated that he would put on his call light to have her get it for him. She had seen him take a hit and saw the smoke. Last time she helped him was 3 weeks ago as she doesn't work in that area often. About 2 weeks ago, other staff told her that he could not vape anymore. Prior to that she did not know he could not vape in his room. Management did not tell her.In an interview on 4/8/26 at 9:15 the Administrator stated Resident #7 can have his vape locked in his room against the current policy since he is not actually using it but is simply chewing on it for PTSD. The decision to be able to have it in his room but not use it was decided in his quarter 3 care conference on 10/13/25. Resident #7 and his mom both agreed he would not use it except to chew on unless he was with mom or in the designated smoking area. In the previous interview the Administrator clarified that when he said the plans did not work, he meant that they could not be sure that the vape was locked up as his mom would forget and he had lots of friends visiting. He had it now as he had agreed not to use it in his room. He can only use it in the designated area at the designated time or when out with his mother. They do not monitor the vape as he is using it when leaving with mom. The vape is now red since mom came yesterday. He has never been able to use the vape in his room. He stated that staff were aware as they are re-educating staff during in-services, huddles and team applications. The education included the night shift.In an interview on 4/8/26 at 5:01 PM Staff G, CNA stated that she did not usually work on the top assignment but there was a guy in room [ROOM NUMBER] that she did not remember his name. He had a vape around his neck. She did not remember if he still had it. She added that at one point, he used to have a THC vape in his locked drawer in his room. She did not remember how long ago and she did not know if he still had it in there.In an interview on 4/9/26 at 8:15 AM Staff H, Activities Supervisor stated that she bought vapes for many of the residents but some families bring them in. They are not always in the original packaging. She stated that the vapes don't have identifiers to say what kind they are but the smoke attendants would be able to tell if they were THC vapes as they have the smell of THC but fruit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flavored. When the vapes are empty, they are thrown away in the garbage.According to the National Library of Medicine, in an article titled E-cigarette explosions: patient profiles, injury patterns, clinical management, and outcome, it indicated that recently, there is a growing number of reported cases in which an Electronic Nicotine Delivery System (ENDS) exploded, leading to serious injuries to the user. The lithium-ion batteries are considered the main culprit for these events. Conversely, lithium-ion batteries are inexpensive and easy to produce and use. However, there is a known risk of spontaneous combustion, especially in low quality units. The underlying mechanism seems to be a self-induced rapid overheating of the battery. A specific issue of lithium-ion batteries is the known phenomenon called runaway, which seems to be responsible for the chain reaction, eventually leading to their explosion. The article can be found at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10491958/#:~:text=Recently%2C%20there%20is%20a%20growing,(an undated document titled Resident Smoking & Vaping Policy it indicated that smoking and vaping are prohibited in all buildings and anywhere on facility grounds except in designated outdoor smoking areas. It also indicated that residents who do not meet criteria for independent smoking must be supervised per their care plan and smoking materials for supervised smokers are maintained by Nursing and Activities. Also, vaping devices are subject to the same rules as combustible smoking and may only be used in designated areas.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, hospital record review, and facility policy review, the facility failed to obtain an order for supplemental oxygen for 1 of 1 resident (Resident #3). The facility reported a census of 66 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented diagnoses of acute pulmonary edema (sudden fluid buildup in the lungs), atrial fibrillation (heart rhythm disorder causing an irregular and usually rapid heartbeat), pulmonary hypertension (a type of high blood pressure that specifically affects the lungs), and edema. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated cognition intact. The MDS coded the resident had not received oxygen therapy. The Care Plan for Resident #3 dated 1/12/26 indicated the resident had an infection (which was not specified), was receiving occupational, physical, and speech therapies, was experiencing pain, and planned to be discharged after completing her rehabilitation. Her Care Plan had no focus area for respiratory care or any intervention for supplemental oxygen. In a phone interview on 4/9/26 at 1:38 p.m., Staff N, Licensed Practical Nurse (LPN), stated Resident #3 admitted to the facility on [DATE] and he had completed her initial admission Assessment that day and agreed she was not receiving supplemental oxygen at that time. Resident #3's electronic medical record (EMR) revealed her 1/12/26 Initial admission Assessment documented her oxygen saturation (the percentage of oxygen-carrying hemoglobin in the blood, which reflected how well the lungs and circulatory system were functioning) was 95% on room air and indicated shortness of breath, diminished right lung sounds, wheezes in the left lung, productive cough, and that she was not receiving supplemental oxygen. The Daily Skilled Assessments revealed the following: a. On 1/13/26, the resident's oxygen saturation was 95% on room air with no active respiratory symptoms observed and no respiratory treatments provided, including supplemental oxygen. b. On 1/14/26 documented Resident #3 had conditions effecting her respiratory system with her HOB [Head of Bed] elevated due to shortness of breath [when] lying flat and HOB elevated due to COPD [Chronic Obstructive Pulmonary Disease, a progressive incurable lung disease]. Resident #3's diagnoses had not included COPD. c. On 1/14/26, 1/15/26, and 1/16/26 documented the resident's oxygen saturations from 1/13/26, which failed to provide an accurate, daily assessment of the resident's respiratory status. d. On 1/17/26, resident's oxygen saturation was 97% on room air with no active respiratory symptoms observed and no respiratory treatments provided, including supplemental oxygen. e. On 1/18/26, her oxygen saturation dropped to 94% (a normal, healthy reading was between 95% and 100%) and indicated Staff O, LPN, had provided respiratory therapy by initiating supplemental oxygen through a nasal cannula. No physician notification or physician's order for supplemental oxygen administration was documented. f. On 1/19/26, her oxygen saturation dropped to 91% on Continuous Oxygen Use provided at 2 liters per minute through a nasal cannula. Assessment of her respiratory condition documented Shortness of Breath: with exertion, sitting at rest, [and] lying flat. Despite this decline there was no documentation that her physician was notified of the need for oxygen or her worsening respiratory symptoms. g. On 1/20/26, her oxygen saturation was at 95% with supplemental oxygen through a nasal cannula. Assessment of her respiratory condition documented oxygen therapy was provided with continuous oxygen use at 2 liters per minute. Further review of Resident #3's EMR revealed on the evening of 1/19/26 at 6:47 p.m., a Change in Condition was reported to her medical practitioner regarding the resident's cellulitis (a potentially serious bacterial infection of the deep skin layers characterized by red, hot, tender, and swollen skin) to her right lower leg including a wound on that leg that was draining. New physician orders were obtained for her wound care. That night Resident #3's progress notes revealed she was awake all night, putting light on constantly,. several times stating she didn't know what she wanted. and that she was yelling loudly. Resident #3's Weekly Skilled Review on 1/20/26 at 10:51 a.m. documented she was oxygen dependent at 2 liters per (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minute. The evening of 1/20/26, Resident #3's daughter came to the facility to visit her and called 911 to have Resident #3 transported to the hospital emergency room. Resident #3's Hospital Transfer Form documented the resident was sent to the hospital at 8:00 p.m. During an interview on 4/9/25 at 11:49 a.m. the LPN/MDS Coordinator acknowledged that Resident #3's medical diagnoses had not included COPD. When asked regarding the process for obtaining supplemental oxygen for a resident she revealed that when a resident's oxygen saturation was measured at 90% or below, the nurse should call the physician for an order for supplemental oxygen. She stated the nurse should not wait to obtain the physician's order. During a phone interview on 4/9/26 at 12:35 p.m. with Staff O, LPN, stated she could not recall Resident #3 or her assessments of that resident. When asked about the process for initiating supplemental oxygen for a resident she stated she would call the physician and request an order for oxygen. She agreed that in an emergency situation, staff would administer supplemental oxygen to the resident first, but should call the physician immediately afterwards to obtain the physician order for that oxygen. She could not recall her 1/18/26 Daily Skilled Assessment when she initiated oxygen administration for Resident #3. In an interview on 4/9/26 at 12:54 p.m. the Director of Nursing (DON) revealed she had started her position on 2/6/26 and was not familiar with Resident #3. When asked regarding oxygen administration she stated that a licensed nurse knows when a resident would benefit from supplemental oxygen, but acknowledged they have to get a physician's order for the oxygen administration. Review of the 1/20/26 Hospital Emergency Department (ED)'s report for Resident #3 revealed the Chief Complaint was Shortness of Breath and Patient does not normally wear oxygen, she is on 3 L [Liters] of oxygen and satting [oxygen saturation of] 91 to 92% for EMS [Emergency Medical Services], was satting 77% without oxygen. The ED report documented the Clinical Impression of Resident #3 as follows: 1. Acute Hypoxic Respiratory Failure 2. Acute on chronic congestive heart failure, unspecified heart failure type 3. AKI (acute kidney injury). Review of the facility's policy Change in Condition reviewed April 2025 instructed staff that when the resident's vital signs, including oxygen saturation, have changed the licensed nurse will perform an assessment of the resident and identify the need for additional interventions through communication with the resident's medical provider to obtain new orders. There will be certain circumstances where immediate attention will be warranted,. The nurse shall use his/her clinical judgment and shall contact the physician based on the urgency of the situation. Review of the facility's policy Oxygen Administration reviewed April 2024 documented that oxygen therapy is administered by licensed nurse as ordered by the physician or as a nursing measure and an emergency measure until the [physician] order can be obtained.

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	165175	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, hospital record review, and facility policy review, the facility failed to administer medication as prescribed and ordered by the physician for 1 of 5 residents (Resident #3) reviewed for medication. Resident #3 required hospitalization due to acute hypoxia (low oxygen saturation in the blood). The facility reported a census of 66 residents. Findings include: The admission Minimum Data Set (MDS) assessment dated [DATE] for Resident #3 documented a [DATE] admission date to the facility from an acute hospital stay. Her diagnoses included a left humerus fracture (upper arm bone break near the shoulder joint), and a subsequent encounter with routine healing (which indicated the resident had received active care for the fracture and was in the routine healing/recovery phase), acute pulmonary edema (sudden fluid buildup in the lungs), atrial fibrillation (heart rhythm disorder causing an irregular and usually rapid heartbeat), pulmonary hypertension (a type of high blood pressure that specifically affects the lungs), opioid dependence, and edema. The MDS showed the Brief Interview for Mental Status (BIMS) score of 13, which indicated cognition intact. The MDS documented the resident's health conditions included pain management with scheduled pain medications and that the resident had not received PRN (as needed) pain medications or non-medication interventions for pain. Resident #3's Pain Assessment Interview revealed she frequently had experienced pain which made it hard for her to sleep at night and limited her participation in her rehabilitation therapy. The MDS documented the resident's pain rating was 10, which was the highest rating. The MDS further documented the resident had shortness of breath when lying flat and with exertion. The MDS documented the resident's medications included antianxiety, diuretic, and opioid medications. The MDS documented the resident had not received any oxygen therapy. The Care Plan for Resident #3 dated [DATE] indicated the resident had an infection which was not specified, was receiving occupational, physical, and speech therapies, was experiencing pain with interventions that included to administer pain medications as ordered and to follow pain scale (a standard 0-10 tool where 0 is no pain and 10 is the worst imaginable pain) to medicate as ordered, and planned to be discharged after completing her rehabilitation. Resident #3's electronic medical record (EMR) review revealed the following pain medications were prescribed upon her [DATE] admission: a. Tylenol Extra Strength (Acetaminophen) Oral Tablet 500 MG (milligrams) with orders to Give 2 tablets by mouth every 6 hours as needed for pain/fever.The following medications were classified as Opioid Narcotic Controlled drugs:b. Hydrocodone-Acetaminophen Oral Tablet 10-325 MG with orders to Give 1 tablet by mouth every 8 hours as needed for MAX DAILY AMOUNT IS 3 Tablets. c. Oxycodone Oral Tablet 10 MG with orders to Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. d. Hydromorphone Oral Tablet 2 MG with orders to Give 1 tablet by mouth every 4 hours as needed for SEVERE PAIN THAT IS FOR BREAKTHROUGH WITH PAIN LEVEL OF 10[,] PAIN LEVEL MUST BE A 10 or above to give. The above medications (b, c, and d) contained an ALERT! Black Box Warning! that included: a. Warning: Addiction, abuse, and misuse. Because the use of hydrocodone/acetaminophen - oxycodone - hydromorphone exposes patients and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death, assess each patient's risk prior to prescribing and reassess all patients regularly for the development of these behaviors and conditions. b. Life-threatening respiratory depression. Serious, life-threatening, or fatal respiratory depression may occur with use of hydrocodone/acetaminophen - oxycodone - hydromorphone. To reduce the risk for respiratory depression, proper dosing and titration of hydrocodone/acetaminophen - oxycodone - hydromorphone are essential. c. Risk from concomitant use [the administration of two or more drugs, such as prescription medications, at the same time] with. other CNS [Central Nervous System] depressants [e.g., opioid pain medications like hydrocodone/acetaminophen, oxycodone, and hydromorphone]. Concomitant use of opioids with other CNS depressants. may result in profound sedation, respiratory depression, coma, and death. Further (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #3's EMR revealed her Medication Administration Records (MAR) for [DATE] documented: a. On [DATE], at 11:22 p.m.; [DATE] at 3:58 a.m. and 8:22 a.m. she received both her Oxycodone and Hydromorphone medications (i.e. concomitant use). Her pain rating at those times were 7, 5, and 6 respectively, which had not met the physician orders for the Hydromorphone medication. b. On [DATE], at 3:52 p.m. she received both her Oxycodone and Hydromorphone medications with her pain rating at 10. c. On [DATE], at 8:31 p.m. she received both her Oxycodone and Hydrocodone-Acetaminophen medications. Her pain rating was 7. Four minutes later, at 8:35 p.m. she received her Hydromorphone medication. Her pain rating was 6, which had not met the physician orders for that Hydromorphone medication. d. On [DATE], at 7:54 p.m. she received her Oxycodone medication.Two minutes later, at 7:56 p.m. she received her Hydrocodone-Acetaminophen medication. Five minutes later, at 8:01 p.m. she received her Hydromorphone medication. Her pain rating for all three opioid medications (i.e., concomitant use) was 7, which had not met the physician orders for the Hydromorphone medication. e. On [DATE], at 3:38 p.m. she received her Hydromorphone medication. Her pain rating was 6, which had not met the physician orders for the Hydromorphone medication. f. On [DATE], at 12:04 a.m. and 7:16 a.m. she received her Hydromorphone medication. Her pain rating was 5 and 6 respectively, which had not met the physician orders for the Hydromorphone medication. g. On [DATE], at 7:19 p.m. she received her Hydromorphone medication. Her pain rating was 5, which had not met the physician orders for the Hydromorphone medication. h. On [DATE], at 12:18 a.m. she received her Hydromorphone medication. Her pain rating was 4, which had not met the physician orders for that Hydromorphone medication. i. On [DATE], at 9:19 p.m. she received her Hydromorphone medication. Her pain rating was 7, which had not met the physician orders for that Hydromorphone medication. Further review of Resident 3's January MAR for her Hydromorphone medication ordered to be given for severe pain that must be at a pain level of 10 revealed that from [DATE] through [DATE] that pain medication was administered 17 times of which four of those times met the physician's orders. 76.5% of those 17 administrations of the Hydromorphone medication had not met the parameters of that order. In a phone interview on [DATE] at 3:17 p.m. with a pharmacist at the facility's preferred pharmacy regarding pain medications prescribed for an individual resident that included Tylenol Extra Strength Oral Tablet 500 MG, Hydrocodone-Acetaminophen Oral Tablet 10-325 MG, Oxycodone Oral Tablet 10 MG for moderate to severe pain, and Hydromorphone Oral Tablet 2 MG for severe pain reported she had rarely seen those three opioid pain medications given at the same time. She stated that taking those opioid medications together could cause excessive sedation, and agreed that a resident should not be receiving those medications at the same time which she agreed would be concomitant use of those opioid pain medications. In reviewing the parameters given for those medications, she stated that the Hydrocodone-Acetaminophen medication should have been given first to address a resident's pain. Followed by the Oxycodone medication for moderate to severe pain at the appropriate time interval if the resident was still experiencing pain at that level. Then the Hydromorphone medication for severe pain at the appropriate time interval if the pain persisted at the pain level of 10. In a phone interview on [DATE] at 10:53 p.m. with Staff P, Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA) stated she had worked for one year at the facility and this was her first job as a CMA. She recalled Resident #3 and stated the resident would take her medications right away and needed no instructions regarding her medications. After reviewing Resident #3's pain medications and physician directions she stated the resident had used her narcotic pain medications one to two times during her 12-hour shift. We discussed her process for giving PRN (as needed) medications and she stated she would go to the resident requesting the medications and ask them if they were requesting anything specific, ask about their pain level, location of pain, and then she would go to the med cart to view the resident's prescribed pain medications. She would then let the resident know of the pain medications available. When asked if she had consulted a licensed nurse regarding the pain medications, she stated she had not with Resident #3. When asked regarding haven given more than one opioid pain (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication at the same time to Resident #3, she stated she would have only given multiple pain medications under the direction of a nurse. When asked regarding the nurse, she could not recall the nurse who gave that direction. After reviewing Resident #3's pain medications she had documented on:a. Tuesday, [DATE] at 8:22 a.m. that had included both the Hydromorphone and Oxycodone medications and that she had documented the resident's pain at a level 6.b. Tuesday, [DATE] at 3:52 p.m. that included both the Hydromorphone and Oxycodone medications and that she had documented the resident's pain at a level 10.c. Monday, [DATE] at 12:18 p.m. that included the Hydromorphone medication and that she had documented the resident's pain at a level 4.After discussing the Oxycodone medication was to be given for moderate to severe pain and the Hydromorphone medication for severe pain of 10, she acknowledged she had not followed the physician orders for the Hydromorphone medication with the resident's pain rating of 6 on the morning of [DATE] at 8:22 a.m. and the resident's pain rating of 4 on the afternoon of [DATE] at 12:18 p.m. When asked if she had been provided any guidance on Resident #3's different pain medications and on the difference between moderate pain and severe pain with the pain scale, she stated that no guidance had been provided to her. In an interview on [DATE] at 11:49 a.m. the LPN/MDS Coordinator stated Resident #3 was on a lot of different pain medications, that her pain level was typically high on the pain scale, and the she asked for two pain medications to be given at the same time, but that she was not comfortable administering those opioid pain medications at the same time as individual residents' reactions are different to those pain medications. She stated for Resident #3 she would alternate the resident's pain medications, giving only one pain medication at a time and keep the next pain medication until at least three to four hours later. She stated she would expect the licensed nurses to follow the physician's orders for a resident's PRN pain medication. She acknowledged that a CMA was able to administer PRN pain medications, but a licensed nurse would need to follow-up with the resident to assess the effectiveness of that pain medication. In a phone interview on [DATE] at 12:21 p.m. with Staff Q, Registered Nurse (RN) stated Resident #3 was on a lot of pain medications and she had requested them frequently and that she wanted all three of the pain medications at the same time. Staff Q, RN stated she had tried to convince the resident not to take all those pain medications at one time, but that she insisted the she had been on those same pain medications for years and that was how she took them in the past. Staff Q, RN acknowledged she had reservations and that it was not good to take them all at one time, but had given those three narcotic pain medications at the same time due to the resident's insistence. She recalled discussing Resident #3's reported pain level of 10 with the resident as intractable pain (severe, constant, and incurable pain state that does not respond to conventional medical treatments) and that she may need to be sent to the hospital for that type of pain. Staff Q, RN stated Resident #3 had then replied that her pain level was at a 7, and that Resident #3's pain level was always at a 7 for her after that discussion. In an interview on [DATE] at 12:54 p.m. the Director of Nursing stated she had been in her position since [DATE]. She stated her expectation was that licensed nurses and CMAs would follow the physician orders regarding medication parameters. She was not working at the facility during Resident #3's stay, in [DATE] and hesitated to answer any questions regarding her medication regimen as she was not familiar with that resident. When discussing opioid pain medications in general and the giving of three opioid pain medications at the same time, she stated that would be a lot of opioid pain medications and that individual resident's reactions are different due to their individual diagnoses and she would expect a licensed nurse to contact the resident's medical provider for guidance. The DON was informed and acknowledged the above findings regarding Resident #3's opioid pain medications. Review of the facility's CMA Job Description revealed the CMA administers prescribed medications and treatments as defined by state regulations in accordance with company policy and procedure under the direction of a licensed nurse. It included instructions that a CMA may not administer:a. The first dose of a new medication.b. Any new medication that arrives at the facility. c. As-needed (PRN) medications. Review of the facility's Medication Administration policy, dated [DATE] revealed that medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. The procedure included: a. only licensed medical and nursing personnel or other lawfully authorized staff members may prepare, administer, and record medication administration.b. Medications must be administered in accordance with the written orders of the attending physician. c. When PRN medications are administered, the nurse or medication technician (CMA) must record the date and time administered, and later the results achieved from the PRN medication as appropriate. Review of Resident #3's EMR revealed on [DATE] at approximately 8:00 p.m. Resident #3's daughter came to the facility to visit and called 911 to have Resident #3 transported to the hospital emergency room. Review of the hospital's EMR report for Resident #3's hospitalization from [DATE] through her [DATE] discharge revealed the Emergency Department (ED)'s [DATE] report for Resident #3 documented as follows; Significant lower extremity swelling, tachypneic [rapid, shallow breathing, typically exceeding 20 breaths per minute in adults at rest], hypoxic [a condition characterized by, caused by, or relating to a low level of oxygen in bodily tissues or cells. It indicated inadequate oxygen delivery to tissues, which can be caused by. breathing problems, or cardiovascular issues] requiring supplemental oxygen. Suspect acute heart failure and reviewed previous medications, current med list, and previous hospital notes. Diuretic had been discontinued previously and not restarted which is likely contributory. On anticoagulation. Abnormal chest x-ray with oral effusion. IV diuresis started in ER, medicine consulted for admission for further workup and management.Chief Complaint was Shortness of Breath and History of Present Illness included Patient does not normally wear oxygen, she is on 3 L [Liters] of oxygen and satting [oxygen saturation of] 91 to 92% for EMS [Emergency Medical Services], was satting 77% without oxygen. The ED report documented the Clinical Impression of Resident #3 as follows: 1. Acute Hypoxic Respiratory Failure 2. Acute on chronic congestive heart failure, unspecified heart failure type 3. AKI (acute kidney injury) She was admitted to Adult Critical Care. The Critical Care report, dated [DATE] documented Critical care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: Respiratory failure and cardiac failure. The Hospital Course documented: Patient. admitted on [DATE] with dyspnea [shortness of breath, is defined as uncomfortable, labored breathing often caused by underlying heart or lung conditions like asthma, COPD, pneumonia, or heart failure]. She was originally admitted to hospitalist service in which she began to have lower oxygen saturations. resulting in transfer to the CCU [Critical Care Unit]. She was found to have bilateral pulmonary edema and pleural effusions requiring diuresis. Patient was intubated the morning of 1/26. While on the ventilator she was requiring increased oxygen concentrations leading to continuation of mechanical ventilation. We continued to give pulmonary treatments and diurese to help with her current condition. On the morning of 1/28 patient passed her breathing trial and was able to be extubated and stated that she wanted to be extubated. Upon extubation she did not want to escalate supplemental oxygen therapy further and did have decision-making capacity at this time and understood that this would ultimately lead to respiratory failure and her death. Patient was understanding of these consequences and understood the risks and benefits of treatment and wanted to pursue comfort cares. Patient's family was agreeable to her wishes. Patient underwent comfort cares and was deceased at 11:35 AM on [DATE].