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	04/24/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35434 Based on clinical record review, policy review, and staff interview, the facility failed to ensure staff had access to an accurate code status for 1 of 24 residents reviewed for advance directives (Resident #16). The facility reported a census of 81 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated [DATE], listed diagnoses for Resident #16 which included mild intellectual disabilities, heart failure, and depression. The MDS listed a Brief Interview for Mental Status(BIMS) score as 12 out of 15, indicating moderately impaired cognition. The facility policy Advance Directives including Cardiopulmonary Resuscitation(CPR) and Automated External Defibrillator(AED), revised [DATE], stated the facility would keep advance directive orders in a binder easily accessible to the nursing staff. On [DATE] at 11:42 a.m., Staff A Registered Nurse(RN) stated he would look in the computer first for code statuses and then would look in the binder at the nursing station next. On [DATE] at 11:42 a.m., a binder at the 100 Hall nursing station contained Resident #16's Iowa Physician Orders for Scope of Treatment(IPOST), dated [DATE]. The IPOST directed staff to carry out CPR if the resident had no pulse and was not breathing. On [DATE] at 11:42 a.m., the resident's electronic health record(EHR) face sheet stated the resident wished to be a Do Not Resuscitate(DNR) status. Resident #16's Iowa Physician Orders for Scope of Treatment (IPOST), dated [DATE], stated the resident wished to be a DNR status. On [DATE] at 12:31 p.m., the Director of Nursing(DON) stated she expected the IPOSTs in the binders at the nursing station to be accurate.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35434 Based on observation, policy review, and staff interview, the facility failed to ensure floors were clean and non-sticky for 1 of 24 resident rooms reviewed (Resident #16). The facility reported a census of 81 residents. Findings include: The facility policy Housekeeping, Resource Packet, revised 10/2/24, stated the facility would keep a daily schedule for cleaning floors that included more thorough cleaning on a routine schedule. On 4/22/25 at 9:15 a.m., the floor of Resident #16's bathroom was very sticky throughout. While walking, shoes noticeably stuck to the floor. Subsequent observations on 4/23/25 at approximately 8:15 a.m. and 4/24/25 at 9:48 a.m., revealed the floor remained sticky. On 4/24/25 at 1:02 p.m., the Ancillary Services Manager stated he was informed of Resident #16's bathroom floor stickiness today and contacted the floor cleaner company to make sure the cleaning solution dilution ratio was correct. On 4/24/25 at 3:01 p.m., the Administrator stated she had a conversation with the Ancillary Services Manager last week about the solution being too concentrated. She stated the cleaner company was coming next week to remedy the situation.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, observations, resident and staff interview, and policy review the facility failed to protect residents from abuse for 1 of 2 residents reviewed for abuse (Residents #69). The facility reported a census of 81 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 had diagnoses of cancer, Alzheimer's Disease, dementia, and diabetes. The MDS recorded the resident had impaired short-term and long-term memory, severely impaired decision-making skills, and inattention. The MDS revealed the resident had a wanderguard alarm, and had independence with transfers. The MDS assessment dated [DATE] revealed Resident #50 had diagnoses of sexual dysfunction not due to a substance or known physiological condition, dementia, and malignant neoplasm of the pancreatic duct. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 6, indicating severely impaired cognition. The MDS recorded the resident had no behaviors, and did not have an alarm or wanderguard. The MDS indicated the resident independent for transfers and had the ability to ambulate at least 150 feet independently. The Care Plan initiated 11/7/24 and revised on 2/28/25 revealed the resident had impaired cognition and thought processes related to dementia. The resident ambulated and transferred independently with and without a cane. The Care Plan revealed the resident displayed inappropriate sexual advances towards another resident related to fondling, grabbing and touching the resident (initiated 11/7/24). The Care Plan directed staff to monitor the involved residents and know the resident's whereabouts, specifically while the resident was in the hallway (added on 11/7/24). A motion detector sensor was placed on the resident's door (added on 2/27/25), and 15-minute checks utilizing a monitor at the nurse's station and 1:1 whenever the resident was outside of his room (added to the care plan on 4/16/25). The Order Summary revealed the following orders: 11/7/24 - Medroxyprogesterone Acetate (a hormone) 20 milligrams (mg) daily for hypersexual behavior 2/24/25 - send Resident #50 to the Emergency Department (ED) for complaints of chest pain, shortness of breath (SOB), and elevated blood pressure. 2/24/25 - Sertraline (an antidepressant) increased to 75 mg by mouth (PO) daily 2/25/25 - obtain a UA (urinalysis) for increased behaviors for 2 days. 2/26/25 - Doxycycline (antibiotic) 100 mg BID (twice a day) for 10 days and Prednisone 20 mg daily for 7 days for pneumonia. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4/24/25 - increase Medroxyprogesterone to 40 mg PO daily for hypersexual behavior Incident reports revealed the following: a. On 11/5/24 at 4:42 PM, Staff H, certified nursing assistant (CNA), heard a female resident state no, no, no and turned to see Resident #50 cupping the female resident's vagina through her clothing while the resident stood in the hallway. Resident #50 was told to stop. Resident #50 stopped and walked away from the female resident. Resident #50 was placed on medication for sexual behavior. Resident #50 ambulatory without assistance and oriented to person. Resident #50 snickered when staff asked him what happened. Resident #50 said no when staff asked him if he touched the lady. Resident #50 educated is was inappropriate to touch other residents. A medication review was completed. b. On 2/23/25 at 11:00 AM, Registered Nurse (RN) paged to a resident's room STAT (immediately). CNA notified the nurse a male resident was in a female resident's room touching the resident inappropriately. CNA immediately told male resident to stop, do not touch her, get out, that is not ok. Male resident was directed back to his room. A full assessment was completed. Female resident was lying in bed sleeping with her brief pulled down. She stated not remembering what happened. Female resident notified of what occurred and became tearful. Resident #69 said she did not say Resident #50 could do that. Male resident placed on 1:1 observations. Resident #50 stated I know what I was doing, I needed to please her and that is what I was going to do. Resident #50 notified he could not to go into (resident) rooms that aren't his. The Director of Nursing (DON), Nurse Practitioner (NP), Assistant Director of Nursing (ADON), Administrator, and family were notified. The Quarterly MDS dated [DATE] documented Resident#69 had diagnoses including, Stroke, difficulty swallowing, left sided weakness, slurred speech, and muscle weakness. The MDS revealed the resident required total assistance of staff for transfers, and dressing. The MDS did not reveal any mood or behavior concerns. The Annual Assessment MDS dated [DATE] documented Resident#69 had the following symptoms present nearly every day over the last two weeks; trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy. The MDS revealed the resident had the following symptoms present 2-6 days in a 14 day look-back period, trouble concentrating on things, such as reading the newspaper or watching TV, moving or speaking so slowly that other people could have noticed, to the opposite- being so fidgety or restless that you have been moving around a lot more than usual. The Facility's Investigation File revealed a summary of the incident that occurred on 2/23/25: Staff G, RN, paged to Resident #69's room STAT. Staff F, Certified Medication Aide (CMA), notified Staff G she walked in on Resident #50 in Resident #69's room and found him touching Resident #69 inappropriately. The residents were separated immediately. Staff F stated to the Administrator she saw Resident #50 within the last 5 minutes and at that time he was not in Resident #69's room. Resident #50 had not had previous inappropriate sexual behaviors with Resident #69. The staff noted Resident #50 was not at baseline on this day. He spoke non-stop and something just seemed off. It was noted later that he had an infection (pneumonia). A UA was obtained on 2/28/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #69 had a BIMS of 13, indicating intact cognition. Resident #69 stated to Staff G she was confused about what was going on and she was alarmed by all of the yelling by staff as she had been relaxing in her bed half asleep when Resident #50 came into the room. She told the nurse she was not traumatized by the event. A full body assessment revealed no concerns. Social Services (SS) followed up with both residents for 3 days. Resident #50 had a BIMS of 3. He was unable to sign a statement due to his cognition and functional conditions. Resident #50 had expressed his preference to spend most of the time in his room but he came out of his room at times. Resident #50 moved to a different room away from Resident #69, by all male residents and nearby the nurse's station in order to keep an eye on him. Staff stated they felt the root cause of the resident's behavior may have been related to an infection. The police were contacted. A Psychiatry (Psych) visit occurred on 2/27/25. The physician reviewed the resident's medication and increased Sertraline to 75 mg for sexual behavior on 2/23/25 at 4:04 PM. An order for Prednisone 20 mg daily for pneumonia started on 2/26/25. The Ombudsman visited the facility on 2/27/25. Resident #69 had no concerns regarding the event and felt the facility addressed everything accordingly. A room change was offered to her but she declined. A motion detector monitor and baby monitor placed to ensure staff got alerted if Resident #50 was awake and to monitor if he came out of his room. Other female residents in the facility that had the potential to be impacted stated they felt safe and had no issues with the male resident. A typed statement dated 2/23/25 revealed Staff F, CMA, went to get a blood sugar on Resident #50's roommate. Resident #50 was not in the room. Staff F went to look for Resident #50 throughout the building where he normally went. Staff F started opening doors and checked other residents' rooms and found Resident #50 in Resident #69's room. Staff F saw Resident #50 sitting at the foot of Resident #69's bed with her brief all the way undone and his hand between her legs. Staff F was unsure if Resident #50 penetrated Resident #69. Staff F told Resident #50 to stop, don't touch Resident #69, that is not ok, this is not his room. Resident #69 woke up and looked like what is going on? Resident #50 got out of Resident #69's room. Staff F called for Staff G to get there STAT. Staff then met up at the nurse's station to call the people that needed notified. Resident #50 came out of his room looking for Resident #69 again. The police came ten minutes later. Staff F showed the police officer what happened and what she walked into. Resident #50 was placed on 1:1 watch while staff figured out what to do. An undated typed statement from the Administrator revealed the Administrator spoke with Staff F again on 2/28/25. Staff F witnessed the female resident's brief located to the side and the male resident by the bed next to her in a wheelchair with his hand by her legs. Staff F had just seen Resident #50 less than five minutes before. Staff F went to administer medications to Resident #50's roommate, then Staff F went to administer Resident #50's medications and found Resident #50 in Resident #69's room. Staff F screamed at Resident #50 because she assumed he was touching Resident #69 because her brief had been pulled to the side. Staff F said that startled Resident #69. She again told the Administrator she immediately separated the two residents and got the nurse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A written statement by Staff G, RN, revealed: RN was paged to Resident #69's room STAT. The CNA notified the nurse that the male resident was in the female resident's room touching the resident inappropriately. The CNA told the male resident to stop, do not touch her, get out, that is not ok. The male resident was directed back to his room. A full assessment was completed. The female resident was lying in bed with her brief pulled down. Resident #69 stated not remembering what happened. Resident #69 was notified about the incident and she was tearful. Resident #69 stated she did not say he could do that. Resident #69 stated she is ok at that time. Resident #50 in his room on 1:1 observation. Resident #50 stated he knew what he was doing. He needed to please her and that is what he was going to do. Resident #50 was notified he could not go into rooms that are not his. The DON, NP, ADON, Administrator and families of both residents notified. A typed statement signed by Resident #69 on 2/23/25 revealed the resident stated she did not remember what happened. Resident #69 said she did not say that Resident #50 could do that. Police Reports revealed: a. On 11/04/2024 at approximately 3:35 PM, an officer responded to the facility for a report of sexual abuse between residents. The officer met with the staff who witnessed to event. Staff O stated that at approximately 5:00 PM, Resident #50 and Resident #37 walked down opposite sides of the hallway. Staff O stated she saw Resident #50 grab Resident #37 vagina over her clothing and stated there it is. Staff O escorted Resident #50 back to his room and he was giggly but that is his normal demeanor. Staff O stated that Resident #50 had dementia and did not understand what he had done due to his mental status. Staff O also stated that Resident #37 was autistic and unable to comprehend what had happened. Staff at the facility stated they contacted the family members of both individuals regarding plans moving forward. It was reported that Resident #50 would have another psych evaluation and medication review to help treat his condition and for the safety of others in the facility. Staff reported they would make sure Resident #50 kept separate from Resident #37 in the future. b. On 2/23/2025 around 10:56 AM, a police officer was dispatched to the facility for a report of sexually inappropriate activity. Staff G stated that earlier that AM, a nurse walked into a female resident's room and observed her diaper around her ankles while a male was performing a sex act on her. The female victim, Resident #69, was sleeping during the assault. Resident #69 suffers heavily from dementia. She stated that she did not remember anything that happened. Resident #69 stated that she was told a man was in her room that AM. Resident #69 stated that she did not remember anything about the incident. She stated that her legs were in some pain, but that she had leg pain daily. Resident #69 stated that she had no knowledge of who the male was. The Officer then spoke with Resident #50. Resident #50 stated that he went into Resident #69's room and asked her if he could try what I wanted to try and she agreed. Resident #50 then began rambling incoherently about sexual things that happened in his past. Resident #50 stated that he knew what he was doing and also acknowledged that it was wrong. Resident #50 began rambling incoherently about people unrelated to the incident. The police officer asked Resident #50 if he knew he was supposed to stay in his room and not visit Resident #69 anymore and Resident #50 acknowledged. The officer then spoke with staff who witnessed the incident. Staff F stated that when she walked into Resident #69's room, Resident #50 was sitting at the foot of Resident #69's bed. Resident #69's undergarments were around her knees/ankles and Resident #50 appeared to be touching Resident #69's vagina. Staff F then confronted Resident #50 and he exited the room. Resident #50's Progress Notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a. On 10/24/24 at 5:17 PM, resident inappropriately touched a CNA while she gave him medication. Resident educated and hand removed (from the area). b. On 11/4/24 at 5:44 PM, resident touched another resident in the private area as he passed by her in the hallway. CNA present at this time and separated the residents. Resident #50 snickered when he was asked what happened. Resident #50 asked if he touched the lady resident. He said no. Resident educated not to touch other residents. Medications reviewed. c. On 11/6/24 at 1:15 PM (late entry), around 7:45 AM, Resident #50 asked the housekeeper to get into bed with him. He then stated, your pants are baggy. Your ass would look better if your pants were off. d. On 11/6/24 at 1:49 PM, attempted to call the resident's representative to inform of the resident's behaviors. New orders received from the NP to start hormone and antidepressant medications for hypersexual behaviors. NP declined to refer the resident to psych because the resident had declined to see psych in the past. e. On 11/8/24 at 3:10 PM, information added to the Care Plan to include monitoring the resident in the hallways because he most frequently exhibited behaviors with other residents in this area, and to monitor the resident during meal times when he was outside of his room as well as in the dining room. f. On 11/21/24 at 8:32 AM, CMA tried to administer Medroxyprogesterone medication for hypersexual behavior but the resident refused the medication three times. g. On 1/29/25 at 5:35 PM, resident came up behind dietary aide and tried to get handsy with her. Resident was asked to leave the dining room. h. On 2/23/25 at 11:00 AM, RN paged to Resident #69's room STAT. The CNA notified the RN that Resident #50 found in Resident #69's room touching a female resident inappropriately. CNA immediately told Resident #50 to Stop, do not touch her, get out, and that his actions were not okay. Resident #50 was directed back to his room and placed on 1:1 observations. Resident #50 stated I know what I was doing, I needed to please her and that is what I was going to do. Resident #50 notified he was not to go into any rooms that are not his. i. On 2/23/25 at 12:58 PM, Resident #50 moved to another room away from the female resident, closer to the nurse's station, and by other male residents. A motion sensor was placed on the door. j. On 2/23/25 at 4:04 PM, order obtained to increase Sertraline to 75 mg PO once a day for hypersexual behaviors. k. On 2/24/25 at 12:01 AM, resident on 1:1 for sexual behaviors. At 12:15 AM, resident sent to the ED for complaints of chest pain and shortness of breath. At 5:55 AM, the ED nurse advised the facility that the resident would be returning to the facility. l. On 2/24/25 at 3:35 PM, psych referral for sexual aggression and medication management. Hope Harbor was called to look for a locked male unit. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	m. On 2/25/25 at 2:39, resident talked to the aide in his room and stated he and his buddy used to go looking for 5-year olds and used to molest/please the little girls. n. On 2/25/25 at 5:42 PM, order for UA collected due to resident increased behaviors. o. On 2/26/25 at 2:58 PM, visual monitor in resident's room and at the nurses station to monitor Resident #50's activity. Resident room is insight of the nurse's station. p. On 2/27/25 at 1:16 AM, resident noted to be playing with his penis upon check and change. Resident advised to stop but not easily redirected. q. On 2/27/25 at 7:31 AM, SS Coordinator attempted to talk to Resident #50 over the past two days about the incident but he was sleeping. r. On 3/13/25 at 12:56 AM, resident yelling at staff for not letting him go to his old room. s. On 3/26/25 at 2:11 AM, resident not been sleeping at night. He requested all night long to go to the dining room. He was not easily redirected because within a few minutes he was back up and tried to go to the dining room again. A message was sent to the physician. t. On 4/9/25 at 1:45 AM, resident asked staff about people being up and down the hall having sex. Resident talked about his penis and how big or small his penis was and he talked about having sex. Resident not easily redirected. u. On 4/16/25 at 9:48 PM, per the Administrator on 4/16/25 at 9:41 PM, the resident is supposed to be on routine 15-minute checks for being outside of his room without supervision due to an allegation incident that was unwitnessed earlier in the day. v. On 4/24/25 at 9:04 AM, SS Coordinator left a message for Hope Harbor to see if the resident would qualify for placement. A NP Visit Note dated 2/24/25 revealed Resident #50 had increased sexual aggressive behaviors and a fall over the weekend. The resident was evaluated in ED but had no new diagnosis or change in the plan of care. He is on Sertraline and Medroxyprogesterone for hypersexual behavior. The NP recommended a psych consult for sexual aggression and medication management. Resident #50 was moved closer to the nurse's station and the plan of care was reviewed. Medications reviewed with no changes. The Plan of Care included to observe for change in condition and notify the provider with any questions or concerns. Continue prevention, and practice proactive medical treatment to allow the resident to remain in the home. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The Physician's Encounter Note dated 3/3/25 revealed Resident #50 was evaluated in the ED for an atypical infection. Resident #50 started on doxycycline and Prednisone. A UA was negative. Pulse oximetry 96% on RA (room air). A previous visit on 2/26/25, it was reported Resident #50 had an inappropriate altercation with a fell ow resident as he had entered the resident's room and grabbed the genital area. The action was unprovoked. He was with recall and stated he was talked to and he had told the staff he would not do again. He was placed in another room and required 1:1. Resident #50 sustained a fall and was transported to the ED. The CT findings revealed suspected pneumonia. Resident #50 had decreased appetite and slept more than fifteen hours a day. Reported the resident had increased sexual behaviors and inappropriate verbalization and physical contact. Sertraline and Medroxyprogesterone was initiated. The resident also had diagnosis of progressive dementia and pancreatic cancer. A Psychiatric assessment dated [DATE] revealed Resident #50 referred for sexually inappropriate behavior. The resident had diagnoses of adjustment disorder with mixed disturbance of emotions, Alzheimer's Disease, and dementia with behavioral disturbance. No new orders. A Fax communication dated 3/26/25 revealed the resident antsy, not sleeping at night, and came out of his room at night. Observations revealed the following: a. On 4/22/25 at 9:58 AM, Resident #50 smiled and laughed as he spoke to the surveyor. An alarm sounded while the resident was lying in bed. Staff A, RN, responded to the resident's room. Staff A adjusted the alarm pad under the resident and reset the alarm but the alarm continued to sound. Staff A stated he thought maybe the batteries needed to be replaced. b. On 4/23/25 at 7:43 AM, Resident #50 sat in bed looking toward the doorway of the room and smiled. The door to the DON's office was closed and locked. Staff A, RN, stood by the nurse's desk. c. On 4/23/25 at 11:10 AM, Resident #50 sat on the bed in his room. The DON's office door was open but no staff observed in the office. A staff person walked with another resident down the 200 hall. d. On 4/23/25 at 12:14 PM, Resident #69 sat in a wheelchair by the nurse's station (2 doors from Resident #50). e. On 4/23/25 at 2:54 PM, Resident #69 propelled her wheelchair down the 200 hall until Staff A offered to push the resident in the wheelchair to her room. f. On 4/23/25 at 3:00 PM, Resident #50 sat in a chair in his room approximately 5 feet from the doorway of his room. The resident smiled and talked to himself. 2. The MDS assessment dated [DATE] revealed Resident #69 had diagnoses of cerebrovascular accident (CVA)(stroke), hemiplegia, and muscle weakness. The MDS documented the resident had a BIMS of 13, indicating intact cognition. The MDS recorded the resident had impaired range of motion on one side of her body. She required partial to moderate assistance for bed mobility, and had dependence on staff for lower body dressing and transfers. The MDS documented the resident had no behaviors. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	The Care Plan revised on 6/11/24 revealed Resident #69 had limited physical mobility related to a stroke and hemiplegia that affected the left side of her body. The resident was non-ambulatory and required assistance with activities of daily living (ADL's) such as dressing and bed mobility. The Care Plan lacked information about a resident-to-resident incident. An Incident Report completed on Resident #69 revealed a staff statement entered on 2/23/25. Staff F found Resident #50 wandering the halls going in and out of female resident rooms. Staff redirected Resident #50 to his room. Staff F took him back to his room where he told Staff F he was going to pleasure her, she needed to be pleasured. Resident #50 then went into his room and went into the bathroom. Staff F then went and did blood sugars on the [NAME] Hall. Staff D and Staff E shut all of the female doors. When Staff F went to get a blood sugar on Resident #50's roommate, Resident #50 was not in the room. Staff F then looked for Resident #50. Staff F checked the building on where Resident #50 normally went. Staff F began to open the doors to the female rooms and found Resident #50 and Resident #69. Staff F saw Resident #50 sitting at the foot of Resident #69's bed with her brief all the way undone and Resident #50's hand between Resident #69's legs. Resident #50 was touching Resident #69. Staff F told Resident #50 to stop, don't touch her, that is not ok, this is not your room. That is when Resident #69 woke up and looked at Staff F like what is going on? Resident #50 got out of the room and Staff F called for the RN STAT. When staff met at the nurse's station to call people, Resident #50 came out of his room looking for Resident #69's room again. The police arrived 10 minutes later. Staff F told the police what happened and what she walked into. Resident #50 placed on 1:1 while staff figured out what to do next. The physician, Administrator, police, and family were notified. The Weekly Skin Observation dated 2/21/25 at 9:27 PM revealed no skin conditions observed. On 2/28/25 at 4:14 PM, no skin concerns noted. Barrier cream continued to her groin. A Progress Note dated 2/23/25 at 11:45 AM but created on 2/27/25 at 12:57 PM revealed a complete RN assessment completed on Resident #69. No signs of physical trauma noted to the resident's body. The resident denied pain. Staff stayed with the resident and assisted with cares and ADL's, then assisted the resident into the wheelchair per her request. Staff continued to monitor the resident. Progress Notes revealed the following: a. On 2/23/25 at 12:46 PM, Staff G stated to the Administrator that she had spoken with Resident #69 right after the incident with the male resident. At first Resident #69 was tearful because she was not sure what was going on initially but stated that it was not traumatic to her. Social Services to follow up for 3 days. b. On 2/24/25 at 12:16 AM, Resident #69 spoke with the nurse about the incident this morning and resident very sad that it happened. Encouraged her to seek out staff if she needs to talk. c. On 2/24/25 at 3:49 PM, SS Coordinator asked Resident #69 what happened over the weekend. Resident #69 advised she was awakened by screaming and it scared her as she thought she was hurt. A male resident was removed from her room. She later stated she noticed hand marks where the male resident apparently held her down. She was upset and stated she had reached out to have her therapist work with her. She was more upset from the commotion rather than the actual situation. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	d. On 2/25/25 at 3:04 AM, resident does not remember any of the incident that happened. Resident states she only knew what people had told her what happened. She stated she knew he was not supposed to be around her. She stated she didn't even know what he looked like. e. On 2/25/25 at 12:10 PM, SS Coordinator spoke to resident regarding the incident over the weekend. She stated she was not traumatized by the issue. She just wanted to know why it happened. She thought she did something. Resident was reassured it was not her. In an interview on 4/22/25 at 9:45 AM, Resident #69 reported a male resident lived down the hall from her. He came into her room and raped her a month or so ago. She was lying in bed. He took her brief off. She doesn't think he penetrated her but she doesn't know for sure. Staff yelled at him and asked him what he was doing, and got him away from her. Resident #69 stated the male resident had come and stood at her door but staff had caught him in time. Resident #69 reported she had a stroke and unable to move her left arm or leg. Resident #50 got moved to another room down the hall from her. The facility staff put a motion detector on him to keep track of him. Resident #69 stated she was concerned if he would come into her room at night. Resident #69 was tearful as she spoke with the surveyor about the incident. During confidential interviews with three other interviewable residents on 4/24/25, the female residents reported they had not had any staff or residents touch them inappropriately. The female residents reported they would yell if that happened to them. One female resident reported the staff don't like it when she spoke up about something that was not right. Staff told her to mind her own business and worry about herself. Resident #69 told one female resident what happened. One female resident didn't think the facility did enough to keep the male resident from going into other people's rooms. The female resident had asked the facility staff to move her bed to face the door so she could see if someone was coming into her room but they never moved her bed to face the door. One female resident recalled Resident #69's bed faced the window at the time of the incident but now her head of the bed faced the door. The female residents voiced concern the facility could retaliate for talking with the surveyor. Another female resident reported a male resident came into her room uninvited one time looking for his wife. When asked if she would feel uncomfortable with a male resident coming into her room, she said it would depend if the resident was with it. Some people had dementia or another diagnoses and that made people sometimes do things. Another female resident reported Resident #50, a male resident, walked into her room uninvited but she yelled at him and scared him off. She was fortunate. Resident #50 is wacko. The female resident reported an alarm goes off now if Resident #50 went out of his room. She had worked with therapy and built up her strength. She thought she would be able to flatten him if he tried to do anything to her. On the day Resident #50 came into her room she turned on her call light. Staff were busy with other residents at the time. When the CNA came in, she told the CNA she saw Resident #50 going in and out of the resident rooms. Staff got him to his room. The next thing she heard was a big commotion going on next door to her and he was found in Resident #69's room. The resident stated staff can't always come right away but she wanted to feel safe in her home. She is able to stand up for herself and she could talk or yell but not all residents could. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview 4/24/25 at 9:00 AM, Resident #69 reported she talked with another female resident about the incident that occurred with a male resident. A staff member came up to her and the resident and told her not to say anything about the incident. In an interview 4/22/25 at 2:45 PM, Staff A, RN, reported Resident #50 tended to be a lot more mobile at night and he slept during the day. He shared a bathroom with another male resident. Resident #50 had some behaviors. The resident's door had a motion sensor and the bathroom door had a doorbell chime. The chime was plugged into an outlet and sounded at the nurse's station. The alarms had distinct sounds. Staff A reported he kept Resident #50 in his line of site and listened for the doorbells. An alarm also went off if Resident #50 tried to get up without assistance. The resident mainly came out of his room for a shower and some meals. Resident #50 was 1:1 after the incident with Resident #69, but he had been on 15-minute checks for the past week due to him being more mobile. His room was located right across from the DON's office. Staff A reported Resident #50 came out of his room at night, walked to the nurse's station to get a snack or talked to staff, then went back to his room. He was not a group social person but he would talk 1:1 and had a conversation with people. Staff A reported he was not aware of other incidents when Resident #50 had been inappropriate with other residents. Staff A reported Resident #69 was alert and oriented x 4. She could be dramatic and get things blown out of proportion. She had nightmares or vivid dreams and said things happened but in reality things had not happened. In an interview 4/22/25 at 2:55 PM, Staff G, RN/Clinical Care Coordinator reported on the day of the incident with Resident #50 and Resident #69, Staff G got called to Resident #69's room. Resident #69 was in her room sleeping. Resident #50 went into Resident #69's room. Staff F told Staff G she found Resident #69's brief undone. Staff F told Resident #50 he needed to leave. Resident #69 was ok. Social Services came and talked with her. Resident #50 was placed on 1:1. Staff G called activities in to sit with him and called the physician. The police came in. Resident #50 had made sexual remarks in the past. He randomly said things to staff that made them feel uncomfortable. There was a note in the computer for staff to be aware of him and monitor for any behaviors. Resident #50 had some medication changes as he had had a mental health diagnosis in the past. Staff G reported when she first started working at the facility she worked in another unit but she observed residents in the dining room. She saw Resident #50 and his interactions with staff and the residents. He was more reserved. He would get up and go out of the dining room or the area. He was not a big communicator. He walked independently. He would come out of his room and ask for snacks. Staff [TRUNCATED]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34817 Based on record review, resident and staff interview, and policy review, the facility failed to update and revise the Care Plan to reflect a resident-to-resident incident and interventions for one of two sampled residents in order to maintain a resident's mental and psychosocial well-being (Resident # 69). The facility reported a census of 81 residents. Findings include: The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #69 had diagnoses of cerebrovascular accident (stroke), hemiplegia, and muscle weakness. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated impaired cognition. The MDS recorded the resident had little interest or pleasure in doing things and felt down and depressed 12-14 days during the look-back period. The resident had impaired range of motion on one side of her body, required partial to moderate assistance for bed mobility, and had dependence on staff for lower body dressing and transfers. The Care Plan revised on 6/11/24 revealed Resident #69 had limited physical mobility related to a stroke and hemiplegia that affected the left side of her body. The resident was non-ambulatory and required assistance with activities of daily living (ADL's) such as bed mobility and dressing. The Care Plan lacked information about a resident-to-resident incident that took place on 2/23/25, and interventions to address her psychosocial and mental health needs. An Incident Report completed on Resident #69 revealed a staff statement entered on 2/23/25. Staff F, certified medication aide (CMA) found Resident #50 (male) wandering the halls going in and out of female resident rooms. Staff redirected Resident #50 to his room. Staff F then went and did blood sugars on the [NAME] Hall. Staff D, CMA, and Staff E, CMA, shut all of the female doors. When Staff F went to get a blood sugar on Resident #50's roommate, Resident #50 was not in the room. Staff F then looked for Resident #50. Staff F checked the building on where Resident #50 normally went. Staff F began to open the doors to the female rooms and found Resident #50 and Resident #69. Staff F saw Resident #50 sitting at the foot of Resident #69's bed with her brief all the way undone and Resident #50's hand between Resident #69's legs. Resident #50 was touching Resident #69. Staff F told Resident #50 to stop, don't touch her, that is not ok, this is not your room. Resident #69 woke up and looked at Staff F like what is going on? Resident #69 notified of what occurred and became tearful. Resident #69 said she did not say Resident #50 could do that. In an interview on 4/22/25 at 9:45 AM, Resident #69 reported a male resident lived down the hall from her. He came into her room and raped her a month or so ago. She was lying in bed. He took her brief off. She doesn't think he penetrated her but she doesn't know for sure. Staff yelled at him and asked him what he was doing and got him away from her. Resident #69 stated the male resident had come and stood at her door but staff had caught him in time. Resident #69 reported she had a stroke and unable to move her left arm or leg. She was concerned if he would come into her room at night. Resident #69 was tearful as she spoke with the surveyor about the incident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview 4/24/25 at 2:00 PM, the MDS Coordinator reported she began to work at the facility on 3/5/25. The MDS Coordinator reported she updated the resident's care plan whenever the care plan needed updated or revised. She looked at the resident's chart, notes from other departments, orders, and the progress notes to develop and update the care plans. She also entered a progress note or summary regarding the care plan review. The MDS Coordinator reported she wasn't involved or working at the facility when the Resident-to-Resident incident occurred between Resident #50 and Resident #69. She would expect a resident-to-resident incident and resident behaviors would be on the care plan along with any related interventions for the situation. The facility's Comprehensive Care Plan Policy reviewed 1/31/25 a person-centered Care Plan is developed for each resident that included measurable objectives and timetables to meet the resident's physical, mental, spiritual and psychosocial well-being. The resident's care plan updated and included trauma informed care. The care plan became a powerful and practical tool to represent the best approach to providing quality of care and quality of life. If a resident has specific behavioral interventions, they needed to be reflected on the care plan. Care plans must be revised as the resident's needs and/or status changed.

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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. 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to ensure a resident received assistance with incontinence care and nail care for 1 of 4 residents reviewed for activities of daily living(Resident #16). The facility reported a census of 81 residents. Findings include: The Quarterly Minimum Data Set(MDS) assessment tool, dated 2/12/25, listed diagnoses for Resident #16 which included mild intellectual disabilities, heart failure, depression. The MDS stated the resident required partial to moderate assistance with toileting hygiene and listed a Brief Interview for Mental Status(BIMS) score as 12 out of 15, indicating moderately impaired cognition. Care Plan entries, dated 1/15/24, stated the resident used adult disposable briefs and directed staff to check the resident approximately every two hours and assist with toileting as needed. The facility policy Incontinence Care, revised 5/20/24, stated the facility would identify the proper care for residents who needed assistance managing their incontinence and stated all residents needed thorough and routine perineal area skin care when incontinence occurred. A 10/22/24 Care Plan entry stated the resident was incontinent of bowel and bladder. The facility policy Nail Care, revised 4/6/25, directed staff to keep nails clean and trimmed to promote well-being. On 4/22/25 at 9:15 a.m., Resident #16's nails were untrimmed and a black substance was present under several nails. On 4/23/25 at approximately 8:15 a.m., the resident laid in bed. On 4/23/25 at 9:45 a.m., the resident laid in bed. Continuous observation until 11:32 a.m. revealed no staff entered the room to offer him toileting or incontinence care assistance. At 11:32 a.m., the resident wheeled himself out of his room in his wheelchair. The resident's shorts were not pulled all the way up in back and one side of his incontinent brief stuck out of the front of his shorts. At 11:33 a.m., the resident sat in his wheelchair outside of his room and asked Staff M Certified Nursing Assistant(CNA) if it was lunch time and she said it was. Staff M did not attempt to assist the resident with incontinent cares and the resident propelled himself down to the dining room. At 11:46 a.m., the resident sat at the dining room table. One side of his incontinent brief still protruded from his pants and was visible. At 12:26 p.m., the resident wheeled himself out of the dining room to his room and transferred himself into bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:34 p.m., the State Agency(SA) queried Staff A Registered Nurse(RN) with regard to when staff assisted the resident with incontinence cares. Staff A stated they checked him before meals. He stated he would inform Staff M that the resident needed changed after she finished with another resident. At 12:40 p.m., Staff A and Staff M rolled the resident over on his left side in bed and his incontinence brief was heavily saturated with urine and a urine odor was noted. Staff M cleansed the resident's perineal area and placed him in a clean brief. Staff did not offer to assist the resident with toileting or incontinence cares from 9:45 a.m. until 12:40 p.m., after the SA inquired. On 4/23/25 at 12:49 p.m., Staff M stated she did not assist Resident #16 to get up for lunch as she helped other residents. Staff M stated she was the only one working on the hall. On 4/23/25 at 12:50 p.m. Staff A stated staff should check residents (incontinent briefs) every two hours. On 4/23/25 at 3:12 p.m., the resident's nails remained untrimmed and a black substance was present under three nails on his right hand and two on his left hand. On 4/24/25 at 11:22 a.m., when queried with regard to Resident' #16's regular incontinence care routine, Staff N CNA stated when she cared for him, she attempted to change him prior to lunch and supper. On 4/24/25 at 12:31 p.m., the Director of Nursing(DON) stated staff should offer to check and change residents every two hours. She stated nails should be kept clean and trimmed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34817 Based on observation, record review, resident and staff interviews, and policy review the facility failed to answer resident call lights in a timely manner, within 15 minutes for one of two nursing units (Lilac/Daisy). The facility staff also failed to address one of four residents needs for incontinence care (Resident # 16). The facility reported a census of 81 residents. Findings include: 1. Observations revealed the following: On 4/22/25 at 11:35 AM, the light above a resident's door in the 100 hall observed to be on. The resident reported her call light had been on for at least 10 minutes. The resident had a clock on the wall in her room to know what time it was and how long it took staff to answer the call light. The resident reported she wanted staff to get her up. At 11:44 AM Staff C, Certified Nursing Assistant (CNA) entered the resident's room. Staff C turned the call light off and told the resident she would be back. At 11:46 AM, the resident pushed her call light again. The resident stated staff always shut her call light off and told her they would be back. This action made her so mad. At 11:55 AM, Staff D, Certified Medication Aide (CMA) entered the resident's room and administered medication to the resident. Staff D turned the resident's call light off and left the room. At 11:56 AM, the resident turned the call light back on. At 12:01 PM, Staff B, CNA, entered the resident's room and began to assist the resident. In an interview 4/23/25 at 8:21 AM, the Administrator reported the facility's call light system did not record call light times, and therefore she was not able to obtain any call light reports. In an interview 4/24/25 at 2:09 PM, the Director of Nursing reported she expected staff answered the resident's call light within 15 minutes. 35434 2. Interviews conducted during the survey week with 5 of 15 residents who wished to remain anonymous revealed all had concerns with the timeliness of staff responses to call lights. Residents had clocks in their rooms and reported they had to wait up to an hour for staff to respond. Residents stated the facility did not have enough staff and staff ignored call lights. Residents also reported that staff turned off call lights without assisting them and left the room stating they would return. Residents reported they had to wait on the toilet up to 20 minutes for staff to assist. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The Quarterly Minimum Data Set(MDS) assessment tool, dated 2/12/25, listed diagnoses for Resident #16 which included mild intellectual disabilities, heart failure, depression. The MDS stated the resident required partial to moderate assistance with toileting hygiene and listed a Brief Interview for Mental Status(BIMS) score as 12 out of 15, which indicated moderately impaired cognition. Care Plan entries, dated 1/15/24, stated the resident used adult disposable briefs and directed staff to check the resident approximately every two hours and assist with toileting as needed. The facility policy Incontinence Care, revised 5/20/24, stated the facility would identify the proper care for residents who needed assistance managing their incontinence and stated all residents needed thorough and routine perineal area skin care when incontinence occurred. The facility policy Call Light, reviewed 7/29/24, stated the facility would promptly answer resident call lights. A 10/22/24 Care Plan entry stated the resident was incontinent of bowel and bladder. On 4/23/25 at approximately 8:15 a.m., the resident laid in bed. On 4/23/25 at 9:45 a.m., the resident laid in bed. Continuous observation until 11:32 a.m. revealed no staff entered the room to offer him toileting or incontinence care assistance. At 11:32 a.m., the resident wheeled himself out of his room in his wheelchair. The resident's shorts were not pulled all the way up in back and one side of his incontinent brief stuck out of the front of his shorts. At 11:33 a.m., the resident sat in his wheelchair outside of his room and asked Staff M Certified Nursing Assistant(CNA) if it was lunch time and she said it was. Staff M did not attempt to assist the resident with incontinent cares and the resident propelled himself down to the dining room. At 11:46 a.m., the resident sat at the dining room table. One side of his incontinent brief still protruded from his pants and was visible. At 12:26 p.m., the resident wheeled himself out of the dining room to his room and transferred himself into bed. At 12:34 p.m., the State Agency(SA) queried Staff A Registered Nurse(RN) with regard to when staff assisted the resident with incontinence cares. Staff A stated they checked him before meals. He stated he would inform Staff M that the resident needed changed after she finished with another resident. At 12:40 p.m., Staff A and Staff M rolled the resident over on his left side in bed and his incontinence brief was heavily saturated with urine and a urine odor was noted. Staff M cleansed the resident's perineal area and placed him in a clean brief. Staff did not offer to assist the resident with toileting or incontinence cares from 9:45 a.m. until 12:40 p.m., after the SA inquired. On 4/23/25 at 12:49 p.m., Staff M stated she did not assist Resident #16 to get up for lunch as she helped other residents. Staff M stated she was the only one working on the hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 12:50 p.m. Staff A stated staff should check residents (incontinent briefs) every two hours. On 4/24/25 at 11:22 a.m., when queried with regard to Resident' #16's regular incontinence care routine, Staff N CNA stated when she cared for him, she attempted to change him prior to lunch and supper. On 4/24/25 at 12:31 a.m., the Director of Nursing(DON) stated staff should offer to check and change residents every two hours.

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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** 35434 Based on observation, clinical record review, policy review, and staff interview, the facility failed to carry out adequate infection control practices to prevent the spread of infection for 1 of 4 residents reviewed for incontinence cares(Resident #16) and failed to carry out enhanced barrier precautions(EPB) for 1 of 4 residents who required EPB. The facility reported a census of 81 residents. Findings included: 1. The Minimum Data Set(MDS) assessment tool, dated 2/12/25, listed diagnoses for Resident #16 which included mild intellectual disabilities, heart failure, depression. The MDS stated the resident required partial to moderate assistance with toileting hygiene and listed a Brief Interview for Mental Status(BIMS) score as 12 out of 15, indicating moderately impaired cognition. The facility policy Laundry, Resource Packet, revised 8/30/24, stated staff would collect soiled laundry to prevent the spread of potential infectious disease and would treat all soiled clothes and linens soiled with bodily material as potentially infectious. A 10/22/24 Care Plan entry stated the resident was incontinent of bowel and bladder. On 4/23/25 at 12:40 p.m., the resident laid in bed on a fitted sheet and a bed pad. Staff A Certified Nursing Assistant(CNA) and Staff M Registered Nurse(RN) rolled the resident over on his left side in bed and his incontinence brief was heavily saturated with urine and a urine odor was noted. Staff M cleansed the resident's perineal area and placed him in a clean brief. The resident's clean brief was in contact with the bed pad. Staff M then stated she needed to change his sheets and she rolled the resident over and tucked the soiled sheets and pad under the resident. Staff M then tucked a clean sheet under the resident and rolled him over to the other side to pull out the clean sheets. On 4/24/25 at 11:46 a.m., Staff M stated during cares on 4/23/25, the resident's pad and bottom sheet were soiled with urine. She agreed since they changed the sheets after they changed the resident's incontinent brief that his clean brief was in contact with the soiled sheets. On 4/24/25 at 12:31 p.m., the Director of Nursing(DON) stated a resident's clean brief should not be in contact with sheets/pads soiled with urine. 34817 2. The Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident # 9 had diagnoses of multiple sclerosis, neurogenic bladder, septicemia, and a urinary tract infection (UTI). The MDS recorded the resident had an indwelling catheter and had dependence on staff for transfers. The MDS documented the resident had a Brief Interview for Mental Status score of 15, indicating intact cognition. (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	04/24/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan revised 1/16/25 revealed the resident had a suprapubic catheter related to neurogenic bladder and multiple sclerosis, and also had reoccurring UTI's. The resident requires Enhanced Barrier Precautions (EBP's) related to an indwelling catheter. The Care Plan directed staff to empty the catheter drainage bag and perform catheter care every shift. The Care Plan also directed staff to don a gown and gloves whenever they performed high contact care activities such as a check and change, dressing, transfers, and care or use of a device (such as a catheter). The Care Plan also revealed the resident was quadriplegic and required assistance with activities of daily living (ADL's). The Care Plan directed staff to use a mechanical lift and two staff for transfers. Observations revealed the following: a. On 4/22/25 at 11:50 AM, Resident #9 [NAME] in bed and had a catheter bag inside a dignity bag hung on the bedframe but the bottom of the bag touched the floor. An EBP sign was located on the doorframe to the room. A plastic bin with three drawers sat on the floor outside the resident's room. The drawer contained personal protective equipment including gowns and gloves. b. On 4/22/25 at 12:01 PM, Staff B, Certified Nursing Assistant (CNA), entered the resident's room with a mechanical lift. Staff B stated the resident's catheter bag was full and she needed to empty the catheter bag. At 12:07 PM, Staff B donned a pair of gloves and placed a graduate container on a paper towel on the floor next to the resident's bed. Staff B proceeded to empty the contents from the catheter bag into the graduate, clamped the catheter, and replaced the catheter port into the holder. Staff B took the graduate full of urine to the bathroom and emptied the contents in the toilet, then placed the container in the bathroom. Staff B removed her gloves and washed her hands. Staff B did not wear a gown when she handled and emptied the catheter. At 12:09 PM, Staff B donned a pair of gloves and changed the resident's brief, then assisted the resident to don a pair of shorts. At 12:14 PM, Staff C, CNA, and Staff B placed a sling under the resident and changed the resident's shirt. Staff B and Staff C used a mechanical lift to transfer the resident from the bed to a wheelchair. Staff B took the catheter bag and placed it under the wheelchair. Staff B and Staff C did not wear a gown when they transferred the resident or handled the catheter bag. During an interview 4/24/25 at 9:30 AM, Staff K, CNA, reported the resident's door had a sticker indicating the need for EBP's. A resident would be on EBP's if they had a catheter. A gown and gloves should be worn whenever staff took care of a resident with a catheter as well as when staff transferred a resident on EBP's. In an interview 4/24/25 at 12:27 PM, Staff D, certified medication aide, reported an EBP sign on the door whenever a resident required EBP's. EBP's required whenever a resident had a catheter. Staff D reported a gown and gloves worn for EBP's. In an interview 4/24/25 at 2:09 PM, the Director of Nursing reported EBP's used if a resident had a catheter. She expected staff to wear a gown and gloves whenever staff transferred a resident with a catheter and whenever staff performed catheter care or emptied a catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Enhanced Barrier and Transmission-Based Precautions policy reviewed/revised 4/6/25 revealed EBP's used to prevent the spread of infection and communicable diseases to residents, employees, and visitors through infection prevention and control practices. EBP's used for residents with an indwelling urinary catheters and during high-contact resident care activities include transfers, dressing, changing briefs, and catheter device care. Gown and gloves worn during high-contact resident care activities.