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	06/18/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 34817 Based on record review, resident and staff interviews, review of the facility's grievance/concern forms, and policy review, the facility failed to make efforts to investigate and follow up on the residents' concerns regarding missing cigarettes for 3 of 4 residents reviewed for missing belongings. The facility reported a census of 86 residents. Findings include: In a confidential resident interview 06/10/24 at 2:15 PM, one resident reported concerns about her cigarettes getting taken. She bought a carton of cigarettes 3-4 months ago and the carton came up missing. The resident stated the cigarettes are kept at the Lilac nurse's station in a locked room requiring a keycode to enter. The resident stated she reported the cigarettes missing but no cigarettes were found. The resident reported the problem (of cigarettes missing) had gotten worse because other residents had their cigarettes taken too. She reported her concern to the social worker (SW) and other staff at the facility. In an interview 06/10/24 at 03:30 PM, another resident reported a concern for missing cigarettes. The resident reported that other residents had voiced concern about cigarettes getting taken. The resident reported he was missing 6 packs of Marlboro Red cigarettes. He labeled each pack of cigarettes with his name. The resident stated he was aware of a couple other residents who had missing cigarettes. One resident had 8 packs of cigarettes when he went to the hospital, but only had 6 packs of cigarettes left when he returned from the hospital. He told a couple of staff about the missing cigarettes. The nurse looked in his room. The resident voiced concern if he said anything, the facility would take away the option for smoking. In an interview 06/10/24 at 03:45 PM, a third resident reported he had cigarettes missing. He told staff about the missing cigarettes but they hadn't figured out where they went. On 06/11/24 at 07:45 AM, a resident approached the surveyor and reported he talked to the Director of Nursing (DON) about missing cigarettes. She said she was going to figure out a solution, and if not able to figure something out, they would do away with the smoking. The resident stated he didn't want their smoking privileges taken away. (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

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	165186	A. Building B. Wing	06/18/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) assessments dated 12/7/23, 7/2/23, and 10/23/23 documented these residents had a Brief Interview for Mental Status (BIMS) of 14 or 15 which indicated cognition intact. The MDS assessments indicated the residents used tobacco. Two of the resident's MDS documented the resident deemed the care of his/her personal belongings or things were very important to him/her, and having a place to lock things to keep them safe was somewhat important. One resident's preferences was not assessed. The Care Plan for each resident revealed the resident used tobacco products (cigarettes). The staff directives included to store cigarettes and lighter at the nurse's station, and monitor the resident during use of cigarettes. One of the resident's care plan directed for staff to give the resident one cigarette at a time during smoking sessions to prevent the resident from taking cigarettes back to his room. On 06/11/24 at 2:00 PM, the SW provided an unlabeled white binder to the surveyors. The SW reported the binder contained grievance information for 2/2024 to 5/2024. The binder contained resident Suggestions or Concern Forms that had been filled out. Review of the Concern/Grievance Forms inside the binder revealed only one Concern / Grievance Form about a resident's missing cigarettes. The form revealed the following: On 6/11/24, Resident #71 reported someone stole a carton of someone else's cigarettes. Family called on 6/11/24. Family reported they had not brought a carton of cigarettes for the resident recently so they couldn't have been stolen. It was determined, the resident was out of cigarettes and family planned to send more. Review of the facility's Suggestion or Concern forms lacked documentation of suggestion or concern forms for the other residents who reported missing cigarettes. In an interview 06/12/24 at 07:47 AM, Staff H, Certified Nursing Assistant (CNA) stated if someone reported something missing, she let the nurse know. Staff H also stated she looked in laundry to see if they had the missing item. In an interview 06/12/24 at 10:26 AM, Staff F, CNA, reported if a resident reported something missing, she checked with laundry and also tried to look for the item herself. Staff F stated each week the activities staff showed the residents the clothing found without names. Staff F acknowledged she didn't fill out a grievance form whenever someone reported something missing. In an interview 06/12/24 at 11:50 AM, Staff D, Social Worker (SW), reported she had worked at the facility for two months. The SW reported whenever someone reported missing items, she filled out a resident grievance form, and let the maintenance director and management know about the concern. The Maintenance Director let the laundry team know to look for the item. She was not sure what happened if an item could not be found but she would check with the Administrator to see what to do next. In an interview 06/13/24 at 02:30 PM, Staff D reported she was not aware of any residents missing cigarettes except Resident #71 told her about another resident who had missing cigarettes. She filled out a grievance form and called the resident's family. The family denied bringing a carton or packs of cigarettes in for the resident. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 06/17/24 at 12:15 PM, Staff C, Registered Nurse (RN) reported she let the Administrator and/or DON know if a resident reported something missing. She also searched for the missing item and let laundry know to look for the item. She didn't fill out a grievance/concern form, she just let management know and they do what they do for that. In an interview 06/17/24 at 03:00 PM, the Administrator reported the residents sometimes reported cigarettes missing and she followed up on asking questions about how many times the resident went out to smoke and the number of cigarettes the resident smoked, and sometimes determined their cigarettes weren't missing. The Administrator reported they needed to come up with a way to track the residents' cigarettes. In an interview 06/18/24 at 07:30 AM, the DON reported she planned to look at the process for tracking the residents' cigarettes. She was aware of one resident missing cigarettes but when they called the resident's family member, the family had not brought a carton of cigarettes for the resident. The DON stated she was unaware of any other resident missing cigarettes. A Grievances, Suggestions, or Concerns policy reviewed 11/14/23 revealed a resident has the right to voice grievances orally, in writing and anonymously without discrimination or reprisal. The policy revealed the following: a. A grievance will be documented on the Suggestion or Concern form whenever a resident, family member, visitor or employee expressed a concern or grievance and submitted to the grievance official. b. The grievance official will route the concern form to the appropriate department manager as soon as reasonably possible. An investigation must be completed for all grievances. c. The grievance official is responsible for posting this procedure in an area accessible to residents/families and visitors. This responsibility also includes educating employees, residents, family and visitors on the use of this form, as well as where visitors, employees, patients and residents can obtain the concern forms. d. The Suggestion and Concern form will be maintained for three years from the issuance of the grievance decision.

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F 0623 Level of Harm - Minimal harm or potential for actual 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** 49990 Based on record review, staff interview, and facility policy review, the facility failed to notify the Ombudsman of a resident transfer to the hospital for 5 of 5 residents reviewed. Resident #29, #9, #57, #50, and #85. The facility reported a census of 86. Findings include: 1. A facility census report for Resident #29 documented he was hospitalized on [DATE] and was readmitted to the facility on [DATE]. The facility progress notes for Resident #29 dated from 01/14/24 to 01/16/24 which indicated the resident was sent to the emergency room (ER) on 01/14/24, admitted to the hospital, and readmitted to the facility on [DATE]. The facility did not provide proof of ombudsman notification. 2. A facility census report for Resident #9 which revealed he was hospitalized on [DATE] and was readmitted to the facility on [DATE]. The facility progress notes for Resident #9 dated from 01/11/24 to 01/18/24 which indicated the resident was sent to theER on [DATE], admitted to the hospital, and readmitted to the facility on [DATE]. The facility did not provide proof of ombudsman notification. 3. A facility census report for Resident #57 which revealed she was hospitalized on [DATE] and was readmitted to the facility on [DATE], and was hospitalized again on 12/16/23 with a date of readmittance noted as 12/20/23. The facility progress notes for Resident #57 dated from 10/21/23 to 10/31/23 which revealed the resident was sent to theER on [DATE], admitted to the hospital, and readmitted to the facility on [DATE]. The facility could not provide proof of ombudsman notification. The facility progress notes for Resident #57 dated from 12/16/23 to 12/20/23 which revealed the resident was sent to theER on [DATE], admitted to the hospital, and readmitted to the facility on [DATE]. The facility did not provide proof of ombudsman notification. A facility census report for Resident #50 which revealed he was hospitalized on [DATE] and was readmitted to the facility on [DATE]. 4. The facility progress notes for Resident #50 dated from 03/17/24 to 03/19/24 which revealed the resident was sent to theER on [DATE], admitted to the hospital, and readmitted to the facility on [DATE]. The facility did not provide proof of ombudsman notification. 5. A facility census report and facility progress notes for Resident #85 which revealed he was admitted to the facility on [DATE] and discharged against medical advice (AMA) on 03/25/24. The facility did not provide proof of ombudsman notification. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/12/24 at 09:00 AM with the Administrator, she informed the surveyor she had been made aware of staff not following the ombudsman notification process due to a mock survey. As a result, ombudsman notifications hadn't been done from at least December of 2023 until the end of March 2024. In an interview on 06/17/24 at 12:36 PM with Staff D, Social Services Director, she indicated she was aware prior staff members had not submitted ombudsman notifications from a period start in at least December of 2023 and lasting until March of 2024 when it was found during a mock survey. Review of facility policy titled Ombudsman - Rehab/Skilled last reviewed on 12/06/23 does not indicate that ombudsman notifications are required when a resident is discharged or transferred.

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	165186	A. Building B. Wing	06/18/2024

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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** 34817 Based on clinical record review, staff interview, and policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for one of eighteen resident's reviewed in the sample (Residents 64). The facility reported a census of 86 residents. Findings include: The Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had diagnoses of adjustment disorder with anxiety, mood disorder, bipolar disorder, and depression. The MDS indicated the resident not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS documented the resident admitted to the facility on [DATE]. The Care Plan revised 4/1/24 revealed Resident #64 had diagnoses of adjustment disorder, anxiety, depression, bipolar disorder, and dementia. The resident had behaviors such as yelling at staff, non-compliance with cares, stealing cigarettes and lighters, and took antipsychotic and antidepressant medication. The care plan lacked information about a PASRR completion and the PASRR recommended resources. Resident #64's PASRR dated 7/3/23 revealed a PASRR level II determination and the resources recommended, including support services such as but not limited to psychiatric evaluation, medication management by a psychiatrist, individual therapy, and development of a crisis intervention/safety plan. In an interview 06/17/24 at 03:00 PM, the Administrator reported the social worked filled out Section A of the MDS. A facility PASRR policy revised 11/6/22 revealed upon admission, the facility will include the PASRR determinations and evaluation report into the resident's assessment, comprehensive care plan and transitions of care plan. A MDS 3.0 / RAI (Resident Assessment Instrument) policy reviewed 6/13/23 revealed social services completed Section A of the MDS assessment. The resident's electronic medical record reviewed to determine accuracy of documentation in order to support the coding for the MDS.

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	165186	A. Building B. Wing	06/18/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on facility record review, staff interview, and policy review, the facility failed to maintain a valid Pre-admission Screening and Resident Review (PASRR) for 1 of 5 residents screened (Resident #37). The facility also failed to develop a resident's comprehensive care plan and ensure Pre-Admission Screening and Resident Review II service recommendations added to the resident's comprehensive care plan for 1 of 5 residents reviewed (Residents #64). The facility reported a census of 86 residents. Findings Include: 1. The Minimum Data Sample (MDS) for Resident #37, dated 06/11/24, indicated a brief interview for mental status (BIMS) interview could not be completed as the resident is rarely or never understood. The MDS revealed relevant diagnoses of aphasia, non-Alzheimer's dementia, Parkinson's disease, depression, psychotic disorder, schizophrenia, post traumatic stress disorder. Review of a PASRR for Resident #37, dated 10/09/2019, did not include the diagnoses of schizophrenia, or depression. In an email forwarded by the Administrator, originally authored by the Social Services director on 06/12/24 at 11:49 AM stated the facility did not have an updated PASRR. In an interview with the Social Services Director on 06/17/24 at 12:36 PM, she acknowledged the PASRR should have been updated. She further noted PASRR had not been updated under previous staff who were in her role. Review of a facility document titled Pre-admission Screening and Annual Resident Review (PASRR) states the facility will participate in the Pre-admission Screening and Annual Resident Review screening process for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder, intellectual disability, or related condition. It further states provider is responsible for following the guidelines listed in the long term care facility resident assessment instrument (RAI) for determining when a significant change in status should be completed. It notes that if there were new medications or diagnoses that could change the outcome of a PASRR determination, a new form would be completed and submitted within 14 days. 34817 2. The MDS assessment dated [DATE] revealed Resident #64 had diagnoses of adjustment disorder with anxiety, mood disorder, bipolar disorder, and depression. The MDS indicated the resident not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS assessment revealed the resident took antipsychotic, antianxiety, and antidepressant medications, and had no psychological therapy during the look-back period. The MDS documented the resident admitted to the facility on [DATE]. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment dated [DATE] revealed Resident #64 had diagnoses of depression, bipolar disorder, adjustment disorder, and dementia. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicated cognition intact. The MDS documented the resident had little interest or pleasure in doing things 12-14 days during the look-back period, felt down and depressed 7-11 days, and had no behaviors. The MDS revealed the resident took antipsychotic and antidepressant medication during the 7-day look-back period. The Care Plan revised 4/1/24 revealed Resident #64 had diagnoses of adjustment disorder, anxiety, depression, bipolar disorder, and dementia. The resident had behaviors such as yelling at staff, non-compliance with cares, stealing cigarettes and lighters, and took antipsychotic and antidepressant medication. The care plan directives included to attempt non-pharmacological interventions to calm him down, provide medications per physician's orders, and consult with pharmacy and his health care provider to consider dosage reduction when clinically appropriate. The care plan lacked information about a PASRR completion and the PASRR recommended resources. The facility's electronic health records and software program containing medical record documents lacked a PASRR documentation for Resident #64. An email sent to the Administrator on 6/12/24 at 8:50 AM, the surveyor requested Resident #64's PASRR due to the surveyor unable to locate the document in the resident's records. On 6/12/24 at 9:00 AM, the Administrator reported no PASRR for Resident # 64, but the facility staff was in the process of fixing this. In an email on 6/12/24 at 11:00 AM, the Administrator advised a PASRR request was submitted for Resident #64. On 6/13/24 at 8:45 AM, the Social Worker (SW) reported their PASRR vendor had record of a PASRR completion on Resident #64 in 7/2023. The SW provided a copy of the PASRR notice dated 7/3/23 completed on Resident #64. Resident #64's PASRR revealed a PASRR level II determination and the resources recommended, including support services such as but not limited to psychiatric evaluation, medication management by a psychiatrist, individual therapy, and development of a crisis intervention/safety plan. A Notice of PASRR Level II Outcome dated 7/3/23 revealed the admitting nursing facility must incorporate PASRR findings as part of the individual's plan of care. The services and supports nursing facility staff required to provide for the resident included but not limited to psychiatric evaluation, medication management by psychiatrist, individual therapy, and rehabilitation services. A facility PASRR policy revised 11/6/22 revealed upon admission, the facility will include the PASRR determinations and evaluation report into the resident's assessment, comprehensive care plan and transitions of care plan.

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	165186	A. Building B. Wing	06/18/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, review of facility bath records, resident and staff interviews, and policy review, the facility failed to ensure residents' groomed and received their scheduled baths for two of eight residents reviewed for bathing (Resident #50 and #64). The facility reported a census of 86 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 50 had diagnoses of Parkinson's Disease, diabetes, and dementia. The MDS documented the resident required substantial to maximum assistance for bathing and personal hygiene. The Care Plan revised 3/27/24 revealed the resident had a self- care deficit in activities of daily living (ADL's) related to Parkinson's Disease, vascular dementia, and Tourette's disorder. The care plan directed staff to provide extensive assistance of one for bathing and limited assistance of one for personal hygiene. During observations 6/10/24 at 11:30 AM, Resident#50 sat in a wheelchair across from the nurse's station. The resident's fingernails were uneven and jagged and had brown debride under the nails. The resident had a long white facial hair present, and appeared unshaven. Review of facility's Skin Monitoring Comprehensive CNA shower review forms (on paper) dated 5/2024 to 6/10/24 revealed a body map and skin assessment documented 5/7/24, 5/10/24, 5/14/24, 5/19/24, 5/21/24, 5/28/24, 6/3/24, 6/6/24, and 6/10/24. The skin monitoring CNA shower review forms lacked the type of bath (shower, bath, bedbath, whirlpool, etc.) provided. The form had an area regarding if toenails needed cut, but no section for if fingernails needed cut. Review of the EHR bathing POC response history 5/14/24 to 6/10/24 revealed showers documented on the following dates: 5/14/24, 5/19/24, 5/21/24, 6/6/24, and 6/10/24 (surveyor entrance date). The record lacked documentation for shower/bath provided 5/21/24 to 6/6/24. In an interview 06/17/24 at 12:15 PM, Staff C, Registered Nurse (RN) reported the nurses documented skin assessments in the electronic health record (EHR). They also had a shower sheet staff filled out about a resident's skin and indicated if the resident had any skin issues. A bath aide gave resident showers/baths typically Monday through Saturday. Staff C confirmed the paper skin sheet doesn't show the kind of bath/shower a resident received. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 06/17/24 at 12:20 PM, Staff G, Certified Nursing Assistant (CNA) and bath aide reported she gave the residents' baths whenever she worked on Monday through Thursdays. Staff G reported she sometimes got pulled to work the floor as a CNA depending upon their staffing needs. She filled out a skin sheet (paper) and made a note of any skin concerns on the resident, and gave the form to the nurse to review. Whenever she gave the resident a bath, she documented the type of bath provided in POC (EHR point of care). Staff G stated the paper skin sheet only had skin information on it, it doesn't show the kind of bath/shower she gave. Staff G reported she often times had to document under PRN bath due to a change with the resident's regular bath day. In an interview 06/18/24 at 07:30 AM, the Director of Nursing (DON) reported shower skin sheets implemented for the CNA/nurse to fill out, and the nurse signed off on the form whenever the resident had their bath/shower. The DON confirmed no area on the form to indicate the type of shower/bath/bedbath given, or if a resident refused, an optional date/time when staff offered the resident a bath/shower. The facility's Bathing Policy revised 8/29/23 revealed bathing done to promote cleanliness and hygiene. The bath/shower is documented in the electronic health record in Point of Care. 2. The MDS assessment dated [DATE] revealed Resident #64 had diagnoses of cerebrovascular accident (CVA) (stroke), dementia, a chronic left foot ulcer, and an unstageable pressure ulcer to his right heel. The resident had a BIMS of 15, which indicated cognition intact. The MDS indicated the resident required partial to moderate assistance for bathing. The Care Plan revised 3/25/24 revealed the resident had a self-care deficit in activities of daily living (ADL's) related to weakness and dementia. The staff directives included provide assistance of one staff for bathing, and a licensed nurse to perform skin observations and provide foot and nail care. In an interview on 6/10/24 at 3:08 PM, Resident #64 reported he hadn't had a bath in 10 days, not even a bedbath. The resident reported he was supposed to get a bath on Mondays, Wednesdays, and Fridays. He had a bath on Wednesday, 6/5/24. The resident stated he didn't think the facility had enough staff to care for all of the residents at the facility. Review of facility's Skin Monitoring Comprehensive CNA shower review forms (on paper) dated 5/2024 to 6/09/24 revealed a body map and skin assessment documented 5/6/24, 5/8/24, 5/15/24, 5/18/24, 5/24/24, 5/27/24, 5/29/24, 5/31/24, 6/3/24. The skin monitoring CNA shower review forms lacked the type of bath (shower, bedbath, whirlpool, etc) provided. The form also lacked skin measurements. Review of the EHR bathing POC response history 5/15/24 to 6/9/24 revealed a whirlpool documented on the following dates: 5/18, 5/24 5/27, 5/29, 5/31/24 and bedbath (spongebath) documented on 6/5.

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	165186	A. Building B. Wing	06/18/2024

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F 0684 Level of Harm - 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** 34817 Based on observation, record review, and staff, interviews the facility failed to provide treatments as ordered for one of three residents reviewed for treatment. The lack of treatment for (R#33) may have lead to a hospitalization . The facility reported a census of 86. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #33 has Brief Interview for Mental Status (BIMS) of 00, which indicated severe cognitive impairment, and diagnosis of Non-Alzheimer's Dementia, Atrial Fibrillation (A-fib), Congestive Heart Failure (CHF), muscle weakness, lymphedema, and cognitive communication deficit. MDS documented admission to care facility began 11/15/2023. The Care Plan dated 4/17/24 revealed Resident #33 is non-verbal, shakes and nods head to respond. Resident #33 is non-ambulatory and totally dependent on staff for transfers and cares. Receives anticoagulant (blood thinners) medication, diuretics for A-fib and CHF. Hospital Discharge Summary dated 11/11/2023 documented as follows; Review of resident #33's records revealed he was admitted to the facility on [DATE] for long term care after a hospitalization for pubic fracture. Hospital discharge documents revealed resident #33 had chronic lymphedema (swelling caused by buildup of lymph fluid in the body between the skin and muscle) treated with Lasix (diuretic) and use of lymphedema pumps (a device that treats chronic edema and venous disease with the use of air and compression into a stocking), peripheral venous insufficiency (circulation disorder), A-fib, stage 3 chronic kidney disease, a history of blood clotting disorder with deep vein thrombosis (DVT, blood clots in the veins), intellectual disability. Hospital discharge orders included medication list and use of lymphedema pumps from home, one hour in the morning and one hour in the afternoon. Plan of Care Note from Hospital Social Worker dated 11/14/23 at 9:20 AM documented Group Home to bring Lymphedema pumps to bedside to go with the resident for the admission to the nursing home. Skilled Nursing Facility/Nursing Facility to Hospital Transfer Form dated 2/11/24 documented the following; Resident#33 was transferred to the hospital on 2/11/24 for shortness of breath and admitted to the ICU (intensive care unit) and diagnosed with urosepsis, septic shock, DVT in both legs with cellulitis in the right lower leg. Resident #33 was discharged from the hospital returning to the facility on [DATE] with continued medications including an anticoagulant medication and to restart lymphedema pumps the day of discharge. Hospital Progress Note dated 2/13/24 at 8:31 AM documented that the resident previously had one year ago DVT's and PE (pulmonary embolism (blood clot)). The resident's bilateral lower extremities are swollen, and his right leg is very painful. The lower extremity swelling and pain may be due to the DVT's, but can't rule out necrotizing fasciitis with the organism in his blood. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Physicians Order dated 2/26/24 for the resident documented lymphedema pump to bilateral lower extremities once daily. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 11/1/23-6/1/24 failed to reveal order for lymphedema pump and documentation of administration. On 6/13/24 at 2:20 PM revealed the resident laid in bed with no lymphedema pump in the room. On 6/17/24 at 12:17 PM Staff C, Registered Nurse (RN) reported the resident did not have a lymphedema pump in his room, and had not received this treatment. Staff C recalled this being discussed after hospital discharge on 2/21/24 but could not recall why this had not been initiated. On 6/17/24 at 2:21 PM the Director of Nursing (DON) stated the lymphedema pump order had not been sent with the original admission in November, and should have been clarified by the nurse at that time. An order was received from a physician on 3/3/24, that was not processed accurately to TAR, and had not been administered as ordered. The DON did confirm the lymphedema pump is in the facility, and the TAR had been corrected and treatments will be started. On 6/17/24 at 4:30 PM the DON was presented with the orders for the lymphedema pump that were received on initial admission documentation on 11/15/23. DON acknowledged the orders and identified the facility failed to accurately review, process and implement the orders for the lymphedema pump. Physician Orders Policy dated 4/1/24 directed staff as follows, Purpose to provide care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders. Following hospitalization when a resident returns from the hospital, physician/practitioner orders must be updated to reflect the resident's current needs. Admission orders and orders received throughout the resident's stay are processed and transcribed into PCC-Clinical-orders (electronic health record), immediately upon receipt of the order. The orders must be noted by the licensed nurse who has processed the order and filed in the central supervised location for scanning/indexing.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, resident, and staff interviews and facility policy the facility failed to document assessments, interventions, and treatments for 1 of 3 residents reviewed for skin management concerns. The facility reported a resident census of 86. Findings include: 1. The MDS assessment dated [DATE] revealed Resident #64 had diagnoses of sepsis (infection), diabetes, Stage 2 pressure ulcer to the left heel, chronic ulcer to the left foot, and an unstageable pressure ulcer to the right heel. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) of 15 indicating cognition intact. The MDS indicated the resident took an antibiotic during the 7-day look-back period. The Care Plan revealed the resident had a left heel ulcer and a pressure ulcer to the right plantar foot. The resident required Enhanced Barrier Precautions (EBP). The staff directives included perform treatments per the physician's orders. Review of the treatment record (TAR) 4/1/24 to 6/10/24 revealed treatments not documented for the following: a. To the left toes on 4/12 (day shift), 4/16 (day shift), 4/18 (evening shift), 4/19 (day shift), 4/29 (evening shift), and 5/12 (day shift) b. To the right plantar foot and right plantar hallux on 4/12, 4/16, 4/19, 4/23, 5/12, and 5/16 c. To the right plantar foot on 5/31 and 6/6 d. To the left heel wound on 5/16, 5/31, and 6/6 Health Status Note dated 5/16/24 at 1:15 PM documented that the resident refused to go to a wound clinic appointment. Documentation for the remainder of the day lacked the reapproach of the resident to offer to complete the dressing changes for the resident. Medication and Treatment Order dated 6/6/2024 from the residents foot doctor documented treatment had been provided to the right foot and left heel. The facility staff failed to document completion of this treatment on the residents treatment administration record, or the progress notes. Progress Notes dated 4/1/24 to 6/10/24 lacked documentation of the resident's refusal for wound care. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 6/10/24 at 3:08 PM, Resident #64 stated he had a pressure sore on his left heel and a sore on his right mid-foot (plantar) that is not consistently getting cleaned. The left foot had seepage (drainage) so bad, it drained through the bandage, his sock, and onto the floor when staff didn't change the dressing like it should be. The resident stated it depended upon the nurse on duty and if the treatment got done. His podiatrist told him the wounds were serious. At the time, a dressing over the left heel had no date on it, and the dressing on the right mid-foot had 6/10 listed on it. In an interview 06/13/24 at 09:33 AM, Staff A, Registered Nurse, reported Resident #64 had a wound on his right plantar foot for a long time and a wound on his left heel for about 6 weeks. Staff A stated Resident #64 noncompliant and refused wound care, medications, and cares a lot. Staff A stated they changed or altered the time they did things for the resident to help make him more compliant. She knows not to ask him about performing his wound assessment/care until after he has had his cigarette break. In an interview 06/18/24 at 07:30 AM, the Director of Nursing (DON) reported she expected staff documented treatments and dressing changes on the treatment record. If a treatment not documented it wasn't done. Skin Assessment Pressure Ulcer Prevention and Documentation Requirements with revised date of 4/26/24 directed facility staff as follows: *To systematically assess residents regarding risk of skin breakdown *Accurately document observations and assessments of residents *To appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers Maintenance of Active Medical Records Policy dated 5/11/23 coached staff as follows; the location will maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

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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. 49990 Based on resident interview, direct observation, staff interview, family interview, and facility document review, the facility failed to provide sufficient staff to provide needed cares and supervision to ensure safety of residents at the facility. The facility reported a census of 86. Findings include: 1. A direct observation on 06/11/24 at 08:41 PM revealed Resident #9 wandering the hallway of the facility without staff in sight. Resident #9 wheeled himself into the activities room and was unobserved by facility staff for a period of time from 08:41 PM until staff checked on him at 09:37 PM. Review of Resident #9's care plan at the time of the incident indicated that Resident #9 was on 15-minute checks. In an interview on 06/12/24 at 03:00 PM the Director of Nursing (DON) acknowledged the resident had not had staff eyes on for a period of 56 minutes. In an interview on 06/13/24 at 03:02 PM with the Administrator, she stated that the only staff members who have access to internal security camera footage are herself, the DON, and the Director of Maintenance. On 06/13/24 at 03:15 PM the DON provided signed resident check forms for the incident on 06/11/24 in which the resident was unobserved for a period of 56 minutes. The resident check forms indicated the resident was checked every 30 minutes despite contradictory evidence. In interviews with nine residents who wished to remain anonymous, it was stated the residents do not feel the facility has adequate staffing to support all of their needs. The residents detailed long call lights, especially during the second shift after dinner and the overnight shift. Several residents stated the call lights had resulted in them being incontinent on more than one occasion. They stated they had missed baths several days in a row. In an interview on 06/10/24 at 10:38 AM, one resident reported she had not received a shower since 6/4/24, and now she had a yeast infection. She is supposed to get a shower on Tuesdays and Fridays. Staff said they didn't have time to give her a shower. In an interview on 6/10/24 at 3:08 PM, one resident reported he hadn't had a bath in 10 days, not even a bed bath. The resident reported he was supposed to get a bath on Mondays, Wednesdays, and Fridays. The last bath he had was on Wednesday, 6/5/24. The resident reported the facility didn't have enough staff to care for all of the residents at the facility. The facility continued to use the same number of staff even though more residents had moved into the same hall he resided. The facility couldn't keep staff for some reason. Staff called in all of the time, and staff worked double shifts. One resident reported wounds not consistently getting cleaned. The seepage (drainage) is so bad from his foot it drained through the bandage, through his sock, and onto the floor when the dressing was not changed like it should. He stated it depended on who the nurse was if treatments got done. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/24 at 03:08 PM, one resident reported she had been incontinent due to slow help after pressing her call light on more than half of the occasions. She reported second shift times were significantly worse than first shift times. In an interview on 06/10/24 02:01 PM with a resident family member, he stated he does not feel the facility has adequate staff to care for all of the residents. He noted meal times don't always have enough staff, it is worse during the evening meal. In an interview on 06/11/24 at 09:14 PM with Staff K, Certified Medication Aide (CMA), it was stated the facility did not have enough staff on the evening shift to adequately care for all of the residents. She detailed being repeatedly forced to perform certified nursing aide (CNA) duties during medication pass times due to an inadequate number of staff to handle mechanical lift transfers requiring two staff to be present during the transfer. She has previously spoken to the DON about staffing considerations, and fears that further attempts to address the situation would result in retribution. In an interview on 06/10/24 at 09:24 PM with Staff L, Licensed Practical Nurse (LPN), it was stated she does not believe the facility has enough staff to care for the residents in a safe and timely manner. She has voiced this on prior occasions to the DON and fears that further attempts to communicate this point would result in retribution. In an interview on 06/11/24 at 07:48 PM with Staff M, CNA, she stated she feels they don't have enough staff to care for everyone in a timely manner. She noted the care requirements of residents in the 200 hallway were significant and require two CNAs or other nursing personnel. In an interview on 06/17/24 at 12:17 PM Staff N stated she knows that staffing on the evening shift, from 2 pm-10 pm is rough. She noted she does not work nights and weekends, but has been told by her coworkers nights and weekends need more staff members. In an interview on 06/17/24 at 12:20 PM Staff O, CMA, stated the evening shift struggles with staffing. She acknowledged she is pulled from CMA duties during medication pass times to help with CNA duties on more than 50% of occasions. She feels her medication passes are rushed as a result. In a review of facility documents, it was reported by the facility that on two occasions, 02/19/24 and 02/20/24, two residents were left unsupervised for a period of 55 minutes on 02/19/24 and a period of 63 minutes on 02/20/24 which resulted in a resident to resident sexual encounter that required investigation by the Iowa Department of Inspections, Appeals, and Licensing. In an interview on 06/13/24 at 12:01 PM with the Administrator and DON, they stated they base staffing off of their facility assessment, as well as input from their staff, residents, and resident families. The Administrator noted she looks to grievance logs as well as resident council notes to look for patterns of low staffing. It was acknowledged by the DON that the facility may need to buff up staff requirements on 2p-10pm. Review of a facility document titled Facility Assessment, completed on 05/04/24, states staffing requirements are based off of feedback, amount of care required for residents, and nurse consultant recommendations. Pool staff and agency staff are to be utilized as needed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on clinical record review, staff interview, and policy review, the facility failed to attempt non-pharmacological and behavioral interventions prior to the use of or in conjunction with antipsychotic medication use for one of four residents reviewed for unnecessary medications (Resident #50). The facility reported a census of 86 residents. Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 50 had diagnoses of Parkinson's Disease, dementia, Tourette's syndrome, and repeated falls. The MDS documented the resident had no hallucinations, delusions, or behaviors. The MDS documented the resident took antidepressant and had no psychological therapy during the 7-day look-back period. The Care Plan revised 3/27/24 revealed the resident had vascular dementia, Tourette's disorder, and a mood disorder. The resident took a psychotropic medication. The care plan directed staff to monitor resident condition and medication side effects. The Care Plan documented a focus area that the resident had behavior symptoms related to non compliance, aggressive comments, and yelling at staff. Interventions for this focus area included interventions for staff to carry out are to provide opportunity for positive interaction, and attention, as well as minimize potential of resident behavior problems by modifying environmental factors and daily routine. The Medication Administration Record (MAR) dated 5/2024 to 6/12/24 revealed Hydroxyzine 10 milligrams (mg) by mouth every 6 hours as needed (PRN) for anxiousness, restlessness, and irritability administered on 5/16/24, 5/24/24, 5/27/24, 5/31/24, 6/1/24, 6/8/24, and 6/12/24. The Progress Notes lacked non-pharmacological interventions attempted and documented prior to administration of Hydroxyzine medication for Resident #64 on the following: 05/31/24 at 10:57 PM 06/1/24 at 11:05 PM 06/8/24 at 7:22 PM 06/12/24 at 7:42 PM The MAR also revealed Lorazepam 2 milligrams (mg) per 1 milliliter (ml) injected intramuscularly (IM) on 06/12/24 at 11:00 PM for psychotic disturbance, mood disturbance, and anxiety. The progress notes lacked non-pharmacological interventions attempted and documented prior to administration of the medication. In an interview 06/17/24 at 12:15 PM, Staff C, Registered Nurse (RN) reported she documented on the MAR whenever she gave a PRN antianxiety or antipsychotic medication, and also wrote a progress note as to why she gave the medication and if any non-pharmacological interventions were done. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/17/24 at 1:20 PM, Staff A, RN, reported whenever she gave a PRN medication such as antianxiety or pain medication, she documented the medication administration on the MAR and listed the non-pharmacological interventions attempted in the progress notes. In an interview 06/18/24 at 07:30 AM, the Director of Nursing (DON) reported she expected staff documented three non-pharmacological interventions attempted in the resident's progress notes whenever a PRN medication administered. A Psychotropic Medication policy reviewed 12/6/23 revealed alternatives behavioral interventions evaluated before psychotropic medication administered. Under Section 3c: non-pharmacological interventions attempted should be documented in the resident care record.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, clinical record review, interviews, and policy review, the facility failed to administer medications to the correct resident (Resident#87) and, administer the correct dose of a pain medication to (Resident#3). Resident#87 was taken to the emergency room , and treated for the overdose of medications as a result of the incident when the resident experienced low blood pressure, and low pulse rate. The facility staff also left medication unattended. Seven residents were reviewed for medications. The facility reported a census of 86 residents. Findings include: 1. The Minimum Data Set (MDS) Admission assessment for Resident #87 dated 4/23/24 documented a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicated intact cognition for decision making. The MDS revealed he had diagnoses of cerebral infarction referring to a recent stroke, renal disease, urinary tract infection, diabetes, depression and age-related cognitive decline. The Care Plan initiated 4/19/23 documented Resident #87 resident will be free from discomfort of preventable adverse reactions related to medication. A Progress Note dated 4/29/24 12:51 PM by Staff A, Registered Nurse (RN), late entry documented Resident#87 spouse medications sitting on bedside, waiting for blood pressure to be obtained, Resident #87 reached and took spouses medication. Provider, Nurse Practitioner (NP) at the facility notified, family aware, monitored per order and sent to ER for evaluations. A Progress Note 4/29/24 9:35 AM documented by Staff B, revealed provider, NP in facility notified took own medication as well as spouses who takes several blood pressure medications. Received new order to monitor blood pressure and pulse every two hours for 8 hours. A Progress Note dated 4/29/24 by Staff B, effective time 11:50 AM documented family notified took spouses medication this morning and blood pressure 82/46 at 11:30 AM. Resident # 87 on way to hospital. A Progress Note dated 4/29/24 by Staff B, created 12:18 PM documented, called and informed the hospital, resident took the wrong medications and has allergies to Atrovastatin and Simvastatin and the resident did take Pravastatin. Informed the Emergency Department (ED) that the medications and recent blood pressures were provided to the paramedics for the ED to review. A statement signed by the Director of Nursing (DON) on 4/29/24 documented on the morning of 4/29/24 at 9:20 AM received a message, Resident #87 received incorrect medications. An investigation revealed, the Registered Nurse (RN), Staff A placed the medication cup of Resident #188 on the bedside table of spouse, Resident #87. The RN left to obtain a forgotten alcohol wipe, when RN Staff A returned the medication cup was empty. Resident #188 and RN Staff A realized Resident #87 had taken the pills. The provider, Nurse Practitioner (NP) was in the facility, was notified along with family. Resident #87 was sent to ER for evaluation, was treated with calcium gluconate and fluids and returned to the NF, no other new orders. Nurse interviewed revealed no other residents affected, no other residents were left with medication unsupervised. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A Facility Incident Report dated 4/29/24 documented, Resident #87 reached over and took Resident #188 medications, not remembering he had already taken his medication. Noted medication error, wrong medication and indicated Resident #87 blood pressure was monitored, resulted in hospital, ED visit. Hospital ED Physician Notes dated 4/29/24 documented inadvertent overdose on medication, diagnosis of beta blocker overdose (refers to mediations to lower blood pressure. Documented inability of Resident #87 to provide clear information, some confusion, undetermined if is baseline. Resident #87 blood pressure dropped to 80/40 after the incident, resident was bradycardic (low pulse rate) and hypotensive (low blood pressure) was treated with intravenous (IV) fluids and IV calcium, observed for seven hours post ingestion until blood pressure and heart rate improved. Coded complexity of problem, high an illness or injury that posed life threat or bodily function threat. The Medication Administration Record (MAR) April 2024 for Resident #87 documented took as directed on 4/29/24. a. Calcium-Vitamin D3 600-10, 1 capsule by mouth in the morning b. Apixaban oral tablet 5 MG, two times a day for anticoagulant c. Atenolol oral tablet 25 MG two times a day for hypertension d. Cetirizine HCl oral tablet 10 MG 1 tablet daily for allergies e. Docusate Sodium oral tablet 100 MG 2 tablet daily, constipation f. Escitalopram oral tablet 10 MG 1 tablet daily for depression g. Ferrous sulfate oral tablet 325 (65 Fe) MG two times a day h. Fish Oil, one oral capsule in the morning i. Magnesium Ox oral tablet 400 MG supplement, two times a day j. Metformin HCl oral tablet 500 MG two times a day for diabetes k. Multivitamin Men 50+ tab daily, ensure no Vitamin K additive l. Oxybutynin oral tablet 5 MG, two times a day for urinary spasms m. Pantoprazole Sodium oral delay release 40 MG daily, heart burn n. Theophylline ER oral extended release, 400 MG daily for asthma o. Macrobid oral capsule 100 MG two times a day for urinary tract infection (UTI) for 7 days beginning 4/27/24 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The MAR, April 2024 for Resident #188 documented the following morning medications, reported was taken by Resident #87 accidentally. a. Calcium, Vitamin D Oral Tablet 600-3.125, supplement, daily b. Cholecalciferol Oral Capsule 50 MCG (2000 UT) supplement, daily c. Docusate Sodium Oral Tablet 100 MG daily for colon health d. Famotidine oral Tablet 20 MG daily for stomach upset/acid reflux e. Ferrous Sulfate Oral Tablet 325 supplement one, Monday & Friday f. Levothyroxine Sodium Oral Tablet 75 MCG one daily for thyroid g. Methylcobalamin Oral Lozenge 1000 MCG supplement daily h. Multivitamin Oral Tablet one time a day for supplement i. Pravastatin Sodium Oral Tablet 20 MG one daily for hyperlipidemia j. Valacyclovir Oral Tablet 500 MG daily for preventative k. Vitamin B12 Oral Tablet 500 MCG one supplement daily in AM l. Amlodipine Besylate Oral Tab 5 MG twice daily for hypertension m. Buspirone HCl Oral Tablet 10 MG twice daily for anxiety n. Labetalol HCl Oral Tablet 200 MG twice a day for hypertension o. Verapamil HCl Oral Tablet 120 MG three times a day for hypertension In an Interview on 06/13/24 at 09:34 AM, RN Staff A reported she did prepare medications for Resident #188 set them on the table per resident requested, went out of the room and came back, Resident #188 said you didn't set my pills there. Was determined Resident #87 took the pills, was evident as blood pressure assessed and it continued to go down, Resident #87 sent out to the hospital In an interview on 6/13/24 01:44 PM, RN Staff B recapped events of 4/29/24 relayed was the charge nurse, other RN, Staff A was working to administer medications relayed, can't believe what happened, relayed had put Resident #188 pills on the table left to get an alcohol wipe and came back the pills were gone. Staff A asked where are pills went, Resident #188 replied, Resident #87 took them. Staff B also relayed she alerted the ED what medications were taken by printing off both resident MAR's and highlighting the AM medications taken, from Resident MAR's # 188 and 188. Staff B recalled hospital report of treatment included calcium gluconate and fluids and thought a Beta blocker reversal was indicated medications to reverse the low blood pressure in regards to the extra medications taken. In an interview on 06/13/24 at 07:57 AM the DON relayed medication should not be left unattended. (continued on next page)

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	06/18/2024

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 0760 Level of Harm - Actual harm Residents Affected - Few	Facility Electronic file dated 4/29/24 revealed hospital visit summary dated 4/29/24, diagnosis noted, Poisoning by beta-adrenoreceptor antagonists, accidental (unintentional toxicology problem). Medication Policy with revised date 5/21/24 directed staff as follows; *To administer medications correctly and in a timely manner *Once medication pass has begun, interruptions should be avoided. Unless emergent, no one should interrupt the nurse/medication aid during the medication pass. *Medications are administered to the resident according to the Six Rights. -Right resident -Right medication -Right dose -Right time -Right route -Right documentation *Do not leave medications at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration. 2. Observation on 6/11/24 from 7:20 AM to 8:25 AM of medication administration by Registered Nurse (RN) Staff C, prepared med's and went to residents' room to give medication, cart unattended, prepared med's for another resident, left cart to go to resident room and repeated leaving cart unattended while entering rooms of five (5) residents to administer medications. On top of the medication cart a plastic container with individual boxes labeled for residents, translucently viewed various insulin medication pens in the individual boxes, the container also contained diabetic supplies a glucometer, cotton, cleansing wipes, a cup of insulin pen needles was also observed on the top of the cart. On 6/11/24 at 8:25 AM, Staff B, RN queried regarding diabetic supplies and insulin left on the cart unattended. Staff B relayed in the morning took diabetic medications and supplies from the med room and is usual to leave it on the cart, generally they sit out when actively used in the mornings. Staff C, RN reported, she felt the pens need a needle added to inject so felt it was not a concern. A separate cup of insulin needles observed remained accessible on the top of the cart. Staff C in addition relayed, was not told not to do this. In an interview on 06/13/24 at 7:57 AM with the Director of Nursing (DON) acknowledged medication should not have been left unattended. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	49698 3. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #3 had diagnoses including of Multiple Sclerosis (MS), Malnutrition, Stage 4 pressure ulcers, anxiety, depression, and diabetes. The MDS documented that the resident received scheduled pain medication.The MDS documented the residents pain as follows; pain experienced almost constatly, pain frequently made it difficult for the resident to sleep, pain frequently limited the residents day-to-day activities. The MDS documented the resident described her pain as a 7 on a scale of 0 to 10. The Care Plan dated 3/11/24 revealed Resident #3 had unclear speech, slurred or mumbled words, receives pain medication due to chronic pain, is immobile and needs total assistance for all transfers and cares. Review of resident #3's physicians orders revealed the following orders: 3/21/24 Fentanyl Patch 72 hour 25 MCG/HR, Apply one patch transdermally every 72 hours for pain and remove per schedule. Discontinued on 3/25/24 3/25/24 Fentanyl Patch 72 hour 50 MCG/HR, Apply one patch transdermally every 72 hours and remove per schedule. Review of resident #3's Medication Administration Records (MAR) for 3/1/24-6/12/24, revealed on 4/9/24 no nurse's signature was noted, indicating no Fentanyl patch had been administered. Review of Controlled Drug Receipt/Record/Disposition Form (form used to document dispensed and inventoried controlled medications) revealed the following: On 4/10/24 at 1600, two 25 MCG/HR Fentanyl patches were signed out. Indicating these patches were administered late. (scheduled to be administered on 4/9/24) On 5/18/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. 5/21/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. 5/24/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. 5/27/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. 5/30/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. 6/8/24 at 7:45 PM, one 25 MCG/HR Fentanyl patch was signed out, indicating the wrong dose was administered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of resident #3 ' s nurses progress notes revealed, on 4/9/24 the nursing staff failed to document the scheduled Fentanyl 50 MCG/HR patch had not been administered, reason for not being administered, and notification to family and physician. On 4/10/24 nursing staff failed to document two 25 MCG/HR Fentanyl patches had been administered late and notification to family and physician was made. Review of the controlled medication receipts, provided by the pharmacy, verified the quantity of Fentanyl patches, date, time and signature of staff who received the delivery from the pharmacy. Interview on 6/12/24 at 9:27 AM, A Pharmacy Technician with the Facility ' s contracted pharmacy revealed the process of receiving new and discontinued orders. The order is faxed from the facility to the pharmacy. When it is a controlled substance, the pharmacy will contact the writing physician for signature of ordered medication. When a controlled substance is discontinued by the physician, the pharmacy is to be notified by a faxed discontinuation order from the facility. The facility is responsible for disposing of the discontinued controlled medications by destroying them in a pharmacy provided, DEA approved, Rx destroyer. This is a container that contains a formula that neutralizes the substances placed inside. The Pharmacy Technician confirmed the facility has been provided a Rx destroyer. During an interview on 6/17/24 at 3:35 PM, the facility Administrator acknowledged administering the 25 MCG/HR Fentanyl patch was not following physicians orders, indicated a significant medication error. Review of Medication Administration policy dated 5/21/24 revealed: 1. Medications are administered to the resident according to the Six Rights. (Right medication, right dose, right resident, right route, right time and right documentation). 2. Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication. Document that the medication was given as soon as possible after administration. 3. Do not leave medications at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration. If the resident has not been assessed for safety of self-administration and there is not a physician order to leave the medication with the resident, stay with the resident until the medication is taken and you observe the resident swallow. 4. An incident report will be completed for all medication errors. If a medication is not available for 24 hours, the provider must be notified. Review of Maintenance of Active Medical Records dated 5/11/23 revealed, the location will maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34817 Based on observations, record review, staff interview, and facility policy review, the facility failed to ensure complete and accurate records kept, and failed to provide access to electronic health records in a timely manner in order to facilitate an efficient survey process. The facility reported a census of 86 residents. Findings include: 1. On 06/10/24 at 08:40 AM, the Director of Nursing (DON) stated they used the On-Base software system for storing resident documents. At the time, the DON stated she would get facility computers set up for the surveyors. On 06/10/24 at 9:17 AM, the surveyor sent an email to the Administrator with survey documents and items needed for survey, including access to all resident medical records (paper, electronic health records (EHR), etc.) On 06/10/24 at 10:15 AM, the surveyor met with the Administrator and requested access to the EHR's, which included access to On-Base resident records/documents. The Administrator stated she needed to get a couple of computers set-up so the surveyors could access the residents' medical records and documents. On 06/10/24 at 4:40 PM, the Administrator reported she was in the process of getting the facility's computers for surveyors and would have them first thing the following day when the surveyors entered the facility on 6/11/24. Due to security concerns, the On-Base could only be accessed by the company's wifi connection. On 6/11/24 at 7:30 AM, no facility computers were available in the conference room for the surveyors. On 06/11/24 at 8:35 AM, the surveyor inquired about the facility's computers for surveyors to use to access resident record documents such as advanced directives, etc. The Administrator apologized to the surveyor and stated the computers she designated for the surveyors were taken home by staff. She was in the process of calling the staff to bring the computers back to the facility. She planned to check around and see what she could do in the interim. On 6/11/24 at 9:30 AM, the Therapy Director provided two laptop computers for surveyors to use. The Therapy Director advised the wifi connection and user name were different and in addition to the wifi connection, as well as the previous EHR username, prefix and password provided for the other EHR software program accessed by the surveyor's computers. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the survey week, on 6/11/24 at 5:20 PM the DON sat in her office with a stack of papers on her desk. The DON reported she was entering information from the skin monitoring forms because the nurses didn't have time to enter the information. A box of papers sat on the floor in the DON's office. The DON reported if there were certain residents the surveyors needed information on, to let her know and she would dig through the pile of papers to find what was needed. Not all of the resident's paper records were scanned. 3. The electronic health record entrance conference worksheet provided by the facility to the surveyors listed items such as advanced directives, PASRR information, etc. and where or how to locate the information in the records. The step by step list for finding the information was incorrect. 4. On 6/11/24 at 10:54 AM, review of the facility's electronic health records and software program containing medical records documents lacked a Pre-admission screening and resident review (PASRR) documentation for Resident #64. An email sent to the Administrator on 6/12/24 at 8:50 AM from the surveyor requested the PASRR for Resident #64 due to surveyor unable to locate the documents in the resident's records. On 6/12/24 at 9:00 AM, the Administrator reported they did not have a PASRR on Resident # 64 and facility staff were in the process of fixing this. In an email on 6/12/24 at 11:00 AM, the Administrator advised a PASRR request was submitted to their vendor for Resident #64. On 6/13/24 at 8:45 AM, the Social Worker (SW) reported their PASRR vendor had record that a PASRR had been previously completed on Resident # 64 on 7/3/23. The vendor forwarded a copy of the PASRR to the facility. The SW stated she didn't know why the PASRR wasn't in the resident's EHR or paper record. 5. A direct observation on 06/11/24 at 08:41 PM revealed Resident #9 wandering the hallway of the facility without staff in sight. Resident #9 wheeled himself into the activities room and was unobserved by facility staff for a period of time from 08:41 PM until staff checked on him at 09:37 PM. Review of Resident #9's care plan at the time of the incident indicated that Resident #9 was on 15-minute checks. In an interview on 06/12/24 at 03:00 PM the DON acknowledged the resident had not had staff eyes on for a period of 56 minutes. On 06/13/24 at 03:15 PM the DON provided signed resident check forms for the incident on 06/11/24 in which the resident was unobserved for a period of 56 minutes. The resident check forms indicated the resident was checked every 30 minutes despite contradictory evidence. In an interview 06/17/24 at 12:10 PM, the Health Information Management (HIM) Manager reported she had worked at the facility since 3/2024. The HIM stated she collected the paper medical records/documents from each nurse's stations folder. She prepped the papers and scanned them. Currently someone else indexed the documents until she got trained on how to do this part. She also kept track of physician visits, and followed up on documents from the physician to scan into the EHR. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 06/17/24 at 03:00 PM, the Administrator reported resident medical record documents were supposed to be uploaded into the On-base chart but she found out some documents had not been uploaded. A personnel change was made in the Health Information Management (HIM) department. The facility's Maintenance of Active Medical Records policy revised 5/11/23 revealed medical records maintained on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. Electronic documentation maintained in Point Click Care (PCC) and OnBase systems, and paper documentation maintained in folders or record holders sufficient in size for the volume of the record. All current documentation documented in PCC, and paper clinical documents scanned and indexed into OnBase. Paper medical records shall be arranged in an orderly fashion and stored in an overflow file area for current residents.

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	165186	A. Building B. Wing	06/18/2024

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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** 34817 Based on clinical record review, observations, staff interview, and policy review. The facility failed to ensure staff changed gloves and sanitized hands in accordance with proper infection control techniques when contaminated to protect against cross contamination and potential infection for one of five residents observed for treatments/dressing changes (Resident #64). The facility reported a census of 86 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #64 had diagnoses of sepsis, diabetes, chronic left foot ulcer, and an unstageable pressure ulcer on the right heel. The MDS indicated the resident took an antibiotic during the look-back period. The Care Plan updated on 4/29/24 revealed the resident had a left heel pressure ulcer and impaired skin integrity. The resident required Enhanced Barrier Precautions (EBP). The staff directives included a weekly skin observation by a licensed nurse and treatments as ordered. The Physician's Order Summary report revealed the following orders: Cleanse left heel wound and right plantar foot wound with cleanser of choice, apply betadine to wounds, and cover with a bordered foam dressing daily and as needed for wound care (start date of 6/7/2024). During observation on 6/12/24 at 9:55 AM, Resident #64 sat in a wheelchair. Staff E, Licensed Practical Nurse, donned a gown and pair of gloves, and obtained supplies from a dresser drawer in the resident's room. Staff E removed the resident's socks, then removed the soiled dressings on the left heel and right lateral/plantar foot. Staff E opened the door to the room with her gloved hand, and obtained gloves from a box of gloves located inside the isolation door pocket that hung on the outside of the resident's room. Staff E donned a glove, opened the top dresser drawer, and pulled additional supplies from the drawer. Staff E placed the dressing supplies on a chux on the floor in front of the resident. Staff E removed the glove on her left hand and donned another glove. Staff E sprayed wound cleanser on a piece of gauze and cleansed the wound on the resident's right foot, then took additional gauze and wound cleanser and cleansed the wound on his left heel. Staff E used another gauze to dry the areas. Staff E changed her gloves, opened a package of betadine and applied the betadine around and over the wound, then applied skin prep around the perimeter of the wound. Staff E waved a dressing package containing a silicone dressing near the wound site to dry the area, then placed the silicone dressing over the left heel wound. Staff E applied betadine to the right plantar foot wound, applied skin prep to the perimeter of the wound, then applied a silicone dressing to the right plantar/side of the foot. Staff E removed her gloves, donned another pair of gloves, and applied skin prep to the resident's right great toe. Staff E removed her gloves and gown, and sanitized her hands. In an interview 06/18/24 at 07:30 AM, the Director of Nursing (DON) reported she expected staff changed gloves whenever going from a dirty to a clean area, and washed their hands before and after a treatment performed or dressing changed, and hand sanitize whenever they change their gloves. (continued on next page)

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	165186	A. Building B. Wing	06/18/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An infection control policy reviewed/revised 9/19/22 revealed gloves removed and hands washed after handling soiled dressings. Apply clean gloves before proceeded with treatment or reapplication of dressings. Re-gloving and handwashing may be necessary between treatments that involve more than one body site. A wound dressing change policy reviewed 12/4/23 revealed a wound dressing change done to help wounds remain free of infection and to promote wound healing. The procedural steps included: a. Don gloves. b. Remove soiled dressing c. Remove gloves d. Perform hand hygiene e. Don gloves f. Cleanse wound thoroughly with gauze and wound cleanser g. Remove gloves and perform hand hygiene h. Apply treatment /dressing