STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Home & Rehabilitative Center	231 N Jackson St Oakland City, IN 47660

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on interview and record review, the facility failed to accommodate a resident's choice of funeral home for 1 of 1 residents reviewed for death (Resident 218). A resident's body was released to a funeral home that was not designated as the resident's choice. Finding includes: On [DATE] at 10:37 A.M., Resident 218's clinical record was reviewed. Diagnoses included, but were not limited to, intellectual disabilities. The Death in Facility Minimum Data Set (MDS) Assessment indicated Resident 218 died at the facility on [DATE]. Physician orders included, but were not limited to: May release remains to funeral home of choice, dated [DATE]. Resident 218's facesheet listed (name of Crematorium) as the resident's preferred funeral home. A nursing progress note, dated [DATE] at 5:24 P.M., indicated the resident was found without respirations or pulse in her room, and (name of Crematorium) would be called when the family was ready. A nursing progress note, dated [DATE] at 6:56 P.M., indicated (name of Crematorium) was called. A nursing progress note, dated [DATE] at 8:50 P.M., indicated (name of Crematorium) left the building with Resident 218. The Burial Transit Permit, dated [DATE], indicated authorization was granted to release the remains to (name of Crematorium). It indicated that the individual that picked up the remains at the facility was from (name of Funeral Home). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:20 A.M., Resident 218's Health Care Power of Attorney (POA) indicated that she left the faciity on [DATE] after Resident 218 died and before the resident's remains were picked up. On [DATE], she called (name of Crematorium) to make arrangements for the resident and was told they did not have Resident 218's body and had never received a phone call from the facility to pick up Resident 218's body. The POA called the facility to determine where Resident 218 had gone and they informed her that someone from (name of Crematorium) had picked up Resident 218 the night of [DATE], and they would need to investigate further. Resident 218's POA discovered where the resident had been taken when (name of Funeral Home) called later to make arrangements for Resident 218's body. The POA indicated the facility never noticed or caught that they allowed an unauthorized person to enter the building and to take Resident 218's body to an unapproved location. During an interview on [DATE] at 1:16 P.M., Registered Nurse (RN) 5 indicated that when a resident died , the nurse in charge got the preferred funeral home from the resident's facesheet or from the POA. Staff could look in a binder that contained all the funeral home numbers or search for the funeral home's phone number on the internet. During an interview on [DATE] at 2:51 P.M., the Director of Nursing (DON) indicated that the facility called (name of Crematorium) to pick up Resident 218, but (name of Funeral Home) picked up Resident 218. She indicated staff didn't look to confirm if the person picking up the body was the same person the body was authorized to be released to because Burial Transit Permits got signed as the body was leaving the facility. During an interview on [DATE] at 3:03 P.M., the general manager from (name of Crematorium) indicated they never received a phone call from the facility regarding Resident 218. She also indicated they do not share staff or an answering service with (name of Funeral Home). During an interview on [DATE] at 3:20 P.M., the general manager from (name of Funeral Home) indicated someone from the facility called their after-hours answering service on [DATE] to pick up Resident 218's body. She indicated they do not share staff or an answering service with (name of Crematorium). On [DATE] at 1:19 P.M., the Administrator provided a statement signed by the Administrator, dated [DATE], that indicated The paperwork our team filled out also showed [name of Crematorium] is the funeral home [name of facility] was releasing the body too [sic] and signed off by one of my RN's . The signature of the funeral home that picked up the resident did state he was from [name of Funeral Home] once he signed the paperwork and left with the resident. Our records show [name of Funeral Home] was never contacted nor even part of the resident's face sheet. On [DATE] at 10:40 A.M., the Administrator provided a Resident's Rights policy, dated ,d+[DATE], that indicated The Resident has a right to a dignified existence, self-determination and communication with, and access to, persons and services inside and outside the Facility . 3XXX,d+[DATE](u)(3)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48057 Based on interview and record review, the facility failed to ensure notification to family or physician was provided for changes in condition for 2 of 3 residents reviewed for notification of change. (Resident 58 and Resident 218) Findings include: 1. On 1/3/25 at 2:53 P.M., Resident 58's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 12/30/24, indicated Resident 58's cognition was too low to assess and was completely dependent on staff (staff do all of the work) for toileting, bathing, and transfers. A nursing progress note, dated 12/31/24 5:50 A.M., indicated staff found a 12 inch piece of cloth in Resident 58's stool while performing incontinence care, that Resident 58 had been eating pieces of his blanket. An Interdisciplinary Team (IDT) Behavior Review Note, dated 12/31/2024 09:22 A.M., indicated the root cause of Resident 58 eating his blanket was possible urinary tract infection (UTI) with increased confusion and labs were to be ordered. The clinical record, including progress notes, events, observations, and documents, from 12/31/24 at 9:22 A. M. until 1/8/24 at 3:15 P.M., lacked notification to family or physician regarding Resident 58 eating his blanket and pieces of blanket found in his stool, and lacked labs completed to rule out a urinary tract infection or intestinal blockage. During an interview on 1/8/25 at 2:20 P.M., the Director of Nursing (DON) indicated a urinalysis was not performed and no further follow up was documented because the blanket was removed from the resident's room. A nursing progress note, dated 1/6/25 at 4:10 A.M., indicated Resident 58 had congested coughing with coarse bilateral breath sounds in the upper lobes, oxygen saturation 90% on room air, and was afebrile. The clinical record, including progress notes, events, observations, and documents, 1/6/24 at 4:10 A.M. to 1/9/24 at 9:30 A.M., lacked notification to family or physician or follow up documented regarding Resident 58's change in condition. 48147 2. On 1/8/25 at 10:37 A.M., Resident 218's clinical record was reviewed. Diagnoses included, but were not limited to, intellectual disabilities. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 10/16/24, indicated Resident 218 was cognitively intact and required supervision of staff for transferring and toileting and setup assistance for eating. Care plans included, but were not limited to: Resident has been determined to be Intellectually Disabled, dated 5/8/24, with an intervention to involve family in care. Resident experiences short memory deficit with impaired decision making ability. Brief Interview for Mental Status (BIMS) score fluctuates, dated 5/12/24 A New Order Event Report, dated 8/5/24 at 2:20 P.M., indicated a new appointment with (name of Doctor) had been made for 8/19/24 at 9:00 A.M. to evaluate a probable cyst on Resident 218's left armpit. Resident 218's representative was notified of the appointment. A nursing progress note, dated 8/19/24 at 8:20 A.M., indicated the mass on Resident 218's left armpit had popped and was gone. The appointment scheduled for that morning was canceled. The clinical record lacked a progress note or event to indicate Resident 218's representative was notified of the canceled appointment or the change with the resident's mass in the armpit. During an interview on 1/3/25 at 9:20 A.M., Resident 218's representative indicated the facility did not notify her that the cyst in the resident's armpit had ruptured and the appointment was canceled. The representative indicated she found out about the missed appointment when she received a no show message from the Doctor. At that time, she indicated Resident 218 had an intellectual disability that caused the resident to be mentally equivalent to a five-year-old. During an interview on 1/8/25 at 1:16 P.M., Registered Nurse (RN) 5 indicated the nurse in charge would notify families about falls, change in condition, new orders, weight changes, wounds, new roommates, room changes, new appointments, and canceled appointments. All notifications to family were documented in the progress notes. During an interview on 1/9/25 at 1:19 P.M., the Administrator indicated staff would not notify a resident representative about an appointment cancellation if the resident's BIMS score was a 13 or higher (indicating no cognitive impairment) even if the resident's BIMS score fluctuated or the resident had an intellectual disability that hindered the resident's cognitive ability. On 1/9/25 at 10:40 A.M., the Administrator provided a Resident Change of Condition policy, dated 11/2015, that indicated It is the policy of this Community that changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs . The nurse in charge is responsible for notification of physician and family/responsible party prior to end of assigned shift when a significant change in the resident's condition is noted. If unable to reach the physician or family/responsible party, all calls to physicians or exchanges and family/responsible party requesting callbacks will be documented in the resident care notes. Document resident change of condition and response on the resident care notes and continue in the nursing progress notes if necessary. Documentation will include time and family/physician response. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 10:40 A.M., the Administrator provided a Resident's Rights policy, dated 11/2015, that indicated Every resident and the responsible party of his responsible family member of his guardian has the right to be fully informed of the resident's medical condition unless medically contraindicated and documented by a physician in the resident's medical record . The resident's responsible party or family member or his guardian shall be notified immediately of any accident, sudden illness, disease, unexplained absence, or anything unusual involving the resident . 3.1-5(a)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48057 Based on record review and interview, the facility failed to follow pharmacy recommendations for 1 of 1 residents reviewed for hospice services. (Resident 58) Finding includes: On 1/3/25 at 2:53 P.M., Resident 58's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease. The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 12/30/24, indicated Resident 58 was completely dependent on staff (staff do all of the work) for toileting, bathing, and transfers. Current physician orders included, but were not limited to: lorazepam (antianxiety medication) tablet; 0.5 mg (milligram) oral every 30 minutes as needed, Start date 11/28/24. hyoscyamine sulfate (muscle relaxant) tablet; 0.125 mg oral every two hours as needed, Start date 9/27/24. morphine concentrate (pain medication) solution 10 mg/0.5 mL (milliliter) every 15 minutes as needed, 9/30/24. A nursing progress note dated 12/19/24 at 2:40 P.M., indicated hospice services would be discontinued on 12/23/24. Resident 58 received the following medications after discharge from hospice on the following dates and times: 12/25/24 4:24 A.M. lorazepam tablet 0.5 mg 12/24/24 9:28 A.M. morphine concentrate 0.5 mL 12/26/24 5:05 A.M. morphine concentrate 0.5 mL A pharmacy consultation report, dated 12/24/24, indicated the pharmacist requested clarification on medications currently prescribed to Resident 58, stating if hospice had been discontinued to obtain orders to discontinue hospice related orders for lorazepam, hyoscamine, and morphine. The clinical record lacked physician review of the pharmacist recommendations. During an interview on 1/8/25 at 2:20 P.M., the Director of Nursing indicated Resident 58 no longer received hospice services. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 10:38 A.M., the Administrator provided a policy titled Medication Regimen Reviews and Pharmacy Recommendations, revised 10/2018, that indicated The consultant pharmacist recommendations will be reviewed by the Director of Nursing and the attending Physician will be notified promptly of any recommendations needing immediate attention. On 1/9/25 at 10:38 A.M., the Administrator provided a policy titled Psychotropic Management, revised 9/24, that indicated PRN (as needed) orders for psychotropic drugs are limited to 14 days unless it is deemed appropriate to use longer by the physician or prescribing practitioner. The prescriber must document their rationale in the medical record including the duration (this does not apply to PRN anypsychotic medication which must be evaluated every 14 days). 3.1-25(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 2 of 2 kitchen observations. Food was not labeled correctly and expired food was not disposed of from the reach in refrigerator. (Kitchen, spice rack, reach-in refrigerator) Findings include: On [DATE] at 9:25 A.M., during the initial tour the following were observed in the reach in refrigerator: 1 container of sausage links prepared [DATE] with a discard date of [DATE] 2 containers of cheese with no open date 1 container of chicken soup with no open date 1 jar of grape jelly with no open date 1 container of pasta dated [DATE] with expiration date of [DATE] 1 bag of salad with no open date 1 bag of salad with use by dated of [DATE] On [DATE] at 9:40 A.M., the following were observed in the dry storage: 2 bags of dry noodles with no open date 1 box of potatoes with no open date 1 empty bread rack on the floor 1 moldy onion in a box with no open date On [DATE] at 9:50 A.M., the following was observed on a metal spice rack in the dry storage area: 1 bottle of Karo Syrup with no open date 1 bottle of Soy Sauce with no open date 1 container of Ground Mustard with a use by date of [DATE] 1 container of Lemon Pepper with no open date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 jar of Pork Base with no open date 1 container of Basil with no open date 1 bottle of Honey with open date [DATE] 1 container of Sugar Sprinkles with no open date On [DATE] at 11:25 A.M., during a second kitchen observation the following were observed under the metal preparation table in the center of the kitchen: Flour bin with open date [DATE] and use by date of [DATE] 1 container of Leaf Basil with no open date During an interview on [DATE] at 9:40 A.M., the dietary manager indicated containers should be dated with open date and there should be no expired items in the refrigerator. On [DATE] at 10:30 A.M., the Administrator provided a current policy Food Storage revised ,d+[DATE]. The policy indicated .Left over prepared food .must clearly be labeled with the name of the product, the date prepare, and marked to indicate the date by which the food shall be consumed .left overs can be held .for no more than 3 days .Dry Storage containers should be labeled on and dated on both the container and the lid . 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(3)

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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. 48057 Based on observation and record review, the facility failed to ensure infection control procedures were followed for hand washing technique for 1 of 1 observations of wound care. (Resident 13) Finding includes: On 1/3/25 at 2:16 P.M., Resident 13's clinical record was reviewed. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 11/22/24, indicated Resident 13 had one stage four pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle). Current physician orders included, but were not limited to: Coccyx Pressure Cleanse with wound cleanser, apply Hydrofera Blue (an antibacterial foam dressing used to pack deep wounds), Leave Hydrofera Blue to wound base for seven days, secure with bordered foam dressing. change foam dressing daily and as needed. Start date 1/3/25 During an observation on 1/8/25 at 9:15 A.M., Licensed Practical Nurse (LPN) 12 entered Resident 13's room and put a protective gown on. LPN 12 washed her hands for nine seconds, and put gloves on. Qualified Medication Aide (QMA) 7 was in room with gown on assisting Resident 13 rolled on her left side. LPN 12 opened packs of gauze and a dressing, sprayed wound cleanser to the coccyx wound, applied the dressing over the coccyx wound, and dated the dressing with a marker. LPN 12 removed her gloves, and washed her hands for seven seconds. QMA 7 removed her gloves and gown, and washed her hands for ten seconds. During an interview on 1/9/25 at 8:59 A.M., the Infection Prevention RN indicated hand hygiene should be performed for at least 20 seconds. On 1/9/25 at 10:38 A.M., the Administrator provided a policy titled Hand Hygiene Policy, revised 12/2021, that indicated American Senior Communities will follow the Center for Disease and Prevention (CDC) guidelines for the standards of hand hygiene. (Scrub your hands for at least 20 seconds) Five moments of hand hygiene - a term that describes the hand hygiene opportunities that prevent infection transmission linked to healthcare activities. Before touching a resident, before clean/aseptic procedure, after body fluid exposure risk, after touching a resident, after touching resident surroundings. 3.1-18(l)