STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105809	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Center	10676 Marvin Jones Blvd Live Oak, FL 32060

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40559 Based on record review and interview, the facility failed to conduct a comprehensive assessment in accordance with the specified submission timeframes for 1 of 4 residents reviewed for discharge status, Resident #8. Findings include: Review of Resident #8's medical records showed the resident was admitted on [DATE] with diagnoses including fracture of upper end of right humerus, hypertension, chronic pain syndrome, GERD (Gastroesophageal Reflux Disease), and anxiety disorder. Review of Resident #8's physician order dated 5/23/2024 showed it read, Discharge Home with Home Health Care. PT [Physical Therapy] to Evaluate and Treat as Required. Review of Resident #8's Interdisciplinary Notes dated 5/22/24 showed it read, Today SW [Social Worker] informed [Resident #8's Name] that her last day of therapy is 05/27/24 and her daughter will be picking her up on 5/28/24. [Resident #8's name] agreed. Review of Resident #8's transfer history showed the resident was discharged to home on 5/28/2024 at 2:00 PM. Review of Resident #8's electronic file did not show a Discharge MDS (Minimum Data Set) Assessment conducted when the resident was discharged on [DATE]. During an interview on 10/29/2024 at 2:45 PM, the MDS Coordinator, RN (Registered Nurse), stated, [Resident #8's Name] discharged and went home. The discharge assessment was not opened. Review of the facility policy and procedure titled Resident Assessments with the last review date of 8/20/2024 showed it read, Policy Statement. A comprehensive assessment of each resident is completed at intervals designated by OBRA [Omnibus Budget Reconciliation Act] regulations and PPS [Prospective Payment System] requirements . Policy Interpretation and Implementation: 1. OBRA-Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include . g. Discharge Assessment (return anticipated and return not anticipated).

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46523 Based on observation, interview, and record review, the facility failed to ensure accuracy of the Minimum Data Set (MDS) assessment for 1 of 4 residents reviewed for nutrition, Resident #84, for 2 of 4 residents reviewed for discharge, Residents #70 and #117, and for 1 of 5 residents reviewed for unnecessary medication, Resident #219. Findings include: 1) Review of Resident #84's physician order dated [DATE] showed it read, Soft and Bite Sized/Thin Liquids. Review of Resident #84's Quarterly MDS dated [DATE] revealed no nutritional approach of a mechanically altered diet. During an interview on [DATE] at 3:00 PM, the MDS Coordinator, Registered Nurse (RN), stated, It should have been triggered. Any diet that is not regular should be triggered. The dietitian is the one who fills out that section. It will have to be modified. During an interview on [DATE] at 1:00 PM, the Registered Dietitian stated, Based on [Resident #84' name] dietary order, the section for mechanically altered diet should have been coded in the assessment. 49777 2) Review of Resident #117's medical records showed the resident was admitted on [DATE] with diagnoses including fracture of unspecified part of neck of left femur, chronic obstructive pulmonary disease (COPD), and iron deficiency anemia. Review of Resident #117's interdisciplinary notes dated [DATE] at 8:30 AM showed that the resident was transferred to a local hospice facility in lake city at 12:27 AM. Review of Resident #117's MDS dated [DATE] showed the resident was discharged to short-term general hospital under section A2105- Discharge Status. During an interview on [DATE] at 3:01 PM, the MDS Coordinator, RN, stated, I did this one. I was sure [Resident #117's name] went to hospital. He should have been coded a 10- discharge status hospice (institutional facility). 49289 3) Review of Resident #70's nursing note dated [DATE] showed it read, Resident's body was released to [name of funeral home, city, and state] at 3:50 PM. Review of Resident #70's physician order dated [DATE] showed it read, Discontinue as of [DATE]; Release body to [name of funeral home, city, and state]; expired. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #70's MDS dated [DATE] showed it read, Section A2105. Discharge Status . 08. Intermediate Care Facility. During an interview on [DATE] at 12:22 PM, the MDS Coordinator, RN, stated, I should have put [code] 13 for 'deceased ' not [code] 8 for Intermediate Care Facility. I don't know what happened. I coded it wrong. [Resident #70's name] was deceased . We use the electronic RAI [Resident Assessment Instrument] Manual for policies and procedures on the MDS process. We don't have a printed policy because the RAI Manual is updated so often. 50123 4) Review of Resident #219's physician order dated [DATE] showed it read, Plavix 75 mg [milligram] by mouth once daily. Review of Resident #219's MDS dated [DATE] revealed that the resident was not receiving antiplatelet medication under Section N0415: High Risk Drug Classes-Use and Indication. During an interview on [DATE] at 10:00 AM, the MDS Coordinator, RN, stated, The system automatically triggers the classes. [Resident #219's name] is taking Plavix. I need to modify it. Review of the facility policy and procedure titled Resident Assessments with the last review date of [DATE] showed it read, Policy Interpretation and Implementation . 11. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to accuracy of such information. 12. Information in the MDS assessment will consistently reflect information in the progress notes, plans of care and resident observations/interviews.

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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** 49289 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for behaviors for 1 of 4 residents reviewed for nutritional services (Residents #74). Findings include: 1) Review of Resident #74's medical record revealed the resident was admitted on [DATE] with the diagnoses including mood disorder, anxiety disorder, dementia, and chronic congestive heart failure. Review of Resident #74's care plan dated 1/17/2024 revealed a focus for nutritional status that read, [Resident #74's name] dietary needs are sufficient at this time related to adequate PO [by mouth] intake . (A [Approach]) Resident prefers to eat on the dining room. Further review of the care plan revealed a focus for activities that read, [Resident #74's name] has potential for altered activity pursuit pattern, is at risk for social isolation. There was no care plan focus or intervention for behaviors related to eating in the dining room. During an observation on 10/28/2024 at 12:40 PM, Resident #74 was sitting at a table by herself outside of the nursing station in front of the television in the resident common area. There were no other residents in the common area. Several residents were sitting together at the tables in the dining room waiting for the afternoon meal service. At 12:45 PM, Resident #74 received a meal tray in the common area and began to eat her food and drink her fluids. At 1:07 PM, Resident #74 entered the dining room and Staff A, Certified Nursing Assistant (CNA), redirected the resident back to her chair and table in the common area away from the dining room. During an interview on 10/28/2024 at 1:07 PM, Staff A, CNA, stated, We put [Resident #74's name] out in the common area by herself away from the other residents for all her meals. She gets up a lot and wanders around and she puts her hands in other resident's plates, so we keep her out here for meals. She tries to carry her tray around the unit. During an observation on 10/29/2024 at 12:30 PM, Resident #74 was sitting at a table by herself near a side entrance/exit to the outdoor patio. There were no other residents or staff in the common area. Several residents were sitting together at the tables in the dining room. At 12:55 PM, Resident #74 received her afternoon meal tray consisting of a bowl of taco meat and vegetables, and a cup of chocolate milk with a sip cover. Resident #74 ate by herself while the nursing staff assisted other residents in the dining room or in their rooms, with meal delivery and setup. Resident #74 remained alone until she finished eating at 1:10 PM when she brought her bowl and cup to the dining cart in the dining room. During an observation on 10/30/2024 at 7:52 AM, Resident #74 was sitting by herself near a side entrance/exit to the outdoor patio. There were no other residents or staff in the common area. Several residents were sitting together at the tables in the dining room waiting for the morning meal tray service. Resident #74 ate by herself in the common area until 8:10 AM when she brought her bowl and drink cup to the tray cart in the dining room. (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 10/30/2024 at 8:10 AM, Staff B, Licensed Practical Nurse (LPN), stated, It's better for her to eat alone where we can watch her. I believe she is care planned for not eating in the dining room. During an interview on 10/30/2024 at 9:50 AM, the Director of Nursing stated, I know that staff often seat [Resident #74's name] by herself in the common area away from the other residents for her behaviors. She wouldn't be care planned for dining alone or away from the dining room. If her preferences are the dining room, then the care plan should be based on her behaviors, whether she eats in the dining room or not. Review of the facility policy and procedure titled, Care Area Assessments last reviewed on 8/20/2024, showed it read, Policy Statement: Care area assessments (CAAs) are used to help analyze data obtained from the MDS [Minimum Data Set] and to develop individualized care plans. Policy Interpretation and Implementation . 2. The care area assessments (CAAs) process consists of the following steps . c. Define the problem(s): (1) Identify the functional, physical, and/or behavioral implications of the problem(s) . d. Make decisions about the care plan . (2) Evaluate the resident's goals, wishes, strengths, and needs . e. Document interventions on the care plan. Review of the facility policy and procedures titled Care Plans, Comprehensive Person-Centered last reviewed on 8/20/2024, showed it read, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychological and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation . 7. The comprehensive, person-centered care plan . b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable psychical, mental, and psychosocial well-being, including . c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions.