STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165187	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - West Union	201 Hall Street West Union, IA 52175

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, clinical record review, policy review and staff interview the facility failed to provide education and obtain informed consent prior to starting psychotropic medication that have black box warnings (the most serious safety warning used by the Food and Drug Administration (FDA) and requires the healthcare provider to have a comprehensive discussion with the resident about the risks, benefits and alternatives for use) for 1 of 5 resident sampled (Resident #7). The facility identified a census of 38 residents.Findings include: Resident #7's 2/19/26 Minimum Data Set (MDS) Assessment documented the resident utilized a hearing aid and was able to hear with minimal difficulty. Resident #7 had unclear speech but was usually able to understand others. The MDS showed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating intact cognition. The MDS documented Resident #7 had little interest/pleasure in doing things 2-6 days; felt down, depressed or hopeless 7-11 days; had little energy 2-6 days; felt bad, or a failure of letting herself or family down 7-11 days; and moved/spoke slowly 12-14 days. The MDS documented diagnoses of cancer, heart failure, end stage renal disease, diabetes mellitus, Parkinson's Disease and depression. The MDS identified Resident #7 received antidepressant medication.A 9/05/25 Note to Attending Physician/Prescriber documented to start Mirtazapine (antidepressant medication) 15 Milligrams (MG) at bedtime.A 9/06/25 11:29 PM Health Status Progress Note documented Resident #7 was not making sense. Stated, have to get the stuff to keep them away. Nurse had to perform a sternal rub to get the resident's attention.A 9/06/25 11:44 PM Mood/Behavior Progress Note documented Resident #7 had been started on Mirtazapine 15 MG and is drowsy and talking in her sleep. A 9/07/25 1:22 PM Summary of Skilled Services Daily Skilled Note documented Resident #7 appeared drowsy and confused. A 9/07/25 4:08 PM Mood/Behavior Progress Note documented Resident#7 was drowsy in the afternoon. A 9/07/25 9:36 PM Other Progress Note documented Resident #7 was confused and thought it was morning. A 9/08/25 Urgent, Response Required facsimile (fax) sent to the provider detailed Resident #7 started mirtazapine 15 MG and had been extremely drowsy, talking in her sleep and was believed to be sensitive to the dose of antidepressant medication. The fax requested to reduce the dose of antidepressant medication to 7.5 MG for 14 days, then take the dose back up to 15 MG. The Provider responded 9/08/25 to reduce the antidepressant medication.The September 2025 Electronic Medication Administration Record (EMAR) documented Resident #7 received 15 MG of Mirtazapine 9/6/25 - 9/8/25 and Mirtazapine 7.5 MG from 9/9/25 -9/30/25.The October, November, December 2025 and January, February, March 2026 EMARs showed Resident #7 continued to receive the antidepressant medication each day at bedtime. An Order Review History Report electronically signed by the Provider on 12/19/25 documented a continued current order for Mirtazapine 7.5 MG, one tablet daily related to major depressive disorder. Interview completed on 3/10/26 at 3:00 PM Staff A, Licensed Practical Nurse (LPN) reported to her knowledge the psychotropic education and consent is completed by the Director of Nursing (DON). Interview on 3/10/26 at 3:03 PM the DON explained the physician is responsible for providing psychotropic medication education and getting consent when they order the medication. She completes the psychotropic medication education and consent for residents that newly admit to the facility on psychotropic medications. During an interview on 3/11/26 at 3:44 PM the MDS Coordinator explained there is a psychotropic medication assessment (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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurses have to do before they start a psychotropic medication. Education is part of the psychotropic medication assessment. The education and consent should be addressed by the nurse that is taking the physician order for the medication before the medication is started. To her knowledge the nurses had received education regarding the psychotropic medication education and consent. The MDS Coordinator further explained the education and consent can be done by the resident if they are alert enough, otherwise it should be done with a family member. They have a three page document they go over with the resident/family and have signed. During an interview on 3/11/26 at 4:30 PM the Director of Nursing (DON) reported they still had not found any documentation that Resident #7 or a legal representative had received education and given informed consent for the use of the antidepressant medication. During an interview on 3/12/26 at 11:50 AM the DON explained she or the charge nurse, if she is not available, meets with the resident if they can understand or a family member to go over the medication, why the medication was ordered, dose, risk factors/side effects and benefits. The resident or family signs a psychotropic medication form to indicate they understand and they are consenting to the nurses administering the medication to the resident. The facility was not able to find documentation Resident #7 or a legal representative had received education or signed informed consent to start the antidepressant medication. The Psychotropic Medications Policy revised 12/09/25, provided by the facility, directed a consent form must be signed for the use of psychotropic medications. The Policy defined a psychotropic medication as any drug that affects the brain activity associated with mental processes and behavior which included anti-depressant medications.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, policy review and staff interview, the facility failed to serve the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) as required; failed to outline the specific Medicare services that would be ending and failed to document the estimated charges to continue skilled services for 2 of 3 residents sampled (Resident #1 and #13). The SNF ABN Form communicates to a resident and/or legal representative when Medicare services will no longer be covered and they may be liable for payment of services. The facility identified a census of 38 residents.Findings include: 1.Resident #1's Electronic Healthcare Record (EHR) Census showed he admitted into Medicare skilled services on 1/22/26. A 1/22/26 10:10 PM Health Status Progress Note documented Resident #1 admitted to the facility and would be receiving physical therapy (PT) and occupational (OT) therapy services. A Center for Medicare and Medicaid (CMS) SNF Beneficiary Protection Notification Review Form documented Resident #1 started Medicare Skilled Services on 1/22/26 and received the last covered day of service on 2/11/26. The Provider initiated the discharge from the Medicare Part A Services when the benefit days were not exhausted. The CMS SNF Beneficiary protection Notification Review Form completed by the facility documented a SNF ABN was not provided to Resident #1 without an explanation as to why the notice was not provided. During an interview on 3/11/26 at 11:33 AM the Interim Administrator reported Resident #1 had not been served a SNF ABN when skilled services were ending and it should have been done. 2. Resident #13's EHR Census showed admission to the facility on [DATE] for Medicare A Skilled services. A 10/20/25 11:39 PM Other Progress Note documented Resident #13 admitted to the facility on skilled level of care and required PT and OT services to increase strength. A 12/4/25 10:55 AM Communication with Family Progress Note documented Staff B, Social Services Designee (SSD) reached out to a family member on the Medicare part A stay ending. Staff B informed the family member they would get back to them regarding pricing to stay at the facility after the skilled stay.A SNF Beneficiary Protection Notification Review completed by the facility documented Resident #13 discharged from Medicare Part A services when benefit days were not exhausted. The SNF ABN signed by Resident #13 on 12/4/25 lacked documentation PT and OT services were ending and the estimated cost for services to continue. The Form documented Resident #13 choose Option 2 indicating she wanted the services listed which included custodial services, room and board charges, but not to bill Medicare. The resident would be billed because they were responsible for the payment of the care and could not appeal because Medicare would not be billed. During an interview on 3/11/26 at 11:35 AM the Interim Administrator verified beneficiary notices did not specifically address the ending of PT and OT services, only the nursing skilled services and Resident #13's estimated cost had not been addressed on the SNF ABN. She stated she would look into who covered the cost of Resident #13's skilled stay. On 3/11/26 at 11:48 the Interim Administrator provided a United [NAME] (UB) Form showing the facility billed Medicare, Part A for Resident #13's skilled stay from 10/20/25 to 12/06/25. Resident #13 did not pay for the skilled stay. During an interview on 3/12/26 at 9:18 AM the Social Service Director reported when a resident goes off of skilled care services, which would be physical therapy (PT), occupational therapy (OT) or speech therapy (ST), she is to serve the Notice of Medicare Non-Coverage (NOMNC). She has to fill out the NOMNC form with the facility name, resident's name, skilled services that are ending, provide information if the resident/family wants to contact the Quality Improvement Organization (QIO) and then the resident or family member signs the form. The SSD voiced she had been informed yesterday that she could not use acronyms such as PT/OT/ST when referring to therapy services on the NOMNC. She was not aware she needed to serve the SNF ABN or the components that had to be addressed on the SNF ABN. The Beneficiary Notice of Non-Coverage (SNF ABN) Policy revised 2/13/23 directed the SNF ABN should be issued prior to extended care items or services that are furnished, reduced or (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	terminated when the skilled nursing facility believes Medicare may not pay for the extended care services due to the services not being reasonable and necessary or a a custodial care level (level of care not covered by Medicare). The Facility must allow enough time for the beneficiary to make an informed decision on whether or not to receive the item/services in question and accept potential financial responsibility. The Center for Medicare and Medicaid Form Instructions for completing the SNF ABN directed the following:Care Section - the SNF chooses the appropriate check boxes to indicate the care that it believes may not or won't be covered by Medicare. These include Physical Therapy, Occupational Therapy, Daily Skilled Nursing Care and Other. If Other is checked, the SNF must enter the exact nature of the service that had previously been provided. The description must be written in plain language that the patient can understand. Estimated Cost Section - the SNF should enter the estimated cost of the corresponding care that may not be covered by Medicare. The SNF should enter an estimated total cost or a daily, per item, or perservice cost estimate. SNFs must make a good faith effort to insert a reasonable cost estimate for the care. Option Boxes - there are 3 options listed on the SNF ABN with corresponding check boxes. The patient must check only one option box. If the patient is physically unable to make a selection, the SNF mayenter the patient's selection at his/her request and indicate on the notice that this was done for the patient. Otherwise, SNFs are not permitted to select or pre-select an option for the patient as thisinvalidates the notice. When the patient selects Option 2, the care is provided, and the patient pays for it out-of-pocket. The SNF does not submit a claim to Medicare. Since there is no Medicare claim, the patient has no appeal rights. Medicare requires a SNF ABN to be provided to the resident when discharging from skilled care services when the resident will continue to reside in the nursing facility.

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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** Based on clinical record review, policy review, Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Version 1.20.1, dated October 2025 (RAI) review and staff interview the facility failed to correctly code insulin on the Minimum Data Set (MDS) for 1 of 3 residents (Resident #12) reviewed for insulin use. The facility reported a census of 38 residents.Findings include:The admission Record for resident #12 documented an admission date of 10/10/22.The MDS dated [DATE] documented the resident received insulin 1 time during the assessment period of 12/19/25- 12/25/25.The Order Summary Report dated 12/25/25 lacked an order for insulin.The Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked documentation of insulin being given.Facility policy titled MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab last reviewed on 10/27/25 directs staff to determine if there is accurate documentation to support coding for the MDS. The policy documents nursing staff is responsible for entering the medications on the MDS.The RAI instructs staff to code the number of days insulin was received by the resident.During an interview on 3/11/26 at 3:49 PM the MDS coordinator explained the insulin should not have been coded on the MDS as the resident was not taking insulin.During an interview on 3/12/26 at 1:53 PM, the Director of Nursing (DON) explained she expected the MDS to be accurate. She further explained she expected staff to follow the RAI guidelines and directions when completing the MDS.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, clinical record review, policy review, and staff interview the facility failed to implement a revised Restorative Nursing Program (RNP) and failed to provide active assist range of motion (AAROM) per the RNP for 1 of 1 residents sampled (Resident #2). The facility identified a census of 38 residents. Findings include:Resident #2's 1/1/26 Minimum Data Set (MDS) Assessment showed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. The Resident exhibited impaired functional mobility on one side of the upper and lower body; utilized a walker and wheelchair. The MDS listed diagnoses of stroke, hip fracture, and multiple sclerosis (a disabling autoimmune disease of the central nervous system (brain, spinal cord, and optic nerves) that causes disruption of communication between the brain and body, leading to symptoms like fatigue, mobility challenges, vision problems, and numbness). The MDS documented Resident #2 participated in 1 day of restorative nursing active range of motion in the last 7 days.A 2/25/26 Therapy and Nursing Communication Form signed by the Physical Therapist specified a goal to maintain the current mobility level. The Form specified a restorative nursing program for the upper extremity, 3 times a week, 3 pound dowel for 15 repetitions, static standing for max time for 2 repetitions, arm bike, level 1 for 1 minute for 3 repetitions and lower extremity RNP laying or seated Therex with AAROM, 15 repetitions, standing at the wheeled walker with assist of one for max time for 2 repetitions. The Restorative Care Plan revised 3/01/26 directed the following:a. Nursing Rehabilitation #1: Active Range of Motion (AROM) laying down or seated Therex with AAROM (means to actively assist a resident with exercise when not able to complete the exercise themself) 15 repetitions, 3 times a week, updated 2/28/26).b. Nursing Rehabilitation #2 AROM standing at the wheeled walker, 1 assist for maximum time, 2 repetitions, 3 times a weekly.c. Nursing Rehabilitation #3 AROM, 3-pound dowel exercises, 15 repetitions, 3 times weekly. d. Nursing Rehabilitation #4 AROM static standing for maximum time for 2 repetitions, 3 times weekly.e. Nursing Rehabilitation #5 AROM, arm bike for 1 minute, 3 repetitions, 3 times a week. Observation on 3/11/26 at 12:47 PM revealed Resident #2 sunk into the seat of a wheelchair on a two inch pressure reducing cushion with her hips situated to the right and her upper torso to the left. Staff C, Restorative Aide (RA)/Certified Nursing Assistant (CNA) instructed Resident #2 to start lower body marches/knee raises while seated in the wheelchair. Resident #2 completed approximately 4 marches and struggled to get her knees lifted on both lower extremities. Staff C continued to count out the steps but did not provide any active assistance to help Resident #2 with the lower body marching. At 12:48 PM Staff C assisted Resident #2 to pull up her socks. Resident #2 stated she was sitting crooked in the wheelchair. Staff C adjusted Resident #2's position in the wheelchair and then continued to instruct her to lift her knees five more times. Resident #2 lifted her right knee approximately two inches up off the ground and stated her left (leg) couldn't do it. Staff C did not provide any AAROM during the marches/knee raises. Staff C instructed the resident to start leg kicks. Resident #2 completed three repetitions of 15 leg kicks on the RLE kicking out 5-8 inches. At 12:54 PM Staff C instructed Resident #2 to start leg kicks on the left leg verbalizing she knew it was harder for Resident #2 but to do what she could. Resident #2 was not able to kick the left foot forward and used her right foot under her left foot to try to kick the leg forward 1-2 inches for two repetitions. On the second set of leg kicks Resident #2 did the leg kicks with her right leg instead of her left leg. Staff C did not correct the resident. Staff C assisted Resident #2 to complete the third set of leg kicks on the left leg. At 12:57 PM Staff C instructed Resident #2 to perform leg pulls using a green resistance band. Resident #2 was only able to pull the left leg back 1/2 inch to 1 inch for six repetitions, then stopped. Resident #2 stated, It moves but not enough to stretch it. Staff C stated that is a hard one to do, then moved on to another resident to perform their exercises. Staff C did provide AAROM to fully complete the exercise. At 1:06 PM Staff C placed a green resistance band around the resident's knees and asked her to pull her knees apart. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 completed the first exercise repetition but was only able to move her legs out 1/4 to 1/2 inches. On the last set of leg abductions Resident #2 completed 7 repetitions, but had trouble moving her legs. She completed repetitions 8-15 with only the right leg. Staff C did not assist with any AAROM to finish the exercise on the left leg. At 1:14 PM Staff C placed a 10-inch ball between Resident #2 knees and instructed her to squeeze the ball between her knees. The resident started to fall asleep and was hardly squeezing the ball as the RA counted. Resident #2 was not able to tolerate the ball for the second and third sets. Staff C placed her fist at the knees and asked her to squeeze her fist between her knees. She did not provide any AAROM for the exercise. At 1:19 PM Staff C instructed Resident #2 to complete toe raises with both feet. Resident #2 was only able to complete the exercise with the right foot. Staff C instructed Resident #2 they were going to complete sewing machine raises (heel and toe raises). Resident #2 completed 15 repetitions with the right foot and was not able to do more. Staff C performed passive range of motion for one set of 15 to each foot. Staff C reported she had completed Resident #2's RNP. During an interview on 3/11/26 at approximately 1:38 PM Staff C reviewed Resident #2's Electronic Healthcare Record (EHR) Restorative Program and verbalized she only completes the program as it is in the EHR system. Staff C flipped through a Restorative Communication Book and pulled out a Therapy & Nursing Communication Form. Staff C reviewed the Form and reported she had only completed the program as written in the restorative program EHR. The EHR system did not contain the 2/28/26 updates to Resident #2's RNP, so she had not completed those exercises. Interview on 3/11/26 at 1:48 PM Staff C reported she had reported the issue to the Director Of Nursing (DON) and the updates to the RNP had been put under the CNA documentation, not the restorative documentation so she wasn't able to see the updates in Resident #2's program to provide the updated program. Interview on 3/11/26 at 4:08 PM the MDS Coordinator explained sometimes she updates the care plan with the RNP updates, but in Resident #2's case, Staff A, LPN/Restorative Nurse had updated Resident #2's Care Plan with the RNP updates on 3/01/26. A 3/11/26 4:09 PM review of the February 2026 Restorative Record documented the Nursing Restorative #1 AROM supine or seated therex with AAROM 15 repetitions, 3 times a week updated 2/28/26. The February 2026 Restorative Record lacked documentation of the 2/28/26 RNP updates. A 3/11/26 4:12 PM review of the March 2026 Restorative Record documented the Nursing Rehabilitation #1 program completed on March 2, 4, 6, 9, and 11th. The March 2026 Restorative Record lacked documentation of the Nursing Rehabilitation programs #2, #3, #4 and #5 being completed. Observation on 3/12/26 at 9:15 AM Resident #2 in the restorative exercise room performing the arm bike exercises per the RNP. During an interview on 3/12/26 at 10:10 AM Staff A explained she just updated Resident #2's RNP today, so it will not show in the EHR program until 3/13/26. Resident #2 came in today and did the arm bike and standing exercises and did very well. She reported when the DON updated Resident #2's program, it was put under the CNA documentation, not restorative. The program updates have to go into the EHR in the Restorative Only area to communicate over to where they document the RNP programs. If the RNP is not put in the EHR correctly it will not communicate over. Staff A further explained AAROM means once a resident is not able to perform the exercise themselves fully, then the aide should actively assist the resident hands on to complete the exercise. In an interview completed on 3/12/26 at 11:56 AM the DON reported they recently had to move the restorative nurse out to the floor to work as a charge nurse which was supposed to be temporary, but they are needing to get her back in the restorative room along with a restorative aide. She needs the restorative nurse to manage and oversee the RNPs. She plans to provide the restorative staff with more training. As for the documentation, she tried to go in and input Resident #2's program and it went over to the CNA documentation and she made it worse because that was not where the documentation was supposed to go, but they have that figure out now. The Restorative Nursing Care Implementation and Screening Policy, revised 12/08/25, defined a Purpose to provide appropriate restorative nursing care to each resident and assist in the implementation of a RNP. The Policy lacked staff direction on specific communication and implementation of revised RNP programs.