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	06/10/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had diagnoses that included metabolic encephalopathy, diabetes, hypertension (high blood pressure), and respiratory failure. The Care Plan revised [DATE] revealed the resident desired a full code status or DNR status per the IPOST (Iowa Physician's Orders for Scope of Treatment) form. The staff directives included to refer to the IPOST form on file and review the advanced directives routinely at the care conferences and PRN (as needed). The Electronic Medical Health Record (EHR) physician's orders revealed Resident #30's code status as a Full Code. The order was created on [DATE] and listed as active. The Order Summary Report revealed a prescriber's active order for a full code ordered on [DATE]. The IPOST signed by the Nurse Practitioner and Resident #30 on [DATE] revealed a DNR/do not attempt resuscitation status. The IPOST binder kept at the nurse's station revealed the IPOST order signed by the Nurse Practitioner and Resident #30 on [DATE] and the box next to DNR was marked. In an interview [DATE] at 02:14 PM, the Director of Nursing (DON) reported the Social Worker (SW) entered the resident's code status. The Advanced Directives was part of the admission packet. The IPOST got scanned into the resident's EHR and placed into a binder located at each nurse's station. At the time, the DON reviewed Resident #30's EHR order and IPOST. The DON confirmed a DNR status marked on the resident's IPOST but a full code status listed on the orders. The DON reported Resident #30 had gone to the hospital a couple of times and thought maybe the resident's code status did not get updated. An Advanced Directives policy revised 6/2023 revealed the care plan team reviewed the resident advanced directives periodically to ensure the wishes of the resident. Such reviews were made during the assessment process and recorded on the resident assessment instrument (MDS). Changes or revocations of a directive must be submitted to the facility in writing. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the MDS and care plan. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on resident record review, staff interviews, and facility policy review the facility failed to document an accurate code status for 2 of 18 residents reviewed (Res #30 and #52). The facility reported a census of 72. Findings include: 1. The Iowa Physician Orders for Scope of Treatment (IPOST) of Resident #52, dated [DATE], identified the resident desired Full Treatment as a medical intervention and desired for Cardiopulmonary Resuscitation (CPR) should she have an episode of not breathing and having no pulse. Review of the Electronic Health Record of Resident #52 on [DATE] at 10:28 am revealed the resident had a Code Status in the facility of DNR/Do Not Attempt Resuscitation. The EHR revealed the order for DNR status was placed by Staff A, Licensed Practical Nurse on [DATE], stating it was verified by Medical Record Only. On [DATE] at 10:15 am, Staff B, LPN stated each nursing station has an IPOST book where code status sheets are kept. When looking at the Side 1 (area of facility where Resident #52 resides), no IPOST was found for Resident #52. Staff B stated that Resident #52 used to reside on Side 2 and her IPOST might still be at that station. On [DATE] at 10:29 am, the IPOST Book for Side 2 was checked, and there was no IPOST found for Resident #52 in this book either. On [DATE] at 10:39 am, Staff B, LPN was asked what the code status was for Resident #52. He looked at her electronic health record and stated she was a DNR. When Staff B was asked that if Resident #52 were to experience an emergency event, would he perform CPR, he stated he would not perform CPR as he would abide by her wishes to be a DNR. He stated he would look for her IPOST and get it printed and in the book. Staff B then proceeded to locate Resident #52's IPOST in her electronic health record and verified her IPOST stated she wished to be a full code. Staff B then immediately changed her order in her EHR to reflect Full Code. On [DATE] at 1:45 pm, the Director of Nursing stated there is a nurse who handles the admissions for the facility. He stated an IPOST is included in admission paperwork. He stated he was unsure if the resident had a prior DNR status but it is now resolved. The facility policy Care and Treatment, Advance Directives, revision date of 6/2023, detailed a policy statement of: It is the policy of this facility that a resident's choice about advance directives will be respected. Point 1: With admission paperwork the care plan team will ask residents, and/or their family members, about the existence of any advance directives. Point 2: Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, staff interview, and policy review, the facility failed to ensure timely follow-up for the initiation of an as-needed (PRN) use of a psychotropic drug for 1 of 5 residents reviewed for unnecessary medications (Resident #37). The facility reported a census of 72. Findings include: The Quarterly Minimum Data Set (MDS) Assessment completed on 4/16/25 revealed Resident #37 unable to complete the Brief Interview for Mental Status and is severely impaired for daily decision-making. Diagnoses on the MDS include aphasia (communication disorder), autistic disorder, and profound intellectual disabilities. Resident #37 displayed behaviors not directed towards other, such as yelling/screaming. The MDS documented the use of antipsychotic, antianxiety, and antidepressant medications which are all types of psychotropic medications. The Care Plan, which was last updated on 5/13/25, included the use of an antipsychotic mediation related to explosive disorder and an antianxiety medication related to mood disorder/autism. Review of Physicians Orders for Resident #37 revealed the initiation of the psychotropic medication Ativan 0.5 milligrams (mg) administered two times daily on 5/9/25 and ended on 5/23/25. Physician Order further revealed the initiation of Ativan 0.5 mg every 12 hours as-needed (PRN) for anxiety and yelling on 5/10/25. A stop date for the PRN Ativan was not included in the order. The Progress Note dated 5/9/25 at 6:43 PM documented Resident #37 was seen by the facility physician with new medication orders. The start of PRN Ativan was not included in the Progress Note. Review of the Medication Administration Record (MAR) for May 2025 showed PRN Ativan was utilized five times between 5/10/25 and 5/31/25. Review of the MAR for June 2025 showed PRN Ativan was utilized six times between 6/1/25 and 6/9/25. The Electronic Health Record lacked documentation indicating the prescribing practitioner completed a 14-day evaluation for continued use of the PRN Ativan. During an interview on 6/4/25 at 2:15 PM, the Director of Nursing (DON), acknowledged the need for a 14-day re-evaluation from the Primary Care Provider when use of a PRN psychotropic drug, like Ativan, is initiated. The policy Psychotropic Drug Use, last reviewed 11/2021, documented the following: 1. Residents do not receive psychotropic drug pursuant to a PRN order unless medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. 2. PRN orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes that the PRN psychotropic order should be extended beyond 14 days, they should document the rationale in the medical record and indicate the duration for the PRN order. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Psychotropic medications are to be administered only when required to a medical symptom and will be considered only after non-pharmacological interventions have failed

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on clinical record review, staff interview, and guidance from the 2024 Resident Assessment Instrument (RAI) Manual, the facility failed to accurately reflect the status of 3 of 3 residents in the Minimum Data Set (MDS) Assessments (Resident #11, #13, #37). The facility reported a census of 72 residents. Findings include: 1. The Pre-admission Screening and Resident Review (PASRR) of Resident #11, dated 7/30/24, identified the resident to require PASRR Level II Services. (Considered by the State Level II process to have a serious mental illness and/or intellectual disability or a related condition). The PASRR identified the Resident to have diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder and identified symptoms the resident commonly expressed including being easily upset, not having desire to eat, having trouble sleeping, worry, anxiety, not wanting to be around others and having a passive death wish. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility included ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) as well as individual therapy by a licensed behavioral health professional. The MDS of Resident #11, dated 8/14/24 failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 2. The PASRR of Resident #13, dated 9/9/23, identified the resident to require PASRR Level II Services. The PASRR identified the Resident to have diagnoses of Major Depressive Disorder, Alcohol Dependence, Anxiety Disorder and history of Schizoaffective Disorder. The PASRR identified symptoms the resident commonly expressed including having trouble sleeping, worry, anxiety and restlessness. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility included ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services) as well as individual therapy by a licensed behavioral health professional. The MDS of Resident #13, dated 12/26/24 failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. 3. The PASRR of Resident #37, dated 12/6/24, identified the resident to require PASRR Level II Services. The PASRR identified the Resident to have diagnoses of Mood disorder and Intermittent Explosive Disorder. The PASRR identified specialized services the facility needed to provide to the resident while remaining in the nursing facility included ongoing psychiatric medication management by a psychiatrist or a psychiatric ARNP (to evaluate response and effectiveness of psychotropic medications on target symptoms, modify medication orders, and to evaluate ongoing need for additional behavioral health services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS of Resident #37, dated 1/17/25 failed to document the resident to be considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The 2024 RAI Manual, under Steps for Assessment of question A1500, directed: Point 2: Review the Level I PASRR form to determine whether a Level II PASRR was required. Point 3: Review the PASRR report provided by the State if Level II screening was required. In the next section, titled Coding Instructions, the RAI Manual directed: Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. On 6/5/25 and 10:13 am, Staff A, Licensed Practical Nurse/former MDS Coordinator stated when she completed comprehensive MDS, she would look in the resident's medical record for a PASRR status and if she was unable to locate one, she would ask the facility Social Worker about the resident's PASRR status. Each PASRR was reviewed during the interview and was verified to have been uploaded into the resident's Electronic Health Record (EHR) prior the date of the MDS. Staff A stated when the facility changed names in August of 2024 some of the medical records did not transfer over to the new EHR correctly. The facility Policy/Procedure - Resident Assessment Instrument, updated 10/1/2023 documented the following: Point 7: Each person completing a section of the MDS attests to its accuracy by affixing his/her electronic signature to that section of the MDS.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on clinical record review, staff interviews, and policy review, the facility failed to ensure completion of a resident's baseline Care Plan within 48 hours of admission for 1 of 2 residents reviewed with an admission date within the past 30 days (Resident #223). The facility reported a census of 72. Findings include: The admission Minimum Data Set (MDS) Assessment completed on 6/5/25 documented Resident #223's facility admission date as 5/30/25. The Brief Interview for Mental Status score was 14, indicating intact cognition. Diagnoses on the MDS include anemia, atrial fibrillation, non-Alzheimer's dementia, and unsteadiness on feet (with one fall in the last month prior to facility admission). The facility document Therapy to Nursing Communication Form, dated 5/30/25, indicated Resident #223 was an assist of 2 staff members for stand-pivot transfers, an assist of 2 staff members for toileting (to and from commode and wheelchair), and an assist of 1 staff member to utilize a manual wheelchair. The Initial Care Plan-V2.0-V3, located in the Electronic Health Record, showed an initial admission date of 5/30/25 with the Care Plan effective date of 6/2/25. The Care Plan Report, obtained on 6/5/25, documented an initiation date 6/2/25. The Care Plan Report lacked information related to Resident #223 level of staff assistance and supervision needed to complete Activities of Daily Living, such as bed mobility, transfers, toileting, and personal hygiene. During an interview on 6/10/15 at 9:20 AM, the MDS Coordinator explained they have been in the position for approximately three weeks. Responsibilities include completion of resident MDS Assessments and Care Plans. The MDS Coordinator stated they collaborate with the Unit Managers to complete baseline Care Plans but still require clarification on who specifically initiates. During an interview on 6/10/25 at 11:10 AM, the Director of Clinical Services acknowledged the lack of a clear process on Care Plan initiation given the staffing changes with the MDS Coordinator position at the facility. The policy Baseline Care Plans, last revised 5/2021, documented the following: 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline Care Plan that includes instructions to provide effective and person-centered care 2. The Care Plan will include minimum healthcare information necessary to properly care for a resident including, Physician orders, therapy services, dietary orders, and social services 3. The facility will provide a written summary of the baseline Care Plan to the resident or resident representative

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, and policy review the facility failed to carry out therapy recommendations and provide restorative exercises for 1 of 2 residents reviewed for rehabilitation services and/or limited range of motion (Resident #30). The facility reported a census of 72 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #30 had diagnoses of arthritis and muscle weakness. The MDS indicated the resident had independence with toileting and transfers. The MDS revealed the resident began Physical Therapy services (PT) on 6/21/24 and Occupational Therapy (OT) services 8/7/24. The MDS indicated the resident had Restorative Nursing Program (RNP) for zero (0) days during the look-back period. The MDS assessment dated [DATE] revealed Resident #30 had unsteadiness on his feet and muscle weakness. The MDS revealed the resident had impaired range of motion (ROM) to the upper extremity on one side. The MDS indicated the resident had independence with bed mobility, and required partial to moderate assistance for toileting and transfers. The MDS indicated the resident had RNP for 0 days during the look-back period. The MDS revealed the resident began OT services on 11/18/24 and PT services on 11/18/24. The MDS assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status of 15 indicating cognition intact. The MDS indicated the resident had impaired ROM to his upper extremities on one side and lower extremities bilaterally. The MDS documented the resident required partial to moderate assistance for bed mobility, and substantial to maximum assistance for transfers and toileting. The MDS indicated the resident had RNP for 0 days during the look-back period. The MDS documented the resident had PT services that started on 2/17/25 and OT services that started on 2/18/25. The MDS assessment dated [DATE] revealed the resident started PT services on 5/28/25 and OT services on 5/27/25. The Care Plan updated on 12/16/24 revealed Resident #30 had diagnoses of a right above the knee amputation (AKA), a prosthesis, and had a deficit in Activities of Daily Living (ADL's). The Care Plan directed staff to ambulate the resident with assistance of one and a wheelchair to follow, and walk to and from meals as tolerated (initiated on 08/08/24 and resolved date 11/19/24), and ambulate the resident with the assistance of one and a four-wheeled walker (FWW) in his room (initiated 12/16/24). The Order Summary revealed a PT and OT evaluation ordered 8/5/24, 11/18/24, 2/17/25, and 5/27/25. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Therapy to Nursing Communication Form dated 8/8/24 revealed the resident required assistance of one for transfers and toileting, ambulate with the assistance of one and a FWW with a wheelchair to follow, and walk to and from meals as tolerated. The form dated 11/25/24 revealed the resident had independence with transfers to and from the wheelchair/bed, and required assistance of one for toileting. The form dated 12/9/24 revealed the resident required assistance of one with a FWW in the room, assistance of two and a FWW with the wheelchair to follow in the hallway, and recommended a walk to and from dining program. An OT Discharge summary dated [DATE] revealed a restorative ROM program recommended for maintaining the resident's strength and ROM. The resident's prognosis to maintain his current level of function (CLOF) was deemed excellent with consistent staff support and resident participation in a RNP. A PT Discharge summary dated [DATE] revealed the resident required assistance of one staff with FWW and a wheelchair to follow for short distances. The PT recommended a restorative ambulation program, and a ROM and transfer program. The EHR POC response (tasks) indicated a nursing rehabilitation order for active ROM, omnicycle for the upper and lower extremities as tolerated, Nustep as tolerated, and weights and bands for 15 repetitions as tolerated. Review of restorative activities (RA) 5/4/25 to 6/3/25 revealed no nursing rehab restorative exercised documented. The Documentation Survey Report 12/2024 to 5/2025 revealed no restorative program exercises listed. In an interview on 06/03/25 at 09:22 AM, Resident #30 sat in a wheelchair in his room. Resident #30 reported he had a right leg amputation and used a prosthesis. Resident #30 reported he was getting therapy again. Resident #30 acknowledged he did not get any exercise program before this, the staff just left him alone. In an interview 06/04/25 at 02:24 PM, the Director Nursing (DON) reported a therapy communication forms kept in a binder at the nurse's station for staff to review a resident's transfer status and therapy recommendations. The DON reported Staff H, certified medication aide (CMA), did the restorative program activities with the residents. Staff H also transported residents to appointments or the hospital and helped out on the floor. The DON reported he was unsure where RA was documented but thought it was listed under the tasks in Point of Care (POC). In an interview 06/05/25 at 07:50 AM, Staff H, CMA, reported she was assigned to do restorative but it was too much with all of the other duties she had been assigned. She transported residents to appointments or picked residents up from the hospital, ordered supplies (Central Supply), and was also assigned on the medication cart to pass medications to residents. Staff H reported Staff I, CNA, did the restorative activities before this time and was recently assigned to do restorative functions. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 06/05/25 at 10:20 AM, Resident #30 sat in a wheelchair in his room and had a prosthesis on his right leg. Resident #30 reported he was currently getting therapy services. He had therapy services previously but the time ran out. Resident #30 reported he was on his own to do exercises after he was discharged from therapy services. The staff did not ambulate him to/from the dining room or do any kind of exercise activity with him. Resident #30 reported he wanted to be able to walk, get in and out of the car, and load his wheelchair on the car. In an interview 06/05/25 at 11:45 AM, Staff I, CNA, reported she had done the restorative with residents, but she was assigned to work the floor as a CNA a lot. She encouraged residents to do things such as ADL's rather than the CNA doing things for the resident. Staff I reported the restorative program was going back into play, but it had been a few years. The new company had stepped up the therapy services for residents. The plan was to implement a restorative program on 6/16/25. Restorative activities were documented in POC and any CNA could see and work the program. Staff I reported Resident #30 was on a walk to dine program, however when she asked him if he was ready to go for walk or do exercises, he would say he would do it later. In an interview 06/10/25 at 08:55 AM, Staff J, PT, reported therapy filled out a paper communication form regarding recommendations such as restorative and gave it to nursing when a resident had completed therapy services. Staff J thought the MDS nurse or Medical Records followed up on the communication form. Staff J was uncertain if the facility had a designated restorative aide, but reported nursing sat the restorative program up. Staff J acknowledged she had seen a decline in residents at times. Residents had decreased strength, became less ambulatory, or had a change in transfer status. At the time, Staff K, PT, reported Resident #30 was currently on therapy caseload. Resident #30 went up and down in his willingness to participate with exercises. Staff wanted to avoid getting him agitated or escalating behaviors so they tried to develop a rapport and figured out the times of day that worked best for him and his availability to do exercises. In an interview 06/10/25 at 09:23 AM the MDS Coordinator reported she had only worked at the facility for three weeks. The MDS Coordinator reported a therapy communication form filled out regarding communication to nursing about how a resident transferred or what needed to be done whenever therapy serviced completed. She took the information and updated the resident's care plan. The MDS Coordinator reported she was unsure who set up the restorative program and unsure if restorative information would be on the care plan. In an interview 06/10/25 at 11:10 AM, the Director of Clinical Services (DNS) reported she noticed restorative was not getting done a few months ago. Restorative was currently in the works to get set up. The plan was for Staff I, CNA, to go to another facility to work with a restorative aide and learn what to do for restorative, and then Staff I would return to the facility and work on getting a restorative program set up for the residents. The DNS reported restorative exercises and the resident's progress with restorative were documented in the EHR under the POC. A Restorative Care policy revised 5/2007 revealed restorative care provided to each resident according to his/her individual needs and desires as determined by assessment and interdisciplinary care planning. The resident received services to attain and maintain the highest possible mental/physical functional status and psychosocial well-being defined by the comprehensive assessment and plan of care. The resident's plan of care should include all restorative nursing measures planned for the resident. Restorative services was every employee's responsibility.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, staff interviews, and policy review, the facility failed to offer a morning meal or snack to a resident (Resident #8). The facility reported a census of 72. The Minimum Data Set (MDS) Assessment completed on 3/21/25 revealed Resident #8 unable to complete the Brief Interview for Mental Status, is severely impaired for daily decision-making, and has long/short term memory problems. Diagnoses on the MDS include non-Alzheimer's dementia and malnutrition with weight loss. The MDS reported Resident #8 relies on staff for substantial eating assistance. The Care Plan, last revised on 5/19/25, outlined Resident #8 receives a puree diet with nectar-thick liquids. The Care Plan further documented the presence of an unstageable pressure injury to the coccyx as well as a stage 3 pressure injury to the left ankle. During an observation on 6/5/25 at approximately 9:35 AM, Resident #8 was sitting in the lower (downstairs) dining room with Staff M, Certified Nursing Aide. When asked, Staff M indicated the resident's breakfast tray had already been thrown out and was unable to get another. Resident #8 had a cup full of juice in front of them. During an interview on 6/10/25 at 10:00 AM, the Certified Dietary Manager (CDM) voiced they were not aware of Resident #8 needing a breakfast tray on 6/5/25. The CDM would expect dietary staff to prepare a light breakfast or snack for any resident who missed their morning meal, regardless of the resident's diet order or if outside the meal time. During an interview on 6/10/25 at 10:30 AM, Staff L, Cook, reported they were not informed Resident #8 needed another breakfast tray or snack. They would have been the staff member to prep the meal since Resident #8 is on a puree diet. Staff L confirmed if a resident was unable to eat breakfast during the scheduled breakfast time, some type of meal or snack would be offered, regardless of the resident's diet order. The policy Dining and Meal Service, last updated 11/2019, documented the following: 1. The facility provides an open dining style of service 2. The downstairs dining room breakfast will be served at 8:30 AM 3. Food and substantial snacks are available 24-hours/day The policy Meal Service, Nursing Responsibilities, last revised 11/2007, documented that trays are not delivered to the table before the resident arrives.

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	165175	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, clinical record review, and policy review, the facility failed to assure a medication error rate of less than 5%. Medication errors were observed for Resident #45 and Resident #11. A total of 27 ordered medications were reviewed with two errors, an error rate of 7%. The facility reported a census of 72 residents. Findings include: 1. On 6/4/25 at 8:54 am, at 7:59 am, Staff C, Certified Medication Aide (CMA) prepared a total of 2 medications for Resident #45. Among the medications observed, Staff C prepared one tablet of Vitamin D, 25 micrograms (mcg). 2. Staff A next prepared medications for Resident #11. She was witnessed preparing and administering ten medications for Resident #11 including Atenolol 50 milligrams (mg), a blood pressure medication. When reconciling the observed medication pass against the orders for Resident #45, it was noted the resident's order was for Vitamin D3, 25 mcg rather than the Vitamin D the resident received. It was also noted for Resident #11 that the order for the resident's Atenolol included parameters to not administer the medication for if the resident had a pulse rate of below 60 beats per minute. It was documented the resident's pulse was 53. On 6/4/25 at 8:14 am, Staff C verified she had administered all medications to Resident #11 including the Atenolol. She verified on her computer the order did state to hold for a pulse of under 60. She reported the error to Staff D, Licensed Practical Nurse (LPN). On 6/4/25 at 8:28 am, Staff D stated she would have expected Staff C to go check the stock medications in the medication room for the correct Vitamin D3. She stated she had notified the medical provider of the error regarding Resident #11 and received an order for monitoring the resident. On 6/4/25 at 1:40 pm the Director of Nursing (DON) stated Staff C had been provided education regarding the medication errors. The facility Policy/Procedure with the Subject of Administration of Medications dated 7/2017 identified the following: Point 3: Medications must be administered in accordance with the written orders of the attending physician. Point 11: Prior to administering the resident's medication, the nurse or medication technician should compare the drug and dosage schedule on the resident's MAR with the drug label. NOTE: If there is any reason to question the dosage or the schedule, the nurse or med tech should check the physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on clinical record review, observations, resident and staff interview, and facility policy review, the facility failed to securely store medications for 1 of 7 residents observed during medication administration (Resident #34). The facility reported a census of 72 residents. Findings include: The Minimum Data Set (MDS) of Resident #34 dated 4/3/25 identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The Care Plan of Resident #34 identified Resident #34 had diagnoses of emphysema and Chronic Obstructive Pulmonary Disease (COPD) related to smoking (dated 8/1/24). It directed the staff to give aerosol or bronchial dilators as ordered. The Care Plan failed to identify the resident was able to self administer any medications. On 6/2/25 at 2:04 pm, the State Surveyor was observing Staff B, Licensed Practical Nurse (LPN) administer tube feeding to Resident #33, who shares a room with Resident #34. During the observation, the nebulizer machine on Resident #34's side of the room was heard to be turned on, with no nursing staff present on that side of the room. On 6/2/25 at 2:14 pm, Resident #34 stated the staff provide him as many vials of the nebulizer medication as he needs and the staff leave them for him at his bedside and he places the medication into the nebulizer machine and self administers the medication. He stated he knew how to do it. On 6/4/25 at 11:24 am, Resident #34 was observed to have an unsecured vial of nebulizer medication at his bedside. Staff B, LPN was in the room and verified the medication at the bedside of Resident #34. He asked resident #34 who provided the medication to him and he stated it was Staff E, Certified Medication Aide. On 6/4/25 at 1:40 pm, the Director of Nursing (DON) stated the facility does have forms for self administration of medication but he would need to check if Resident #34 had one or not. On 6/5/25 at 8:33 am, Staff B, LPN stated Resident #34 did not have an documentation of being assessed for self administration of medications. He stated the facility had provided education to the Certified Medication Aides as well as speaking with Resident #34 that no medications can be left at the bedside. On 6/5/25 at 2:18 pm, Staff E stated she had never left the medication vials at bedside. She stated she administers the medications as ordered. The facility policy/procedure with the subject Medication Access and Storage, revision date 5/2007 identified the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to store all drugs and biological in locked compartments under proper temperature controls. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: Point 2: Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (e.g., medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interview, and policy review, the facility failed to ensure the lunch menu and meal met the nutritional needs and preferences for 7 out of 68 resident lunch trays prepared. The facility reported a census of 72. Findings include: During on observation on 6/4/25 at 10:30 AM, Staff L, Cook, pureed 2 pork steaks for lunch service. Staff L confirmed the facility had 2 residents on a puree diet. The puree food was placed in a steamtable pan and into the over for reheat until service. During the observation, Staff L did not measure out the final volume of the puree meat before placing into the steam table pan. A Puree Diet Portion Sizes/Scoops chart was laying on the table where the puree food was prepared. Staff L reported the Diet Spreadsheet listed the use of a #8 scooper size for the puree pork. During a lunch service on 6/4/25 from 11:15 AM to 12:45 PM, the following was observed: a. 1 resident did not receive a Magic Cup supplement which was highlight on the lunch ticket b. 1 resident received a Mighty Shake supplement instead of a Magic Cup which was highlighted on the lunch ticket c. 3 residents did not receive a Mighty Shake supplement which was highlighted on the lunch tickets d. 1 resident did not receive a side dish of cottage cheese which was added to the lunch ticket e. 1 resident did not receive ice cream which was added to the lunch ticket f. 3 residents received approximately three-fourths full #8 scooper serving size of the puree pork steak; 2 residents had puree diet orders; 1 resident had a liquified diet which was prepared by mixing the puree meat with hot water in an 8 oz mug During an interview on 6/10/25 at 10:00 AM, the Certified Dietary Manager (CDM) would expect staff to prepare resident meal trays with items as listed on the meal ticket. The CDM stated they were unsure how Staff L typically prepares the liquefied food for the resident. The CDM did not have a preference if staff prepared liquefied food individually in the Robot Coup, to the correct consistency, or if mixed in a cup with puree food and hot water. During an interview on 6/10/25, Staff L confirmed 2 residents on a puree diet and 1 resident on a liquefied diet. Staff F acknowledged serving 3 residents the puree pork even though 2 intact pork steaks were pureed (representing 2 total servings of puree pork). Sample menus from the facility-provided International Dysphagia Diet Standardization Initiative (IDDSI) Resource packet indicated if 3 total servings of a puree item is needed, 3 servings of the cooked food item should be added to the food processor and processed to the appropriate consistency.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, record review, staff interview, and policy review, the facility failed to ensure a resident was served the correct food texture for 1 of 2 residents on a puree diet (Resident #47). The facility reported a census of 72. The Minimum Data Set (MDS) Assessment completed on 5/7/25 revealed Resident#47 with a Brief Interview for Mental Status score of 10, indicating a moderate cognitive impairment. The MDS stated Resident #47 requires maximum eating assistance. Medical diagnoses listed in the electronic health record include dementia and dysphagia (swallowing difficulties). Review of Physician Orders noted Resident #47 on a puree texture diet with moderately thick liquids as of 3/14/25. During the lunch service observation on 6/4/25, Resident #47 was provided a lunch plate consisting of puree barbeque pork steak, puree baked beans, and mashed potatoes. A short time later, an unknown staff member set a bowl of regular textured potato salad in front of Resident #47. During an interview on 6/10/25 at 10:00 AM, the Certified Dietary Manager acknowledged Resident #47 had a puree diet order and was provided the regular textured potato salad. The CDM explained the staff member who was assisting Resident #47 at lunch did not feed the potato salad to them. The policy Dining and Meal Service, last updated 11/2019, documented food will be at the proper texture/consistency to meet individual needs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the dietary staff failed to maintain clean and sanitary conditions in the kitchen, failed to label and store food items in the kitchen in order to maintain food quality and reduce the risk of food-borne illness, and failed to thaw food to reduce the risk of food-borne illness. The facility reported a census of 72 residents. Findings include: 1. Initial tour of the kitchen on 06/02/25 starting at 11:15 AM revealed the following: a. A large trash barrel with the lid partially off and several broken down cardboard boxes blocked the left door to the Arctic Air freezer. The freezer door handle felt sticky and had dried liquid spillage and crumbs of food lying on the bottom of the freezer. b. One package of what appeared to be blueberries unlabeled and undated. c. The drawer handle with utensils (scoops) inside had a sticky residue. d. A bulk container of sugar had a scoop lying on top of the sugar and the handle of the scoop sat in the sugar. e. A bulk container of flour had no date listed. f. A bulk container of breadcrumbs had a date of 4/18. g. The walk-in cooler had the following: A container of what appeared to be chicken/noodles/broth not labeled or dated. A container of what appeared to be diced peaches not labeled or dated Two bottles of dressing not labeled or dated. h. Two large frying pans hung on a rack above the 3 compartment sink and the inside, sides and the bottom of the pans were black/charred. The Teflon coating was missing. 2. Follow up observations of the kitchen on 06/03/25 at 11:00 AM revealed the following: a. Two packages of ground meat was lying in the sink compartment (by the handwashing sink) and had no water running over the packages. b. The freezer handle remained sticky and had dried liquid spillage inside. c. The bulk sugar container continued to have scoop stored inside with the handle propped along the inside of the container. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation during the breakfast meal service on 06/03/25 at 08:30 AM revealed Staff L, cook, stood by a warming cart and plated food for residents on the lower level dining room. During the meal service, Staff L touched the inside of lipped plates as she picked the plates up and placed scrambled eggs and toast on the plate. Staff L also placed her bare hand/fingers on plates as she looked at the menu slips. An aide served a resident a plate of food, then touched the end of the straw as she inserted the straw into a milk carton for the resident. In an interview on 06/04/25 at 03:01 PM, the Dietary Supervisor (DM) reported the meat that was thawing in the sink on 06/03/25 was ground turkey. She expected staff to run cold water over the package while thawing not just place the package of meat in the sink to thaw. The DM reported she expected food and beverages labeled and dated. She went through things in the kitchen walk in cooler and freezers on 06/03/25 and cleaned equipment and marked food items. The DM confirmed the large frying pans looked like they needed replaced. In an interview 06/10/25 at 09:50 AM, the DM reported staff should not touch the inside of the plates/bowls when they served food. She expected staff held the bottom of the plates/bowls as they plated and served food. 4. Observation during the lunch meal service on 6/4/25 at 11:35 AM reveal Staff N, Dietary Aide, did not complete hand hygiene after picking up a stack drinking cup plastic lids that fell on the floor and before resuming resident meal tray preparations 5. Observation during lunch meal service on 6/4/25 at 12:35 PM, in the lower dining room, revealed Staff L picking out tongs from the resident serving pan of barbeque pork steaks with her bare hands and continued to use the tongs. The tongs slipped into the pan of pork steaks a total of 3 times. No gloves or extra serving utensils were noted on the steam table cart During an interview on 6/10/25 at 9:50 AM, the DM acknowledged that hand hygiene should have been completed after picking the plastic lids from the floor. The DM also acknowledged Staff L should not have used her bare hands to remove the tongs from the pan of food. A Food Preparation and Service policy revised 4/2019 revealed the following: a. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness b. Food and nutrition service staff, including nursing services personnel, wash their hands before serving food to residents c. Bare hand contact with food is prohibited. Gloves are worn with handling food directly and changed between tasks d. Foods will not be thawed at room temperature. The food package should be completely submerged in cold running water (70 degrees F or below) that is running fast enough to agitate and remove loose ice particles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Food Receiving and Storage policy revised 10/2017 revealed foods shall be stored in a manner that complies with safe food handling practices. Dry foods stored in bins will be labeled and dated with a use by date. All foods stored in the refrigerator or freezer will be labeled and dated. The U.S. Food and Drug Administration 2017 Food Code (4-904.11) stated (A) Single-service and single use articles and cleaned and sanitized utensils shall be handled, displayed, and dispensed so that contamination of food-and-lip contact surfaces is prevented and (B) Single-service articles that are intended for food or lip-contact shall be furnished with the original wrapper intact.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review, family and staff interviews, and facility policy review, the facility failed to verify patient identifiers before sending transfer paperwork, resulting in the receiving facility obtaining inaccurate medical records for one of three residents reviewed for discharge planning (Res #172). The facility reported a census of 72 residents. Findings include: On 6/3/25 at 9:30 am, a family member of Resident #172 stated the facility sent the incorrect paperwork for her family member to another facility where Resident #172 transferred to. The family member stated when Resident #172 transferred to the other facility, orders were placed incorrectly and the resident did not receive her own medications due to this error for approximately two weeks. She was prescribed psychotropic medications, but did not receive them as ordered, which resulted in a hospitalization related to her mental health. The Discharge Summary for Resident #172, dated 4/17/25, documented the resident's date of birth as 5/12/1954. The Reason for discharge was documented as discharging to [receiving facility]. A clinical record review conducted on 6/4/25 revealed that Resident #172's Electronic Health Record (EHR) contained a file labeled as discharge orders. Page 1 of the six-page document was a fax cover sheet from the facility's contracted healthcare provider group. The cover sheet indicated it was intended for a different facility (neither the transferring nor the receiving facility). While the patient's name on the cover sheet matched that of Resident #172, the date of birth was listed as 5/10/1935. A handwritten note on the cover sheet authorized the transfer to [receiving facility], indicating the same medications and treatments should be continued, with follow up to be conducted by the Advanced Registered Nurse Practitioner (ARNP) affiliated with that facility. The remaining five pages of the document included the diagnoses, allergies, diet order and medication list for the incorrect resident. The Face Sheet (a document that provides a summary of key information about a resident, including patient demographics and medical history highlights) of Resident#172 listed the her primary diagnosis to be schizoaffective disorder (a chronic mental health condition that combines two psychiatric illnesses of schizophrenia and a mood disorder). The Nursing Note dated 4/17/25 at 1:23 pm documented Staff B, Licensed Practical Nurse (LPN) had reviewed discharge instructions with the Assistant Director of Nursing (ADON) at [receiving facility]. On 6/4/25 at 12:25 pm, Staff B, LPN stated he remembered giving report over the telephone to the ADON at the receiving facility. He stated he recalled talking extensively about Resident #172's mental status and her psychiatric diagnosis. He said they talked about how well she had been doing and discussed her current medications and that she had not been having any behaviors recently. He recalled telling the ADON at the receiving facility about her assistance level and her code status as well. He stated he did not send any physical copies of paperwork with her at the time of the transfer as all of that was handled by the facility's social services supervisor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 12:43 pm, the Administrator stated the contracted healthcare provider group oversees both this facility and the receiving facility as well as the third facility named on the paperwork. He stated he was unaware of how the incorrect paperwork would have wound up in the Resident #172's EHR. On 6/4/25 at 12:49 pm, the Social Services Supervisor stated when she saw the paperwork, she noticed it had the wrong facility name on it. She stated she thought the ARNP had just written the wrong name on the cover sheet. She said the paperwork was sent to one of the nurses and it was scanned to her email. She did not know who scanned it to her as the email only shows it came from the scanner. She stated the receiving facility had requested signed orders, and she just forwarded what she received to them. While she noticed the incorrect facility name, she did not check the date or birth or look through the orders. The Social Services Supervisor stated that she had sent the receiving facility all of Resident #172's correct paperwork during the referral so they did have her correct date of birth and medication list from the earlier paperwork. On 6/4/25 at 1:40 pm, when shown the fax cover sheet, the Director of Nursing (DON) stated he assumed that Resident #172 must have at one time lived at the other facility that was named on the cover sheet and that is why it said that. He was aware the contracted healthcare provider group covered multiple facilities. He said someone on staff at this facility received the paperwork and didn't check it over, just forwarded it to social services for the transfer. He was not aware of who received it and forwarded it to social services. On 6/5/25 at 10:40 am, the ARNP stated that she provides care at both the originating and receiving facilities, but not the third facility listed in the transfer paperwork. She recalled being notified of the error when it was identified by staff at the receiving facility. She then gave orders for resident #172 to resume her prior medications and treatments that had been in place prior to transfer. She noted a different ARNP from her medical group oversees the third facility, and she was not aware of how the incorrect resident's paperwork was mistakenly used. The Facility Policy titled Verification of HIPAA Authorization, dated 7/1/14 documented the following: 1. Employees shall obtain a written authorization, signed by the resident/patient, or the resident/patient's legal representative in all situations other than those described for the Treatment, Payment and Operations (TPO); and those required by law. 2. Employees need to review the written authorization for the below information regarding valid authorization. 3. A valid authorization must contain: a. A specific description of the information to be disclosed, including specific types of records and service dates, b. A specific description of the person/agency identified as authorized to disclose the PHI, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The name or other specific identification of the person(s) or entity(ies) to whom disclosure can be made, d. A statement of the purpose of the requested disclosure, including any limitations on the use of the information, e. An expiration date or valid event expiration date AND check that date has not passed nor has the expiration event occurred, f. A signature dated by the resident/patient or the resident/patient's authorized personal representative. If signed by the authorized representative, a description of such representative's authority to act for the resident/patient is provided, g. A statement of the resident/patient's right to revoke the authorization, exceptions to this rights, and a description of how to revoke, h. A statement that treatment, payment, enrollment or eligibility for benefits may NOT be conditioned upon signing the authorization, i. A statement regarding the potential that the information disclosed pursuant to the authorization may be re-disclosed by the recipient and, if so, it may no longer be protected by a federal confidentiality law, and j. A statement that the person signing the authorization has the right to (or will receive) a copy of the authorization. 4. The signed authorization will be filed with the resident/patient's medical record. Authorizations must be retained for at least ten years after the date the cease to be in effect due to the expiration date or revocations. 5. If a signed authorization is received from an individual that is inconsistent with another document from the same individual regarding the use and disclosure of PHI, the requirements of the most restrictive document should be followed.

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	06/10/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #54 had diagnoses of neurogenic bladder, diabetes, and renal insufficiency. The MDS revealed the resident had a indwelling catheter. The care plan initiated 5/25/25 revealed the resident had a Foley catheter due to neurogenic bladder. The care plan directed staff to use enhanced barrier precautions (EBP). The Order Summary revealed orders for catheter care ordered on 05/28/25 and EBP's ordered on 05/14/25. Gown and gloves were required for residents with a indwelling medical device and during high-contact care activities. During observation on 06/02/25 at 01:31 PM, an EBP sign hung on the door to the resident's room. During observation on 06/05/25 at 08:00 AM, an EBP sign hung on the door to the resident's room. The EBP sign indicated a gown and gloves should be worn during high-contact activity and when catheter care performed. Staff F, certified nursing assistant (CNA) washed his hands, donned a pair of gloves, and drained Resident #54's catheter into a graduate container. Staff F picked the graduate container with urine and a paper towel up from the floor and placed the graduate with urine onto an overbed table. Staff F looked at the numbers on the graduate and reported the amount of urine in the graduate. Staff F emptied the graduate with urine into the toilet, rinsed the graduate with water, then placed the graduate into a plastic bag. Staff F removed his gloves and washed his hands. Staff F did not wear a gown when he handled and emptied the catheter. In a interview 06/05/25 at 08:10 AM. Staff F reported EBP used whenever catheter care performed. Staff F reported a gown and gloves should be worn whenever catheter care performed. Based on observations, clinical record review, staff interviews, guidance from the Centers for Disease Control (CDC) and facility policy review the facility failed to follow infection control standards when providing care for 2 of 3 residents observed (Resident #33 and #54). The facility also failed to properly sanitize a mechanical lift in between use on different residents. The facility reported a census of 72 residents. Findings include: 1. The Minimum Data Set (MDS) of Resident #33 dated 5/7/25 coded the resident to be frequently incontinent of bowel and bladder. The MDS documented the presence of a feeding tube. The Active Orders for Resident #33 documented an order for Enhanced Barrier Precautions: Gown and Gloves required for high resident contact care activities, dated 5/14/25. The Care Plan of Resident #33 identified a focus area of alteration in gastro-intestinal status related to the presence of a Gastronomy tube and directed staff to use enhanced barrier precautions, dated 11/11/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/2/25 at 2:00 pm, Staff B, Licensed Practical Nurse (LPN) was observed preparing and administering a tube feeding for Resident #33. Staff B obtained the necessary supplies, including new tubing, the feeding formula and a bag designated for the water flush. He filled the flush bag with water. Staff B performed hand hygiene and donned gloves prior to beginning the procedure. He verified the physician's orders and appropriately connected and initiated the tube feeding. Upon completion, Staff B removed his gloves and washed his hands before exiting the resident's room. No additional Personal Protective Equipment (PPE) was used during the procedure aside from gloves. 2. On 6/4/25 at 11:13 am, Staff B, LPN was observed administering medication through the Gastronomy tube (G-tube) of Resident #33. Staff B performed hand hygiene using hand sanitizer and donned gloves. He poured the medication into a medication cup and withdrew the appropriate amount of medication into a syringe, and discarded the remaining medication. He then removed his gloves and entered the resident's room and then the restroom. He washed his hands and donned a new pair of gloves. Staff B verified g-tube placement via auscultation and checked for residuals which was zero. He stated the physician's orders were to flush 30 milliliters (ml) of water before and after medication administration. He administered the initial 30 mls of water, and then placed the G-tube on a clean split gauze. Staff B then removed his gloves, performed hand hygiene, donned new gloves, and then administered the medication into the G-tube, followed by the second water flush. Following the medication administration, Staff B was asked about Enhanced Barrier Precautions. Staff B acknowledged he had not worn a gown or a mask. He stated this was an error on his part and stated that he should have worn a gown, gloves and mask when the resident's G-tube would be opened, and once it is closed, the additional PPE is not required. 3. On 6/5/35 at 9:35 am, Staff F and Staff G, Certified Nurse Aides (CNA) were observed performing incontinence care for Resident #33. Both staff members performed hand hygiene and donned gloves and gowns. Staff F then grabbed the footboard of the bed to pull the bed further into the room so that Staff G could stand on the other side of the bed. Staff F then reached for the light chain to turn the light on and then used the remote control of the bed to position the bed to the appropriate height. Staff F continued to wear the same gloves he placed on his hands at the beginning of the observation. Staff F then turned the sheet down over Resident #33 and opened his incontinence brief. Using wet wipes, Staff F cleansed the abdomen and groin area of Resident #33, then assisted the resident to turn on his right side. Staff F then cleansed the buttocks of Resident #33 and tucked the soiled brief underneath him. Staff F then removed his gloves, performed hand hygiene and donned new gloves. Staff F obtained a clean adult brief and positioned it under the resident, and assisted the resident back to his back. Staff F secured the clean brief while Staff G disposed of the soiled brief. Staff F, still wearing the same gloves, reached for the remote control of the bed and lowered the head of the bed, and both staff members then repositioned Resident #33 higher up in bed. He then replaced the pillow under the resident's feet. Both staff members then removed their gloves, performed hand hygiene and placed new gloves on their hands. Staff F obtained a clean hospital gown and placed it on Resident #33. Staff G gathered supplies to clean up the room. Both staff members then removed their gowns and gloves and washed their hands prior to leaving the room. Staff F's isolation gown was not secured around his neck and had been observed falling to his shoulders multiple times during the observation. 5. The Minimum Data Set (MDS) Assessment completed on 3/21/25 revealed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8 unable to complete the Brief Interview for Mental Status and is severely impaired for daily decision-making. Resident #8 has a dementia diagnosis and is dependent on staff for all personal cares. The Care Plan, last revised on 5/20/25, reported Resident #8 requires the use of a mechanical lift with 2 staff members for all transfers. During on observation of resident care on 6/5/25 at 9:05 AM, Staff M, Certified Nursing Assistant, and Staff O, Certified Nursing Assistant, both completed personal cares for Resident #8. A mechanical lift was utilized to transfer the resident from their bed to a wheelchair. After Resident #8 left, Staff O remained to clean-up the room after cares. The mechanical lift remained in the room during this time. When Staff O was finished, the mechanical lift was wheeled out of the room and stored in an area around the nursing station. Staff O then went to her next assignment. For the duration of cares, the mechanical lift was not wiped down/disinfected before or after use with Resident #8. During an interview on 6/9/25 at 3:10 PM, Staff B reported equipment should be wiped down after each use. Disinfecting wipes are typically kept on the treatment cart. During an interview on 6/9/25 at 3:15 PM, Staff P, CNA, reported protocol is to wipe down equipment, such as the mechanical lift, after each resident use. They typically find disinfecting wipes either at the nurse's station, where treatment and medication carts are kept, or in the shower room. The policy IPCP Standard and Transmission-based Precautions, last reviewed 8/2024, documented the following: a. If common use of equipment for multiple patients in unavoidable, clean and disinfect such equipment before use on another patient b. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include device care or use (indwelling urinary catheter, feeding tube); Residents with indwelling medical devices such as a catheter were at high risk of acquiring a MDRO's (multidrug resistant organism). An article from the CDC dated 6/28/24 titled Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes documented the following: Point 1. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Point 3. Enhanced Barrier Precautions require the use of gown and gloves only for high-contact resident care activities (unless otherwise indicated as part of Standard Precautions). Residents are not restricted to their rooms and do not require placement in a private room. Enhanced Barrier Precautions also allow residents to participate in group activities. Because Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as Contact Precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. The facility policy IPCP Standard and Transmission-Based Precautions, revised 08/2024 identified Enhanced Barrier Protection (EBP): Used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs (Multiple Drug Resistant Organisms) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. Point a: PPE: The use of gown and gloves for high-contact resident care activities is indicated when Contact Precautions do not otherwise apply, for residents with: i. Wounds and/or indwelling medical devices regardless of known MDRO infection or colonization. Indwelling medical devices include, but are not limited to central lines, peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes and tracheostomies.