

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Davenport		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Waverly Road Davenport, IA 52804	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>26529</p> <p>Based on observation, clinical record review, and resident, resident family member and staff interviews, the facility failed to respond to activated call lights within in 15 minutes for 4 of 6 (Resident's #3, #4, #6, and #2) residents reviewed for call lights. The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>1. The 8/29/24 Minimum Data Set (MDS) Assessment tool revealed Resident #3 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. The MDS assessed the resident required substantial staff assistance to reposition in bed, transfer to and from bed or chair, for bathing, dressing and use of the toilet. The assessment revealed Resident #3 frequently incontinent of urine.</p> <p>During an interview on 10/17/24 at 10:36 a.m., Resident #3 stated she used the call light several times a day, completely dependent on staff for assistance when she was in bed, it usually took staff 45 minutes to an hour to answer her call light, rarely 30 minutes or less and she had been incontinent as a result of having to wait that long for staff response to her call light when she had to go to the bathroom. The resident stated it was an ongoing problem, she had discussed it with management staff and there had not been any improvement.</p> <p>2. The 7/18/24 MDS Assessment tool revealed Resident #4 scored 14 out of 15 on the BIMS, indicating intact cognition. The MDS assessed the resident required substantial staff assistance for transfers to and from bed and chair, for dressing, use of the toilet and bathing. The assessment revealed Resident #4 always incontinent of bowel and frequently incontinent of urine.</p> <p>During an interview on 10/17/24 at 9:54 a.m., Resident #4 stated he was dependent on staff for assistance with care and used his call light several times daily. The resident stated it usually took 20 to 30 minutes for staff to respond to the call light, it was occasionally under 15 minutes, but usually longer and had experienced that nearly daily. The resident stated he used the call light when he needed to go to the bathroom and had been incontinent at least 4 or 5 times when staff didn't respond to the call light timely.</p> <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. The 9/26/24 MDS Assessment tool revealed Resident #5 scored 15 out of 15 points on the BIMS, indicating intact cognition. The MDS assessed the resident required substantial staff assistance to transfer to and from bed and chair, for bathing, dressing use of the toilet. The assessment revealed Resident #5 occasionally incontinent of bowel and frequently incontinent of urine.</p> <p>During an interview on 10/17/24 at 10:25 a.m., Resident #5 stated he was dependent on staff for assistance with transfers, used his call light if he needed to use the bathroom after he was out of bed, or for any assistance when he was in bed, and it usually took 20 minutes for staff to respond to the call light, sometimes longer, it didn't matter what day it was or time of the day, other than they were always busy around the meal times and took longer for staff to respond then.</p> <p>4. The 9/4/24 MDS Assessment tool revealed Resident #2 scored 15 out of 15 points on the BIMS, indicating intact cognition. The MDS assessed the resident required substantial staff assistance to reposition in bed, transfer to and from bed or chair, for bathing, dressing and use of the toilet. The assessment revealed Resident #2 always incontinent of bowel, and a urinary catheter in place.</p> <p>During an interview on 10/17/24 at 10:01 a.m., Resident #2 stated she used her call light several times a day, dependent on staff for care assistance, and her call light was usually answered in 15 to 20 minutes. There were times when it was longer, up to 25 minutes, and times it was less, around 10 minutes, but usually 15 to 20 minutes and it didn't matter what time of day it was or what day of the week it was.</p> <p>During an interview on 10/16/24 at 5:56 p.m., a family member and responsible party for a resident on Home #2 stated they visited the facility daily. They stated they had observed call lights on for several minutes at a time when staff were in the Nurse's Station area and not engaged in answering the call lights. The family member stated their family member [resident] had been incontinent as a result of the call light not being answered. The responsible party stated they had addressed the matter more than once with the Director of Nursing and the Administrator. The family member stated during a visit on the afternoon of 10/13/24, there were three call lights on in the hallway, including their family members. They stated there were several staff inside the Nurse's Station on their cell phones. The family member stated after 10 minutes they went to get help for the resident. One of the nurses that came out of the Nurse's Station said they couldn't answer the call light because they were on their way home. The family member stated it took 10 more minutes for staff to respond after they specifically asked for assistance for the resident.</p> <p>During an observation on 10/9/24 at 1:51 p.m., a resident call light in the 200 Hall activated. The light illuminated on the wall in the hall outside a resident's room, with no audible signal in the hallway. The electronic call light monitor in the Nurse's Station activated with identification of the resident room, and an audible alert. The Nurse's Station is a room with a door, with a glass window that encases the upper half of the station on 2 walls that face the entry family room area and hallway that lead to the Dining room. The audible sound from the call light monitor device was not heard when in the family room area with the door to the Nurse's Station closed.</p> <p>During an interview on 10/17/24 at 2:56 p.m., Staff B, Certified Nursing Assistant (CNA) stated she thought resident call lights were on for longer than 15 minutes at least 10 times a week, especially if a resident required 2 staff for care and both staff were in the resident's room for the care, there weren't other staff assigned to the hall that looked for activated call lights.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/17/24 at 3:01 p.m., Staff C, CNA stated she thought resident call lights were on for longer than 15 minutes maybe 3 times a week. Staff can't hear that a call light was on unless they were inside the Nurse's Station, the only other way to know a call light was on was to see the call light on by the resident's room, and if they were in another resident's room or not in the hallway they wouldn't know a call light was on until they saw it.</p> <p>During an interview on 10/17/24 at 3:04 p.m., Staff D, Licensed Practical Nursing (LPN) stated she thought resident call lights were on for longer than 15 minutes maybe twice a week, and occurred when the CNA's were on break and when they hadn't communicated about their assigned resident's care needs.</p> <p>During an interview on 10/17/24 at 3:09 p.m., Staff E, Registered Nurse (RN) stated she thought it was rare for a resident's call light to go unanswered for over 15 minutes, and occurred when all the aides were in a resident's room for care, or if 1 of the aides had called off and they were working short. When that happened the nurses had to help out, they had to help check on the residents and answer the call lights.</p> <p>During an interview on 10/17/24 at 2:25 p.m., the Administrator stated she attended the monthly Resident Council meetings and there had not been any concerns raised about call lights at the last 2 Resident Council meetings, and she expected staff to answer activated call lights timely, when they were aware of the resident's call for assistance.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>26529</p> <p>Based on observation, record review, and staff interviews, the facility failed to follow appropriate Enhanced Barrier Precautions for 1 of 10 residents reviewed for urinary catheter care. The facility reported a census of 89 residents.</p> <p>Findings include:</p> <p>The 7/24/24 Minimum Data Set (MDS) Assessment tool revealed Resident #6 scored 10 out of 15 points possible on the Brief Interview for Mental Status (BIMS), indicating a moderate cognitive impairment. The MDS listed diagnoses included: cerebral palsy, obstructive uropathy (blockage of urine flow), and benign prostatic hyperplasia (enlarged prostate). The MDS assessed the resident required substantial staff assistance for transfers to and from bed and chair, for dressing, bathing and use of the toilet. The assessment revealed a urinary catheter used for elimination.</p> <p>The Care Plan, initiated on 5/16/19 with revision on 1/31/24, included a Focus area to address The resident has an indwelling catheter R/T (related to) urethral strictures (narrowing), DX (diagnosis) Obstructive Uropathy. Interventions included, in part:</p> <p>a. Catheter care: Provide every shift and PRN (as needed).</p> <p>The Care Plan, initiated on 4/4/24 with revision on 5/6/24, included a Focus area to address The resident requires Enhanced Barrier Precautions (EBP) R/T (related to) indwelling catheter. Interventions included, in part:</p> <p>a. [NAME] (put on) gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use and wound care.</p> <p>b. Doff (take off) gown and gloves inside resident room. Perform hand hygiene.</p> <p>During an observation on 0/17/24 at 1:05 p.m, revealed a sign Resident #6 door indicating Enhanced Barrier Precautions. The sign directed staff to wear gown and gloves when high-contact resident care provided that included catheter care. A three drawer dresser outside of the door contained an adequate supply of disposable gowns, gloves and other Personal Protective Equipment (PPE) required for care.</p> <p>While Resident #6 sat on the toilet, Staff A, Certified Nursing Assistant (CNA) stated she would cleanse the resident's catheter. Staff A, donned gloves and with disposable wipes cleansed around the urinary catheter, and around the tip of the penis. Staff A cleansed away from the insertion point, and used one disposable wipe for one swipe. Staff A completed cleaning the catheter without wearing a gown.</p> <p>During an interview on 10/17/24 at 3:58 p.m., Staff A, CNA, stated she knew she was supposed to wear a gown when she provided the catheter care, she simply forgot to apply it prior to the care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/17/24 at 1:25 p.m., Staff F, Registered Nurse (RN), Clinical Care Leader stated when resident's have EBP, staff are to wear gown and gloves at a minimum, potentially other PPE depending on the specific care. She stated staff should wear gown and gloves when catheter care provided.</p> <p>During an interview on 10/17/24 at 1:34 p.m., Staff G, RN and Infection Preventionist stated staff were educated on EBP when the standard came out. She stated staff should wear gown and gloves when urinary catheter care provided. Staff G stated the facility was getting more of the isolation door hangers that are applied to the outside of a resident's door and contain the PPE required, phasing out the 3 drawer dressers for isolation PPE, but the supply was on back-order so they continued to use the dressers until they could obtain more of the door hangers. Staff G stated staff would be re-educated on the expectation and they would put monitors in place to ensure staff were compliant with the isolation requirements.</p> <p>The facility policy, dated 4.2.24, titled Standard and Transmission-Based Precautions directed staff:</p> <ol style="list-style-type: none"> 1. Enhanced Barrier Precautions (EBP) expand the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of Multi Drug Resistant Organisms (MDRO's) to staff hands and clothing. 2. EBP are needed for residents with with indwelling medical devices (such as central lines, indwelling urinary catheters and feeding tubes). 3. EBP are intended to be used for the duration of a resident's stay. 4. High-contact resident care activities include: transfers, dressing, changing briefs, changing linens, wound care and device care that included urinary catheter, feeding tube and central line. 5. Post clear signage that indicated the type of Precautions and required PPE: gown and gloves. 6. Signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. 7. Gowns and gloves should be readily available immediately outside of the resident room. 8. Ensure access to alcohol-based hand rub. 9. Position a trash and laundry receptacle can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room. 10. Incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 		