STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Jewish Senior Life Center	900 Polk Boulevard Des Moines, IA 50312

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to notify the State Long Term Care (LTC) Ombudsman for 1 of 2 residents reviewed for transfer out of the facility (Resident #19). The facility reported a census of 40 residents. Findings include: Review of the Census list for Resident #19 revealed the resident's status as on hospital leave on 11/6/24 and returned to the facility on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #19 re-admitted to the facility on this date from the hospital. The Notice of Transfer Form to LTC Ombudsman for the facility for November 2024 lacked documentation of Resident #19 being sent to the hospital on [DATE]. In an interview on 3/12/25 at 11:25 AM, Staff K, Accounting Manager and Staff L, admission Coordinator, reported they had been running the report to send to the LTC Ombudsman monthly off of a report generated from their electronic health records (PCC) and it appeared it had not been capturing the hospitalizations. In an interview on 3/13/25 at 11:37 AM, the Administrator stated the facility did not have a policy related to notification of the LTC Ombudsman with transfers or hospitalizations. In an interview on 3/13/25 at 12:30 PM, the Administrator stated it was the expectation that any resident being sent out of the facility be placed on the Notice of Transfer Form to the LTC Ombudsman list.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy review the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 16 residents sampled (Residents #3 and #32). The facility reported a census of 40 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 1/23/25 revealed Resident #3 had diagnoses of Alzheimer's Disease and diabetes. The MDS recorded the resident took an antibiotic. The Order Summary revealed Resident #3 on droplet precautions since 3/5/25. The Progress Notes revealed the following: a. On 3/5/25 at 10:59 AM, the resident tested positive for RSV (respiratory syncytial virus) (infection of the lungs and respiratory tract) on 3/5/25 and placed on droplet isolation. b. On 3/12/25 at 10:41 AM, resident continues on droplet precautions. The Care Plan lacked information or directives for staff to follow current policy and protocol guidelines related to RSV and droplet precautions. 2. The MDS assessment dated [DATE] revealed Resident #32 had diagnoses of dementia and diabetes. The Care Plan revised 3/5/25 revealed the resident had a risk for ineffective airway clearance. The Care Plan directed staff to encourage participation in coughing, deep breathing and forced expiratory techniques. The Care Plan lacked information the resident had a RSV infection, and lacked interventions such as droplet precautions. The Order Summary revealed droplet isolation ordered on 3/5/25. The Progress Notes revealed the following: a. On 3/5/25 at 12:38 PM, an order to obtain a nasal swab for RSV due to the resident's runny nose, loose nonproductive cough, and hoarse voice. b. On 3/5/25 at 1:26 PM, resident placed on droplet isolation pending RSV test result. c. On 3/5/25 at 10:36 PM, resident diagnosed with RSV and on droplet precautions. d. On 3/12/25 at 9:02 AM, resident continues on droplet precautions for RSV. Observations revealed on 3/10/25 at 11:00 AM, a droplet precautions sign hung on the door to Resident #3 and #32's room. A plastic bin with drawers had gowns inside, and a box of masks and box of gloves sat on top of the bin in the hallway. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25 at 11:35 AM, the Director of Nursing (DON) reported the nurses updated the residents' Care Plans. The DON reported she tried to keep an eye on the Care Plans because the nurses didn't always have time to review and update them. During an interview on 3/13/25 at 11:55 AM, Staff A, Licensed Practical Nurse, reported the MDS nurse, the DON, and the Assistant Director of Nursing (ADON) updated the residents' Care Plan. Staff A confirmed Resident #3 and Resident #32 currently on droplet precautions. Staff A reported a mask, gloves, and a gown worn when staff cared for a resident on droplet precautions. In an interview 3/13/25 at 12:05 PM, the MDS Coordinator reported she updated the Care Plans whenever there was a significant change such as a resident had an infection. She added the infection and the related interventions to the Care Plan. The MDS Coordinator acknowledged droplet precautions should be on the Care Plan so staff knew what was expected. An Isolation #34 policy revised 7/9/24 revealed residents with transmittable diseases will be isolated to the degree necessary to assure resident safety. Isolation is necessary at times to prevent the spread of disease between residents and staff. The type of precautions and reason for the isolation documented in the nurse's notes, and the care plan updated as needed. A Comprehensive Resident Plan of Care policy dated 7/9/24 revealed an interdisciplinary team developed and updated the resident's comprehensive care plan including any medical and nursing needs. The RN Assessment Coordinator collaborated on the resident's plan of care with staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility staff failed to assess and document an injury of unknown origin and perform a skin assessment for 1 of 3 residents reviewed for skin injuries (Resident #33). The facility reported a census of 40 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] reveals Resident #33 had diagnoses of Alzheimer's disease, dementia, and muscle weakness. The MDS recorded the resident had a Brief Interview for Mental Status (BIMS) score of 0, indicating severely impaired cognition. The resident also had inattention, disorganized thinking, and wandered daily. The MDS documented the resident had no falls and no skin issues. The MDS indicated the resident had dependence on staff for toileting, bathing, and transfers, and required substantial to maximum assistance for bed mobility. The Care Plan revised 2/9/25 revealed the resident required assistance with activities of daily living (ADL's) related to dementia and confusion. The resident used a wheelchair as her primary mode of transportation. The Care Plan directed staff to use an EZ stand mechanical lift and the assistance of two staff for transfers, and provide assistance of one staff to turn and reposition her in bed. The Care Plan also revealed the resident had occasional agitation and combativeness, and had a risk for impaired skin integrity. The Care Plan revised on 2/22/25 revealed the resident had a bruise on her left arm. The Care Plan directed staff to use caution during transfers and bed mobility to prevent her from striking arms, legs, and hands against any sharp or hard surface, and perform a weekly skin sweep to include measurements and any other notable changes or observations. A Weekly Skin Sweep dated 2/18/25 revealed the resident's skin clean and intact. The Skin and Wound Evaluations revealed the following: a. On 2/21/25, a bruise on the left outer forearm measured 6.3 centimeters (cm) by 4.0 cm. Education provided on bumping the resident's arm. Family and physician notified. b. On 2/25/25, the bruise measured 7.9 cm by 4.4 cm and turning yellow in color. The POC (Plan of Care) Response history for behavior monitoring revealed the resident had behaviors of grabbing and hitting others on 2/17/25, and no behaviors documented on 2/18/25 to 2/21/25. Incident Reports revealed the following: a. On 11/17/24 at 9:36 PM, a skin tear sustained on the posterior left forearm during cares. Steri-strips applied to the area. Staff educated on the importance of making sure the resident's elbows are in prior to moving through the door (during transfers). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 2/22/25 at 3:13 PM, the resident had a dark purple bruise to her left arm measuring 6.31 cm by 3.98 cm. The resident was confused due to dementia and does not know how she obtained the bruise. The resident propels herself in a wheelchair throughout the building. Staff education to use extra care whenever they transferred the resident with an EZ stand mechanical lift and during bed mobility due to her fragile skin. The Progress Notes revealed: a. On 2/18/25 at 2:50 PM, Staff A performed a weekly skin observation. No skin concerns noted. b. On 2/21/25 at 3:47 PM, a new bruise on left forearm appeared black and blue. Physician notified. The Facility's Investigation File revealed: a. A Grievance Report Form filled out by Staff M, Registered Nurse (RN) revealed the resident's family were concerned and upset about the protective sleeves over the resident's arms. The family thinks staff are hiding injuries and think baby powder was applied to the bruise on her left arm. Family wants to know what staff member applied the protective sleeves. There are no orders for protective sleeves. b. Written Staff Statement by Staff E, certified nursing assistant (CNA), dated 2/24/25 revealed Staff E came to work on Thursday night around midnight. During rounds he noticed the resident had a bruise on her left forearm. At the time, the resident was not wearing sleeves on her arms. Staff E reported the bruise to the nurse immediately. Resident #33 is a check and change at night but the night the bruise was discovered, the resident was not incontinent throughout the entire night. Staff E made sure she was ok and in bed. Staff E did not have any issue of the resident resisting cares that night. c. An undated written staff statement by Staff F, Licensed Practical Nurse (LPN), revealed on the night of Wednesday 2/19/25, I did not notice any bruise on the resident's forearms when I worked. d. A typed statement dated 2/25/25 by the MDS Coordinator revealed she was unaware of the resident's bruise until family pointed it out on Friday 2/21/25. I saw no protective sleeves on her until family was asking about them on Friday 2/21/25. The resident got a little feisty when I attempted to take her blood pressure and pulse in the AM but I quickly backed away and it did not become physical. That is the only contact I had with her that day other than taking off the protective sleeves in the afternoon. Family stated I was too rough pulling one of the protective sleeves off. I immediately apologized and became gentler in removing the other sleeve. d. A written statement dated 2/25/25 by Staff A, LPN, revealed Staff A was not aware of any bruise on the resident until Saturday, 2/22/25 (when Staff A came to work). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. A text message at 10:32 AM from Staff G, RN, revealed Staff G worked the last three night shifts and didn't get the message until leaving for work last night. I really don't know anything about the resident in 108. I am not sure what happened or when. I was told it was 109, so that is who I looked at. I was told at 4:15 AM that 109 had a bruise. I checked at 4:30 AM, but did not see anything. I ran off report sheets, did AM medications, gave report, and left. That is all I did, and that is all I was told. I have no further information. Not sure what happened or when. Not sure if it's from a previous blood draw site? Might be worth checking when her last blood draw was. The DON responded back to Staff G at 12:02 PM: I just want to know if you placed the geri-sleeve on Resident #33 or not. Staff G responded to the Director of Nursing (DON) at 6:14 PM: No The DON documented a summary about the incident investigation: a. On 2/21/25 at approximately 12:00 AM, Staff E, CNA, reported a bruise on the resident's left outer forearm to Staff G, RN. When questioned, Staff G denied getting the report about the resident in room [ROOM NUMBER]. On 2/21/25, the MDS Coordinator reported concerns from the resident's spouse. He was concerned the resident had geri-sleeves in place. The resident had never had the geri-sleeves placed previously. A bruise on the left outer forearm was visualized when the geri-sleeves were pulled up. The MDS Coordinator notified the Assistant Director of Nursing (ADON). The ADON went to the resident's room immediately and assessed the resident. The resident had a BIMS of 0 and unable to recall how she got the bruise. A skin evaluation was completed. The Administrator, physician, and DON were made aware of the incident. An investigation was initiated immediately. Upon completion of the investigation, the facility was unable to substantiate that abuse had occurred but recognized areas that could be improved when reporting a bruise of unknown origin. Interventions included to continue to observe and assess bruising until healed, staff education on the abuse policy and reporting to leadership. b. A Termination Report revealed a self-report was submitted on 2/24/25 due to a suspected abuse case on the resident on 2/21/25 and an investigation was initiated. Staff M reported to the ADON that Resident #33 had a bruise of unknown cause. The bruise was originally found by a resident's spouse and he expressed a concern to Staff M. The spouse wanted to know what caused the bruise and why the area was covered. Staff previously assigned to resident was interviewed. Staff E made a statement that he saw the bruise that AM prior to the end of shift and notified Staff G. Several attempts made to call Staff G but no answer. Days later, Staff G confirmed she did not know anything about the bruise and denied applying the geri-sleeves. Geri-sleeves could only be accessed by a nurse who had a key. Several other staff who took care of residents were interviewed and all denied seeing a bruise. No order found for geri-sleeves and no charting found about a bruise on the resident. Due to the suspected abuse allegation and Staff G not being cooperative with the investigation, Staff G was terminated effective 2/24/25. Observation on 3/11/25 at 9:20 AM revealed Resident #33 sat in a wheelchair in the dining area. The resident had a long sleeve shirt on. At the time, Staff A rolled the resident's sleeve up and showed the surveyor the resident's left arm. The resident's left forearm had a darkened faded bruise. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:45 AM, the resident propelled herself in a wheelchair in the dining room. On 3/11/25 at 9:20 AM, the surveyor asked Resident #33 how she got the bruise on her left arm. The resident looked at the surveyor and voiced some words but did not make sense. The resident was unable to tell the surveyor what happened. In an interview on 3/11/25 at 9:25 AM, Staff A, LPN, reported she was not working on the day the resident got the bruise. She was told about the bruise on the resident's arm during shift report when she came in to work on the weekend. In an interview 3/11/25 at 2:35 PM, the MDS Coordinator reported she was in the DON's office when the resident's husband came and told her and the ADON the resident had a bruise on her arm. Nobody knew how the bruise got there. She started to question staff that were working that day, as well as texted the staff that took care of her over those few days. Staff E said he notified Staff G about the bruise. The resident didn't have geri-sleeves on and that is how he noticed the bruise. Resident #33 didn't normally wear geri-sleeves but the resident had geri-sleeves on the day the husband came to talk to the MDS Coordinator. The MDS Coordinator reported geri-sleeves are locked in the medication room and only a nurse could get them. The MDS Coordinator stated she spoke with Staff G. Staff G said Staff E told her the resident had a bruise but she wrote down the wrong room number. She checked the resident in the room number she wrote down. When Staff G checked the resident and didn't see a bruise or anything but Staff G didn't follow up after that. The MDS Coordinator reported she had not noticed the resident wearing geri-sleeves prior to the incident of finding the bruise on her arm. The MDS Coordinator reported the resident had a solid bruise the size of an orange on her left arm. She did not see any finger marks on the resident's arm. The MDS Coordinator reported she talked to Staff D, CNA, who worked the 2 PM - 10 PM shift, Staff H, CNA, had worked the day prior to staff finding the bruise, and Staff I, CNA, who worked on Friday during the day and none of the staff noticed a bruise on the resident. Staff A also reported Staff H, CNA, had given the resident a shower the day before and had not noticed any bruises at that time. The MDS Coordinator stated they narrowed it down to the night nurse knowing something about the bruise but did not do any follow-up after Staff E reported the skin concern to Staff G. The MDS Coordinator reported the resident flailed her arm and staff had to remind her to hold on tight to the EZ Stand (mechanical lift). The resident was very forgetful and had frail, thin skin. She didn't take an anticoagulant or other medications that caused bruises. In an interview 3/11/25 at 5:55 PM, Staff E, CNA, reported he worked 12 AM -6 AM on the night when he found a bruise on Resident #33's arm. He made rounds on residents. When he turned on the light, he noticed a bruise right away on Resident #33's left arm. The resident was in bed sleeping and had her left arm on her abdomen. There were no geri-sleeves on her arms. He let Staff G know right away. Staff E reported Resident #33 is a check and change and she was dry all night. The prior shift lets him know if a resident had behaviors, but there was no mention about Resident #33 having any behaviors that night. Staff sometimes reported she could be difficult. Staff E reported he had not witnessed coworkers being rough or unkind to any of the residents. He would report this immediately to the charge nurse or Administrator if he had witnessed any concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 3/12/25 at 1:40 PM, the DON reported she had worked at the facility since 1/2025 but had worked part-time while she transitioned from her previous job to the DON position. The DON reported the MDS Coordinator found out Resident #33 had a bruise on her arm. The ADON talked to the resident's family member on Friday, 2/21/25. The resident's husband noticed the sleeve on the resident's arm and came to the office. The MDS Coordinator and the ADON went to the resident's room, and removed a sleeve on the resident's arm and did a skin assessment. The DON was told about the bruised area on Monday, 2/24/25, when she came to work. A self-report to DIAL (the Department of Inspections, Appeals, and Licensing) was submitted on 2/24/25. The DON stated she started calling staff on Monday 2/24/25, and provided staff education to notify her when they had concerns, and made staff aware of the process. During the investigations, Staff E, CNA, was the one who found the bruise on the resident's arm on Thursday night when he worked. Staff E said he reported it to Staff G. None of the nurses or CNA's knew anything about a bruise on Thursday 2/20/24. She narrowed it down to when the bruise was discovered but didn't find any documentation about the bruise. There was no skin assessment or progress note documented, and no incident report filled out. Nobody said anything about a skin concern in report. She talked to the resident's husband. She made several attempts to contact Staff G but did not receive a call back. She finally sent a text to Staff G about the incident. Staff G denied getting a notice from Staff E, denied seeing a bruise on Resident #33, and also denied putting geri-sleeves on the resident. The DON stated the nurses are the only ones had access to the room where geri-sleeves are kept. A key is required to get into the room. Staff M worked days and filled out the grievance form. In an interview on 3/12/25 at 1:50 PM, the ADON reported Resident #33's family member came to the office and said I want you to come and look at something. The ADON saw the resident had a geri-sleeve on her left arm. The family member wanted to know why the resident had the sleeve on and wondered if the facility staff were trying to cover something up. The ADON looked under the sleeve and discovered a fairly large round purple bruise on the resident's left forearm. She did not see any finger marks on the area. The ADON stated she asked Staff M if there were any notes about a skin concern. There were no notes or skin assessment documented. Resident #33 was not able to tell them what happened. The resident had dementia. The ADON reported staff used an EZ stand mechanical lift to transfer the resident. The resident didn't like the EZ stand lift, and sometimes fought staff. Resident #33 was mobile in her wheelchair and she thought maybe the resident bumped her arm on something, but she was not sure how the resident got the bruise. The surveyor attempted to contact Staff G, RN, on 3/12/25 at 9:25 AM, 3/12/25 at 6:25 PM, and 3/13/25 at 8:35 AM. Staff G failed to respond to voice and text messages. During an interview on 3/13/25 at 11:55 AM, Staff A, LPN, reported skin assessments completed by the nurses. Skin assessments documented under the skin assessments. In an interview 3/13/25 at 12:05 PM, the MDS Coordinator reported a skin sweep performed on all of the residents weekly. A Weekly Skin Assessments policy dated 7/9/24 revealed the nurse who finds a new skin issue completed the initial skin assessment in the electronic health record, including a risk management (incident report) and notified the physician and family. The skin assessment is printed and placed in the skin book located at the nurse's station for continued monitoring and follow up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Abuse Prevention Policy and Procedure revised 7/9/24 revealed employees must report any suspicious event that may constitute abuse. Any events of unknown origin are investigated. An allegation of abuse reported to the state agency as soon as possible, but not to exceed 24 hours.

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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 observation, staff interview, and policy review, the facility failed to ensure proper infection control practices to reduce the risk of contamination and food-borne illness during meal service. The facility reported a census of 40 residents. Findings include: On 3/11/25 the facility lunch menu included the following: lemon scallopini with pasta seasoned peas breadstick fresh fruit cup funfetti blondie In an observation on 3/11/25 starting at 11:45 AM during the lunch meal service, Staff J, Cook, used gloved hands to serve the meal and only changed his gloves and performed hand hygiene one time throughout the entire meal service. Staff J touched plates, utensils, refrigerators, lids, and transportation carts with gloved hands during the service. He further touched the seasoned peas on each plate he prepared with gloved hands to keep them from rolling around the plate, used his gloved hands to get parsley from a bowl to sprinkle on top of the scallopini, and touched the spaghetti with his gloved hands to remove dark overcooked pasta from the residents plates or pasta that was hanging over the edge of the plate and put it back on the residents plates. Staff J touched sandwiches being served to residents with his gloved hands, held toaster waffles in his gloved hands after toasted, retrieved a piece of lettuce from a refrigerator and carried it with his gloved hands to rinse it in the sink and placed it on a sandwich, touched a grilled cheese sandwich with his gloved hands to turn it in the frying pan and held on to breadsticks with his gloved hands when cutting them up for the residents with a knife. In an interview on 3/13/25 at 12:27 PM, the Administrator stated it was the expectation that kitchen staff not wear gloves unless used for ready-to-eat foods. She stated gloves gave the staff a false sense of security. A facility provided policy titled Food Preparation and Service, with no date noted, stated: Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. Gloves can become contaminated and/or soiled and must be changed between tasks. Disposable gloves are single-use items and shall be discarded after each use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interview, facility policy review, and the Center for Disease Control (CDC) guidelines, the facility failed to follow infection control practices for three of three residents on droplet precautions (Resident # 3, #30, and #32) and prevent the potential spread of infection to other residents and staff. The facility staff also failed to handle soiled linens to prevent the potential spread of infection for 1 of 2 nursing units. The facility reported a census of 40 residents. Findings include: 1. The Minimum Data Set (MDS) Assessment tool dated 1/23/25 revealed Resident #3 had diagnoses of Alzheimer's Disease and diabetes. The MDS indicated the resident required supervision and touching assistance for eating. The MDS recorded the resident took an antibiotic. The Care Plan lacked information or directives for staff to follow current policy and protocol guidelines related to respiratory syncytial virus (RSV) (a respiratory infection) and droplet precautions. The Order Summary revealed Resident #3 on droplet precautions since 3/5/25. The Progress Notes revealed the following: a. On 3/5/25 at 10:59 AM, the resident tested positive for RSV on 3/5/25 and had an order for droplet isolation. b. On 3/10/25 at 3:26 PM, resident continued on droplet precautions for RSV. The resident continued to have a loose cough and nasal drainage. c. On 3/12/25 at 10:41 AM, resident continued on droplet precautions. He continued to have a loose productive cough and occasional runny nose. Lungs remained diminished after coughing. 2. The MDS assessment dated [DATE] revealed Resident #30 had diagnoses of Alzheimer's Disease and dementia. The resident required substantial to maximum assistance for eating. The Care Plan revised 3/7/25 revealed the resident had a risk for altered respiratory status and difficulty breathing related to RSV. The resident required assistance with feeding at mealtime. The Care Plan lacked staff directives regarding interventions for droplet precautions. The Order Summary lacked an order for droplet precautions. The Progress Notes revealed the following: a. On 3/5/25 at 4:39 PM, resident placed on droplet precautions because she had an occasional cough and hoarse voice. b. On 3/6/25 at 8:50 AM, resident had a cough and runny nose. Viral nasal swab obtained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165006	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Iowa Jewish Senior Life Center	900 Polk Boulevard Des Moines, IA 50312

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 3/6/25 at 10:45 PM, lab results revealed the resident tested positive for RSV. Droplet precautions continued. d. On 3/12/25 at 9:16 AM, resident continued on droplet precautions. 3. The MDS assessment dated [DATE] revealed Resident #32 had diagnoses of dementia and diabetes. The resident required set-up assistance for eating. The Care Plan revised 3/5/25 revealed the resident had a risk for ineffective airway clearance. The Care Plan directed staff to encourage participation in coughing, deep breathing, and forced expiratory techniques. The Care Plan lacked information the resident had a RSV infection and lacked interventions such as droplet precautions. The Order Summary revealed a viral nose swab for cough, runny nose, and hoarse voice completed on 3/5/25, and droplet isolation ordered on 3/5/25. The Progress Notes revealed the following: a. On 3/5/25 at 12:38 PM, nasal swab for RSV due to runny nose, loose nonproductive cough, and a hoarse voice. b. On 3/5/25 at 1:26 PM, resident placed on droplet isolation pending RSV test result. c. On 3/5/25 at 10:36 PM, resident diagnosed with RSV and on droplet precautions. d. On 3/12/25 at 9:02 AM, resident continued on droplet precautions for RSV. Resident had loose cough, occasional nasal drainage, and diminished lung sounds. Observations revealed the following: a. On 3/10/25 at 11:00 AM, a droplet precautions sign hung on the door to Resident #3, #30, and #32's room. A plastic bin with drawers had gowns inside, and a box of masks and box of gloves sat on top of the bin in the hallway. b. On 3/10/25 at 12:10 PM, Staff A, Licensed Practical Nurse (LPN), sat in front of Resident #3 in the common area and fed the resident food from a styrofoam bowl. Staff A wore a mask but no gown worn while she fed the resident. c. On 3/10/25 at 12:10 PM, Staff C, certified nursing assistant (CNA), sat next to Resident #30 and fed the resident food from a styrofoam containers. Staff C wore a mask but no gown worn while she fed the resident. Resident #32 sat in a recliner next to Resident #30. d. On 3/11/25 at 10:50 AM, Resident #3, #30, and #32 sat in recliners in the common area. e. On 3/11/25 at 11:30 AM, Staff A sat by Resident #3 and fed the resident food from a styrofoam container. Staff A wore a mask but no gown or gloves worn. Staff D, CNA, sat by Resident #30 and fed the resident food from a styrofoam container. Staff D did not wear a gown while she fed the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/25 at 11:55 AM, Staff A, LPN, stated staff needed to wear a mask, gloves, and a gown before entrance to the resident's room whenever a resident was on droplet precautions. Staff A confirmed Resident #3, #30, and Resident #32 on droplet precautions. Staff A reported the residents on droplet precautions were difficult to confine to their rooms due to their diagnoses so the staff tried to keep the residents on droplet precautions separate from the other residents. In an interview 3/13/25 at 12:05 PM, the MDS Coordinator reported she was not in the facility when the residents were diagnosed with RSV. The MDS Coordinator acknowledged droplet precautions should be on the Care Plan so staff knew what was expected. A droplet precautions sign posted on the resident's room door, and gown, gloves, and mask worn during cares and whenever staff entered the room. An Infection Control policy revised 7/9/24 revealed procedures were necessary to decrease and prevent the spread of infections in both resident and staff populations. The facility assisted staff in creating an environment to contain infections and to keep negative outcomes at a minimum. Policies and procedures defined the indications for isolation and were based on CDC disease guidelines and criteria. An Isolation #34 policy revised 7/9/24 revealed residents with transmittable diseases will be isolated to the degree necessary to assure resident safety to prevent the spread of disease between residents and staff. Isolation precautions were based on the CDC guidelines. An isolation precautions sign is placed on the resident's room number and specified the protective equipment needed (such as a gown, gloves, and mask). The type of isolation precautions and the reason for isolation are documented in the nurse's notes. Droplet precautions prevented the transmission of diseases spread by respiratory droplets through coughing, sneezing, or talking. PPE for droplet precautions included a face mask. A CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings updated 9/2024 revealed respiratory droplets are generated when an infected person coughs, sneezes, or talks. The CDC recommended healthcare personnel to don personal protective equipment (gowns, gloves, mask) upon entry into the patient's room for patients who are on droplet precautions since the nature of the interaction with the patient cannot be predicted with certainty and contaminated environmental surfaces are important sources for transmission of pathogens. Isolation gowns are used to protect the healthcare worker's arms and exposed body areas and prevent contamination of clothing with body fluids and other potentially infectious material. 4. During observation on 3/12/25 at 08:00 AM, Staff B, housekeeper, walked down the 200 hall carrying bed linens under her arm and against her uniform. Staff B opened the lid on the soiled linen cart in the hallway and placed the soiled linens inside the cart, pushing the linens down with her gloved hands and closed the lid. Staff B then pushed the soiled linen cart down the hall to a soiled utility room in the 300 hall. In an interview on 3/13/25 at 12:30 PM, the Infection Preventionist reported she expected staff placed soiled linens in a bag and into the soiled linen cart. Soiled linens should not be carried against the staff's uniform. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Linens policy dated 6/15/24 revealed linens maintained in a manner to ensure infection prevention and control. Proper linen management is crucial to breaking the chain of infection. Pathogen transmission can occur through direct contact with contaminated linens. Handling of used linens should be minimized including not holding linens close to the body. Used linens shall be placed in designated bags or other containers for transport at the point of use.