STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165186	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Indianola	708 South Jefferson Indianola, IA 50125

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, resident and staff interview, and policy review, the facility failed to speak to the resident in a manner that maintained dignity, failed to change a resident's stained shirt after putting the resident in bed (#4), and delayed feeding a dependent resident (#3). The facility reported a census of 88 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 6/5/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cerebrovascular accident (stroke), hemiplegia (one-sided weakness), and chronic obstructive pulmonary disease (COPD). It also indicated the resident required setup assistance for eating and oral hygiene, maximal assistance with upper and lower body dressing and personal hygiene, and was dependent with all other aspects of Activities of Daily Living (ADLs) and mobility. The undated Care Plan revealed the resident had an ADL self-care performance deficit related to a stroke and indicated she required one (1) person assistance with getting dressed. On 7/29/25 at 8:35 am, Resident #4 asked Staff E, Maintenance Mechanic (MM) to take her out to smoke. Staff E abruptly replied “No, it's not my time. My time is 2:30” and walked away. At 8:38 am, Resident #4 was observed sitting in a wheelchair across from the nurses’ station wearing a shirt with a food stain down the center. She stated it happened during breakfast but stated it bothered her to be out in the hall in front of everyone with it stained. She said she would've liked to have had her shirt changed after breakfast. At 8:43 am, Staff A, Certified Nurse Aide (CNA) approached Resident #4 if she'd worn that shirt the previous day. Resident #4 replied it was the same color but was a different shirt. Staff A stated if it was the same shirt, she'd have to take her down to her room to change her. At 8:52 am, Staff A stated she asked Resident #4 about her shirt because of the stain on it. She also stated staff changes Resident #4’s shirt when they lay her down after she goes outside to smoke. She confirmed the scheduled smoking time was 9:00 am. At 9:16 am, Staff A transferred Resident #4 to bed and exited the resident’s room. At 9:18 am, Resident #4 was still wearing the stained shirt. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:55 am, Resident #4 stated she felt small and like she didn't matter when Staff E responded to her request to be taken outside to smoke. Resident #4 was still wearing the stained shirt. The facility policy titled Resident Dignity-Rehab/skilled revised 12/11/2024 indicated the purpose of the policy was: a. To maintain the dignity of all residents b. To promote, encourage, support and enhance the residents’ self-esteem c. To promote a sense of self-worth d. To assist with respecting and ensuring resident rights On 7/29/25 at 3:30 pm, the Director of Nursing (DON) stated the staff should have said the designated department will take you out to smoke at 9:00 am. She also stated staff should have changed her shirt after putting her in bed. 2. The MDS of Resident #3 dated 4/24/25 identified a BIMS score of 15, which indicated intact cognition. The MDS coded the resident required maximal assistance for eating. The MDS documented diagnoses which included multiple sclerosis and quadriplegia. The Care Plan of Resident #3 identified an undated Focus area of Activities of Daily Living (ADL) self care performance deficit related to quadriplegic, multiple sclerosis. The Care Plan directed the resident was dependent upon 1 staff assist for eating and must be at a 90 degree angle. On 7/29/25 at 11:50 am, Resident #3 arrived at the dining room with a large number of other residents having already received their meals. At 11:55 am a staff member arrived and took the resident's order for lunch. Her food arrived at 12:05 pm. Within one minute, the Administrator sat down to assist the resident with her meal and stayed with her for the approximate 30 minutes it took for her to finish her meal. On 7/29/25 at 12:39 pm, Resident #3 stated that it was unusual that the Administrator was the one to assist her with her meals. She stated other staff members are supposed to help her with her meals but they don't make it to the dining room on time. She stated she is normally the last person to get served because she does not get served until someone is available to help her eat. She stated she had raised concerns about this in the past. She stated she felt the staff cared about the other residents more than they did her and it was only their job to take care of the gray haired people and felt because she is a younger resident she does not get as much help. She stated she had reported this to the Registered Dietitian (RD) who spoke to the Administrator about her concerns. On 7/29/25 at 1:08 pm, the Administrator stated she was not typically the one to feed Resident #3 but if there is nobody else available she will assist her. She stated the Restorative Aide frequently helps. The Administrator stated Resident #3 had not directly ever stated any concerns to her about her meal service. She stated she has brought other concerns to her and tends to be very vocal. The Administrator stated she was not aware of concerns with meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/25 at 1:23 pm, the RD stated Resident #3 had brought concerns to her about eating assistance. She stated the former Activities Director used to assist her a lot and she is no longer employed at the facility. She stated Resident #3 had known the Activities Director a long time and they spent much time together. She stated Resident #3 prefers to skip breakfast but eats lunch in the dining room daily. She stated she often prefers the evening meal in her room which has been problematic with which staff member was responsible for getting her tray from the dining room and bringing it to her to feed her. Trays are not served to residents who need feeding assistance unless a staff member is available to assist so the food stays warm. She stated the resident had brought concerns to her more than once and she offered to discuss it with the facility management which Resident #3 agreed to. She stated she reported the concern to both the Administrator and the Director of Nursing. She stated the resident is unable to feed herself so the facility must provide that service regardless of if she eats in the dining room or her room. Due to her diagnosis of multiple sclerosis, she will always need the assistance. On 7/29/25 at 1:34 pm, the Certified Dietary Manager (CDM) stated Resident #3 typically does not receive her meal until someone is available to assist her with feeding. She explained that the resident chooses not to sit at the feeding assistance table, and staff feed the residents at that table before assisting Resident #3. The CDM further stated that if Resident #3 opts to eat in her room, this causes an additional delay. She explained that the resident must wait until a CNA is available to leave the floor, retrieve her meal from the dining room, and then feed her. The CDM confirmed that on the day of the observation, Resident #3 was the last resident to be served lunch and stated this occurs fairly often. The CDM reported that she had previously discussed this concern with facility management, which led to the intervention of Resident #3's meal not being served to her until a staff member was available to assist in feeding her, in an effort to ensure the food remained fresh and at an appropriate temperature. On 7/29/25 at 1:50 pm, the RD stated she had located an email she had sent to the Administrator and the Director of Nursing regarding Resident #3's concerns about meal service. The email, dated 6/10/25, documented that Resident #3 was experiencing long wait times to be fed since the departure of the Activity Director. The email noted that the RD had spoken directly with Resident #3, who had expressed a preference for the RD to advocate on her behalf. Resident #3 conveyed that she felt forgotten during meals. The RD explained that the resident required total assistance with eating and drinking and preferred to sit at a specific table. However, the RD noted that even relocating her to the front of the dining room would not resolve the issue as the Restorative Aide was often responsible for feeding, assisting and monitoring 8-10 other residents during meals. She concluded by asking the leadership team to collaborate to reach potential solutions to improve Resident #3's dining experience. The Director of Nursing replied to the email the same day stating she had just had a discussion in huddle regarding staff being present in the dining room for meals and would keep working on it. The Administrator also replied to the email stating she had checked on the presence of staff in the dining room the prior evening.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, resident and staff interview, and policy review, the facility failed to respond to resident call lights within 15 minutes for 3 of 6 residents reviewed (#7, #8, #9). The facility also failed to document 15-minute resident checks for Resident #12. The facility reported a census of 88 residents. Findings include: On 7/26/25 at 8:20 PM, State Surveyors entered the facility and observed activated resident call lights (#1, #4, #7, and #8). At 8:23 PM, the State Surveyor was near the nurse's station but without a direct line-of-sight. Staff was overheard having personal conversations while visiting amongst themselves. At 8:25 PM, Resident #9's call light was activated. At 8:26 PM, two (2) staff members passed Residents #1, #4, and #7's rooms and left the unit. At 8:29 PM, a staff member turned off Resident #13's call light and entered Resident #11's room with a mechanical lift. At 8:32 PM, the resident call light notification device at the nurses' station revealed Resident #7's call light had been activated for 20 minutes. At 8:42 PM, a staff member was observed entering Resident #9's room. The resident call light notification device revealed her call light had been activated for 16 1/2 minutes. At 8:43 PM, the resident call light notification device at the nurses' station revealed Resident #8's call light had been activated for 29 minutes. At 8:48 PM, Resident #4 stated evening shift is always short staffed in her opinion. At 9:02 PM, Staff F, Certified Medication Aide (CMA) and Staff G, Certified Nurse Aide (CNA) stated Resident #13 complained that evening about long call light response times. At 9:16 PM, Resident #13 confirmed she complained to staff about long call light response times on 7/26/25. She also stated it happens all the time and on 7/26/25, it took staff 45 minutes to respond to her call light. She stated staff has previously entered her room, turned off the call light, and left. At 9:28 pm, a staff member was observed walking past Resident #8's activated call light and responded to Resident #9's call light. On 7/28/25 at 3:14 PM, Resident #1 stated, she had to wait more than 15 minutes on 7/27/25 to get bathroom assistance after lunch because of lack of staff. 2. The Minimum Data Set (MDS) assessment for Resident #1 dated 7/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of hypertension, chronic obstructive pulmonary disease (COPD), difficulty walking, and abnormalities of gait and mobility. It indicated she was independent with eating and oral hygiene, required setup assistance with bathing and personal hygiene, supervision with toileting, upper body dressing and sitting-to-lying mobility, and moderate assistance with all other Activities of Daily Living (ADLs) and mobility. The undated Care Plan indicated the resident was non-ambulatory and preferred to use the commode for urinary elimination. It directed staff to encourage and assist the resident with repositioning frequently in bed and wheelchair. On 7/28/25 at 3:31 PM, Resident #4 stated it took staff so long to respond to her call light on 7/27/25 around 4:00 PM, she urinated on herself because she couldn't hold it any longer. 3.The Quarterly Minimum Data Set (MDS) assessment for Resident #4 dated 6/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cerebrovascular accident (stroke), hemiplegia (one-sided weakness), and chronic obstructive pulmonary disease (COPD). It also indicated the resident required setup assistance for eating and oral hygiene, maximal assistance with upper and lower body dressing and personal hygiene, and was dependent with all other aspects of Activities of Daily Living (ADLs) and mobility. It also revealed she was incontinent or bladder and bowel. The undated Care Plan revealed the resident had bladder incontinence and directed staff to check and change her frequently. 4 4. The Quarterly MDS assessment for Resident #12 dated 7/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 07 out of 15, which indicated severely impaired cognition. It included diagnoses of cancer, coronary artery disease (narrowed heart arteries), diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia with other behavioral disturbances. It indicated he was independent with eating and toileting, required setup assistance with oral and personal hygiene, and dressing, and supervision bathing. It also indicated he was independent with mobility. It further revealed the resident experienced hallucinations and delusions.The Care Plan dated 11/07/24 indicated the resident displayed inappropriate sexual advances towards another resident related to Fondling, Grabbing, Touching. A Care Plan revision dated 4/16/25 directed staff to perform 15-minute checks on resident while using monitor at nurses' station which room. is in line of site, and when outside of room resident is to be a 1:1.On 7/26/25 at 8:56 pm, a form titled 15-minute checks was observed at the nurses' station. It was filled out through 8:30 PM. An observation started at 8:58 pm and at 9:11 pm, a staff member was observed checking on the resident. A room sensor beeped when anyone entered or exited the room. On 7/29/25 at 12:56 PM, a record review revealed missing 15-minute checks documentation for the following

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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 observations, staff interviews and policy review, the facility failed to secure prescribed medications from the possibility of unauthorized access. The facility reported a census of 88 residents.Findings included: On 7/29/25 at 9:44 AM, Staff D, Certified Medication Aide (CMA) was observed administering resident's medications. She locked the medication cart and walked into the resident's room. An opaque medication cup was observed on the medication cart with an orange, round pill. A resident who self-propelled in his wheel-chair was observed 3 doors away.At 9:46 AM, Staff D returned to the medication cart, poured water into a cup and returned to the resident's room. The orange, round pill was observed still in the opaque medication cup on the medication cart.At 9:47 AM, Staff D returned to the medication cart. She stated the facility's medication handling and storage process was narcotics were locked in the lock box in the medication cart and all other medications were to be secured in the medication cart and not left accessible when staff leaves the cart unattended. At 9:49 AM, Staff D identified the orange, round pill as Senna (stool softener) and confirmed it should have been disposed of and not left unattended on the medication cart.A policy titled Medications: Acquisition Receiving Dispensing and Storage - R/S, LTC revised 03/04/2025 indicated:3. an employee will be responsible for signing for receipt of medication and obtaining the signature of the delivery person. It is preferred that a licensed nurse receive and verify the medications. Once medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received.5. Medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services and/or designee will be permitted to have access to the keys to the medication storage areas.On 7/29/25 at 4:19 PM, the Director of Nursing (DON) stated medications should be secured in the medication cart of appropriately disposed of not left unattended.

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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. Based on observations, staff interview, and policy review the facility failed to implement the infection control policy as staff failed to disinfect a mechanical lift between two residents' use (#4, #11). The facility reported a census of 88 residents.Findings include:On 7/29/25 at 9:16 AM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA transferred Resident #4 from her wheelchair to her bed. Staff A brought the mechanical lift out of Resident #4's room and placed it against the wall outside, beside Resident #4's door. The mechanical lift was not disinfected. At 9:41 AM, Staff B, CNA and Staff C, CNA took the mechanical lift into Resident #11's room to get Resident #11 out of bed. The mechanical lift was not disinfected prior to use. At 9:49 AM, Staff B, CNA brought the mechanical lift out of Resident #11's room and placed it against the wall between rooms 212 & 214. It was not disinfected. At 9:51 AM, Staff D, Certified Medication Aide (CMA) and Resident #11 stated there was no disinfectants (Saniwipes) kept in the resident's room. Staff D also stated disinfectants were not stored in any residents' rooms but were located at the nurses' station. At 9:57 AM, Staff C, CNA stated the Saniwipes were in the storage pouches on the back of the reusable equipment. At 9:58 AM, there was no Saniwipes observed in the storage pouch on the back of the mechanical lift. At 9:59 AM, Staff C, CNA stated staff wipes down the reusable equipment in the hallway after each use and during the night. She added that reusable equipment is not wiped down before being used. She stated the mechanical lift should have been wiped down after being used in Resident #4's room. On 7/29/25 at 3:30 PM, the Director of Nursing (DON) stated staff should have found the Saniwipes and disinfected the equipment. At 5:43 PM, the Administrator provided an email that the facility did not have a policy specific to disinfecting reusable equipment but indicated staff was expected to wipe down the lifts between use.