STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165189	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Villisca	202 North Central Avenue Villisca, IA 50864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 37074 Based on record review, facility investigative file review, surveillance footage, resident and staff interview and policy review the facility failed to ensure 1 of 3 resident (Resident #1) was free from abuse. The facility reported a census of 37 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool, with a reference date of 7/2/24, documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 11. A BIMS score of 11 suggested moderate cognitive impairment. The MDS documented Resident #1 displayed no physical, verbal or other behavioral symptoms during the review period. The MDS indicated he had bilateral upper and lower extremity impairment on both sides and utilized a wheelchair. The MDS documented the following diagnoses for Resident #1: hypertension, renal failure, obstructive uropathy, stroke, hemiplegia, depression, and spinal stenosis. The Care Plan focus area with a revision date of 7/26/2023 documented Resident #1 had an activities of daily living (ADLs) self-care performance deficit related to impaired mobility. The care plan documented Resident #1 required the assistance of one staff for bathing. A second Care Plan focus area with a revision date of 7/18/2023 documented the resident had behavior symptoms related to anger and frustration as evidenced by pinching and attempting to hit staff during cares. The care plan instructed staff to: intervene as necessary to protect the rights and safety of others and staff are to approach/speak in a calm manner. A third Care Plan focus area with a revision date of 10/16/2023 documented the resident is resistive to care related to adjustment to the nursing home as evidenced by refusal of cares, eating, treatments, and bathing at times. The care plan instructed staff to leave and return 5-10 minutes later and try again if the resident is resistant with ADLs. The following Progress Notes documented the following: - 8/27/24 at 11:38 AM called the Primary Care Provider (PCP) to report possible abuse. Described new physical injuries, see Skin Assessment. Resident is reporting pain, especially to his 5th finger on left hand. When asked how he obtained injuries the resident stated, she hit me! Active bleeding to small lacerations under both eyes was stopped with light pressure. The primary care provider (PCP) gave order to send Resident #1 to the emergency room (ER) for evaluation. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 8/27/24 at 4:09 PM the ER nurse called with report. Diagnostic studies were performed including CT scan of his c-spine, CT scan of his head, chest x-ray and x-ray of his left hand. There were no acute fractures noted. Resident returned to the facility via facility vehicle with transport staff at 3:20 PM. - 8/28/24 at 3:21 PM resident denies any pain this shift. Resident out for all meals, good appetite. Resident pleasant mood today and no behaviors noted. - 8/29/24 at 2:08 AM resident cooperative with cares. Voiced no complaints of pain or discomfort at this time. Call light is in reach but resident chooses to tap chew can on bedside table when needing assistance. Resident was in a good mood. - 8/30/24 at 1:43 PM resident chooses to stay in his room for breakfast. Stated that he was tired and was being lazy. Resident denied any pain or discomfort this shift. He did get up for lunch and came out to the dining room. No negative behaviors noted. The following Skin Assessments documented the following: - 8/22/24 no skin conditions observed/skin condition resolved. - 8/27/24 at 10:22 AM skin observations noted: face: 3 centimeter (cm) x 2.5 cm abrasion under R eye with 1 cm x 0.1 cm shallow laceration. Slight amount of bleeding noted. Face: 1 cm x 0.1 cm shallow laceration noted to under L eye. Scant amount of bright red blood noted. Other: 5th finger on left hand and all joints very swollen and painful for Resident. Purple bruising noted to entire finger up to proximal joint. Chest: 8.5 cm x 4 cm area of bruising to L chest. Within area is 5 cm x 4 cm yellow fading bruising, and 3.5 cm x 4 cm bright purple bruising with marked swelling, warmth, and tenderness. Comments: Resident sent to ER for evaluation and treatment, per PCP. Family notified via phone. - 8/29/24 skin observations noted: face: abrasion under right eye measuring 0.8 cm x 1.0 cm. Face: abrasion under left eye measuring 1.0 cm x 0.1 cm. Chest: Yellowish bruising measuring 7 cm x 4.5 cm. Other: dark purple bruise on left 5th finger and knuckles measuring 7 cm x 6 cm - 9/5/24 skin observations noted: face: abrasion under right eye is resolved. Only small area of pink new skin remains where abrasion was. Face: abrasion under left eye is resolved, with the exception of a 0.1 cm x 0.1 cm dark red scab area where abrasion was is pink in color and shiny. Chest: yellow/green bruising remains to left chest. Swelling and heat has resolved. Other: 5th digit on left hand remains edematous but much less than previous assessment. Knuckle is most swollen and painful. 3rd, 4th, and 5th digit have yellow/green bruising in healing stages. Left hand is contracted. - 9.12.24 skin check completed-no skin conditions observed/skin condition resolved. Bruises on chest and hand have resolved. - 9.19.24 skin check completed-no skin conditions observed/skin condition resolved. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's clinical record revealed a hospital document titled Physician Clinical Report with an arrival date and time of 8/27/2024 at 12:03 PM. The report documented a chief complaint of reported physical abuse. Location of injuries-face and left hand and left ring finger. This occurred just prior to arrival. Occurred at a nursing home. He has dementia at baseline by reportedly went into the shower with an aid and came out with new bruises, telling staff that the aid hit him while in the shower. He does not give much detail to physician during exam. He only answers yes and no questions and is confused with orientation questions. This was reported to be baseline. Noted to have a scratch to the left side of his nose, with mild swelling over the bridge of his nose, new bruising to his chest, left hand, and elbow. He reports pain with palpitation of the bridge of his nose and hand. He had a previous stroke and has contractures of the left hand and elbow. Wheelchair bound and use of a mechanical lift to get up. Physical exam: extremities- left elbow small abrasion with controlled bleeding and bruising. Left forearm medium sized bruising. Left little finger: moderate tenderness and swelling and medium sized ecchymosis. Eyes: right periorbital area: small ecchymosis (small scabbed abrasion to upper check). Ears, Nose Throat (ENT): left ear small abrasion behind the ear. Nose: mild tenderness and swelling and small abrasion with controlled bleeding. Neurologic: altered mental status: confused (at baseline mental status per nursing home). Chest x-ray: no trauma. Left hand x-ray: no trauma. Head CT: no trauma. C-Spine CT: no trauma. The facility provided the following statements from their investigation: - On 8/27/24 Staff B Certified Nursing Assistant (CNA) wrote while she was walking up Hall 300 to the dining room to assist with breakfast, she heard from the shower room Resident #1 yell you're hurting me, followed by Staff A CNA saying I am just washing our f****** face. Resident #1 was known to yell out frequently and would say you are hurting me when touched. Staff B did not think anything of it until the resident was brought to the breakfast table by Staff A. His face was swollen and discolored around his nose, eyes and a sore under his right and left eyes. Blood seemed to be draining from the area between his eyes and nose. Staff B then immediately reported to the Staff C Registered Nurse (RN) charge nurse and the MDS Coordinator. Her hand-written statement was signed and dated 8/27/24. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- On 8/27/24 the MDS Coordinator typed Staff B CNA came to her and reported that she had heard Staff A in the bathhouse with Resident #1. Staff B reported she heard Resident #1 state stop you are hurting me. Staff A then stated to Resident #1 I am just washing your face. Resident #1 stated again stop it you are hurting me. Staff A stated I am just washing your f****** face. Staff A came out of the bathhouse with the resident and took him to the dining room for breakfast. The MDS Coordinator went to assess the situation and observed Resident #1 at the dining room table. His face and eyes were red. He had a small area on the left side of his nose/eye area with small amount of blood on it. The MDS Coordinator took Resident #1 into the family room and asked him about his bath and the situation that had just occurred. Resident #1 stated to her that Staff A was washing his face too hard and asked her to stop but she didn't stop. He stated she was too rough even though he asked her a couple times to stop. Staff A told him I am just washing your f****** face. The MDS Coordinator asked Resident #1 if he was harmed in any other way or was hurting, he denied any other pain and stated she is always rough when she moves me. He did not visibly have any other signs of injuries so she asked Staff C to complete a head to toe assessment then he was taken to his room by Staff C for that assessment. Staff A was in the dining room at this time with another CNA assisting residents with breakfast. The MDS Coordinator asked Staff A not to start any further baths and that the Director of Nursing (DON) will be here in a few minutes to speak with her. Prior to this she had notified the DON and Administrator of the potential abuse situation. The MDS Coordinator signed and dated the typed statement on 8/27/24. - On 8/27/24 Resident #1 was interviewed. What happened in the bath today? Resident #1 stated she washed my face too hard and wouldn't stop. Did Staff A hit you? Resident #1 said no. Did the girl that gave you a bath hit you. Resident #1 said no. Did Staff A pinch you? Resident #1 said no. Did Staff A put your head in the water? Resident #1 said no. Did Staff A push you? Resident #1 said no. Did Staff A harm or hurt you in any other way? Resident #1 stated she was always rough when she moved him. How is she rough? Resident #1 stated she doesn't listen. Are you hurting anywhere? Resident #1 stated no. Do you need to go to the hospital? Resident #1 stated no reason to. Do you feel safe? Resident #1 stated yes. - On 8/27/24 Staff A wrote she was giving Resident #1 his bath. As she was undressing him he asked her over and over what are you doing and to stop it. Staff A kept explaining she was giving him a shower. She turned on the water and grabbed a wash rag to wash his face. As she was doing that he was grabbing my arm saying what are you doing. She explained she was washing his face trying to get the dry boogers out of his eyes. He kept saying what are you doing, that hurt, pounding on the shower chair and grabbing her. She hurried and finished the shower, got him dressed and took him out to breakfast. She signed her statement. - During resident interviews the following residents stated: Resident #4 was asked how staff treat her and she stated good except Staff A. Review of Staff A's employee file revealed the following disciplinary actions: - 5/1/24 discussed tone of voice and approach to residents - 5/14/24 discussed approaching residents differently and/or having another aide to bath specific resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- 6/1/24 had discussion with charge nurse at nurse's station. Witnesses stated both were unprofessional. - 6/4/24 the DON and MDS Coordinator sat down with Staff A to discuss recent complaints from residents, staff and family members. Staff A admitted to having a bipolar disorder and that since she is currently taking fertility drugs, she hasn't been great about taking her medications. She also reported not always being aware of her tone, she has difficulty recognizing when she needs to watch her tone. She agreed to be receptive to coaching from her co-workers when they recognize an increase in her stress level affect her tone of voice. - 6/30/24 heated discussion at nurse's station with charge nurse. Witnesses stated that the charge nurse did not de-escalate the situation, but seemed to escalate it when Staff A was trying to calm down after being asked to by the other charge nurse. - 7/25/24 heated discussion at nurse's station with charge nurse regarding Staff A's care given to charge nurse's mother who is a resident. Several residents complain that she is rude and hurried while giving them their baths. Discussion: Staff A was calm and receptive to concerns voiced regarding tone of voice (rudeness), making the residents feel as if she did not want to take care of them and altercations that continue with her charge nurses at the nurse's station in front of residents and families. She stated that she has not been getting much sleep lately and could see why she appears to not want to be here or to take care of the residents. We revisited the discussion about not making the residents feel rushed while she is doing their cares. Regarding the heated discussions with the charge nurse, the DON instructed her that from now on if she believes the discussion is going to be heated, if she cannot walk away, please take it away from the nurse's station to be in private. The DON asked her to repeat what we discussed and she was able to state watch my tone, slow down and take it away from the station. Staff A stated that she felt like she is not doing anything right and so she just does not say anything at all. The DON informed Staff A she would be submitting a formal verbal warning regarding performance/behavior. She acknowledged understanding. Expectations: to slow down with resident cares, choose words wisely and walk away if things begin to escalate at the nurse's station or in front of residents/families. With all of the discussions they have had with Staff A since hire, she has shown improvement, but continues to require guidance. - On 8/27/24 an employee overheard a resident yelling from the shower room you are hurting me. This employee stated it is not unusual for that resident to yell during his cares. That employee then heard Staff A yell I am just washing your f****** face. When the resident came out of the shower, this employee noted that the resident's face was swollen and discolored around his eyes and near left eye appeared to have some blood draining. The CNA reported this and Staff A was suspended. The resident was questioned after he came out of the shower about this and confirmed Staff A provided rough care in the shower. The resident was sent out for evaluation due to some concerns about his finger as well. Staff A denied that she said the word f****** to the resident but states the resident was asking her over and over what she was doing, he was pounding on the shower chair saying that hurts and she had to keep explaining that she was giving him a shower. We have been addressing on-going behavior concerns with Staff A for concerns with her attitude toward staff and her approach with residents. As a result of these on-going concerns and this egregious concern with resident care, we have made the decision to end Staff A's employment, effective immediately. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/20/24 at 1:26 PM reviewed the facility's security camera footage from 8/27/24 with the DON. The footage revealed at 6:34 AM Staff A walked out of Resident #1's room with wheelchair and clothes on it. She walked up the hall to smaller that led to the 300 hall (per the DON) to the bath house. Per the DON there is not camera footage from the 300 hall. At 6:38 AM Staff A went back to Resident #1's room with a mechanical lift and exited the room with Resident #1 in the wheelchair at 6:46 AM. Staff A then propelled the resident up the 200 hall to the adjoining hall that led to the 300 hall. No other staff members were observed to enter or exit the resident's room other than Staff A between 6:34 AM and 6:46 AM. At 7:03 AM Staff A assisted Resident #1 out of the 300 hall by the nurse's station and to the dining room table with peers and Staff B present. Unable to see Resident #'1 face clearly on the video footage. On 9/20/24 at 10:36 AM Resident #1 was observed to be sitting in his recliner watching television. Noted a bruise to his left hand between his index finger and thumb. The bruise was deep purple/maroon in color. No skin issues noted to his face or under his eyes. Resident #1 agreed to speak with surveyor and for his door to be shut. He then offered a chair to sit on. Resident #1 stated he had breakfast and it was pretty good. When asked what happened a few weeks ago while he was receiving a bath he stated he fell . When asked how that happened he stated the floor was wet. When asked if he had any injuries from that fall he stated his ribs hurt but that was it. Eye contact was made during this part of the conversation. When asked what else happened in the bath house he stated nothing. When asked how the staff are with him during his baths he stated fine. He was asked if anyone was ever rough with you during your bath he stated no. When asked how are staff are when they are washing his face he stated he had no concerns. When asked if staff had ever washed his face in a rough manner he stated no and denied staff being rough during his bath. Resident #1 was asked if anyone had ever hurt him in any way, he stated no. When Resident #1 was informed of bruising and open areas to his face documentation in his file from last month, he stated he did not know what happened. Resident also denied knowing why he had bruising on his chest and hands. During this part of the conversation he made no eye contact with me. When asked how things were going here at the facility and he stated it's very peaceful here. When asked if he wanted to talk about anything else he stated no. Resident #1 was thanked for his time and to have a great day. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/20/24 at 12:34 PM the MDS Coordinator stated Staff B came to her about what she heard in the bath house. She heard Resident #1 say you are hurting me and Staff A said I am washing your face. Resident #1 said it again and Staff A said I am just washing your f****** face. Staff B had asked her to come look at Resident #1 because she was concerned about his face. When she went to the dining room, Staff A was assisting other residents with their meal with other staff members present. When she saw Resident #1, she asked Staff A which baths she had left. She wanted to get a game plan on how to talk with her because Staff A has a history of blowing up when confronted. So she told Staff A the DON wanted to speak with her before she completed more baths. She asked Staff B not to leave the area where Staff A was at. The MDS Coordinator did not want Staff A blowing up in front of residents so she made sure Staff B knew to basically supervise her until they figured out a plan. She then called the DON and Administrator to come in. When she went back to the dining room, Resident #1 was done eating so she pulled him into the conference room, closed the door and talked with her for a bit. About the same time the DON had arrived and had Staff A at the front of the building. When asked what happened-he said she was washing his face too hard and could not breath. She noticed a scratch on his face, when asked if he scratched himself he stated she washed my face too hard. Resident #1 said Staff A was rough with him. He denied other physical occurrences while she was washing his face The MDS Coordinator also noted his eyes were reddened, blood shot. But did not see other injuries because the DON and Administrator had arrived and Staff C had completed the head to toe assessment upon request. She has been with Staff A when she has assisted Resident #1 before. He is contracted and would say he was in pain while assisting him and he would yell. She also has had to sit in while the DON talked with her before about concerns and she would do good after speaking with her. She never thought Staff A would be mean with residents as she seemed to care about them. She had been educated previously on slowing down with residents. Staff A did tell them she has mental health issues and stopped taking her medications because she is currently doing fertility injections. When asked how Staff A was as an employee she indicated she can be loud and boisterous. Resident #1's behaviors can be combative at times; swat at staff, nice out of nowhere then back to pinching staff out of the blue. The MDS Coordinator indicated Staff A had told her she gets overstimulated and is task oriented, so what she thinks happened was Resident #1 was saying stop you are hurting me. Staff A may not have understood what she was doing and just wanted to get his eye burgers out, not realizing he has sensitive skin. The MDS Coordinator indicated she has sat in when Staff A would be educated on not rushing residents, slowing down with them. Staff A would be remorseful when spoken to. She did call in a lot, would pick up extra shifts and stay over to help. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/20/24 at 1:07 PM Staff C RN stated she was told by Staff B she walked by the bath house and heard Resident #1 yelling. Staff B stated she then heard Staff A tell Resident #1 to shut up, I am trying to wash your f****** face. When he came to the dining room Staff C noticed he had two black eyes, cuts under his eyes, with brand new bruising on his chest, and the left side of his hand was swollen. Resident #1's pinky on his left hand was 3 times bigger than normal and had bruising originating at the joint. She completed a full head to toe assessment to make sure she saw everything. When she asked happened he stated she hit me then five seconds later he could not remember what happened. But that was normal for him. He was sent to the ER for a full evaluation and they noted no broken bones. Staff C indicated she had given him his medications prior to his bath and did not notice these injuries at that time. When asked about Staff A as an employee, she stated she is very loud, can be disrespectful with other residents. Staff C stated she reported these concerns before. Staff A would yell at residents, was always on her phone when giving baths or supposed to be doing other things. When assisting residents, she would yell at them to hurry up, or would not pay attention at all. When asked to describe his behaviors she stated he would pinch or hit staff's butt, yell a lot. When asked how Resident #1 has been since this she stated good, appears much happier now since she is gone, coming out of his room more often. On 9/20/24 at 1:37 PM Staff B CNA stated she was working on the 300 hall that day. She indicated that is where the bath house is located. When she walked by the bath house she heard Resident #1 tell Staff A to stop hurting my face. Then she heard Staff A say I am just washing your f****** face. Staff B reported the resident tends to yell in pain so she did not think anything of it. She continued to go to the dining room to assist residents with their breakfast. When Staff A brought Resident #1 to the dining room table where those that need assistance sat, she thought his nose looked crooked so she called another staff member over to look. Staff C came over and Staff B stated below his eye was bleeding and under both of his eyes the skin appeared dark in color and puffy. Staff B went and got the MDS Coordinator because it looked like someone punched him in the face. She came to the dining room and took over after that. Staff B indicated the corner of his left eye was rubbed raw with blood in the corner of it. Both of his eyes were dark and puffy. When asked if the resident said anything to her she stated no. When asked how he was while in the dining room during his breakfast she stated he seemed ok but was more shaky than normal. He ate his breakfast then they sent him to the hospital to be evaluated. When she left at 2:00 PM he was still gone. Since then he appears to be fine and never said anything to her about Staff A or that day. When asked how Staff A was as an employee she stated she is rude and acts like she does not care, rough around the edges type of person. She had never witnessed her being rough with residents but were times where she was in a hurry and rushing with residents. When asked if Resident #1 had any behaviors she stated he was not good at expressing himself without yelling out. When she has assisted with his baths he would grab her hair, with cares assist he would smack at them. But if you talk him through what is going on he would stop. Residents have reported to her that Staff A was rude and acted like she did not care. Staff B stated she has noticed other residents appear happier since Staff A was let go. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24 at 10:39 AM Staff A CNA stated she was completing Resident #1's shower and he became very combative: hitting, screaming, and pinching her. So, she rushed through his shower to get him out and to breakfast. He had a bunch of gunk in his eyes that she was trying to get out. As she was rubbing his eyes, he was hitting her, she acknowledged to being overstimulated at that point in time. Staff A admitted she rubbed his eyes with the washcloth too rough and she feels really bad about it. She indicated the bruising to his chest and fingers were there before the bath. When asked if she had told anyone about the bruising on his chest and fingers she stated she let Staff C know about it when she brought him to the dining room that morning. Staff A also stated she told the DON during her interview about the bruising on his chest and finger, during her interview. She brought him to the dining room for breakfast she saw a little mark on the side of his nose, she knew she rubbed too hard to get the gunk out of his eyes. When asked what staff are to do when he has these behaviors she stated she would report them the nurses were supposed to do behavior charting but not sure if they were. She added staff just dealt with Resident #1's behaviors. When explained to her his care plan advised staff to step away from 5-10 minutes she indicated she did not know that. She indicated she would normally step out to get another aide but did not do that, that day because everyone was busy. She denied using foul language with Resident #1 or any resident for that fact. Staff A stated at the time of this incident she was taking a lot of fertility treatments and would get overwhelmed. Staff A also stated she has Polycystic Ovarian Syndrome (PCOS), with the extra hormones, plus anxiety/depression medications, it all made her overstimulated and overwhelmed. Staff A stated she did not mean to hurt him at all, she feels really bad. She stated she again was just overwhelmed/overstimulated that day. When asked what time she gave Resident #1 his bath she stated he was usually done first thing in the morning, so about 6:30 AM-7:00 AM (ish). She indicated Staff D CNA had assisted her with his transfer from his bed to the wheelchair that morning. Staff A acknowledged she had been talked to about rushing prior to this incident. Before she started working at the facility she had worked for a facility that was very short staffed, so she was used to rushing to get things done. She indicated she never stepped back and just relaxed while working at this facility. Staff A admitted to becoming overwhelmed at work and would go speak with the DON about it for guidance and she would tell her to breath. On 9/24/24 at 10:46 AM Resident #2 was sitting in her room working on a diamond art photo. Resident #2 was asked how staff are with her and she stated better now that one is gone. When asked what was going on she stated Staff A would put her socks on and was very rough about it. When Resident #2 would ask her to stop she would not. Resident #2 stated her feet are very tender/sensitive but Staff A would not listen when she asked her to stop. Resident #2 also would not help her when she wanted to move about in her room. She indicated she required assistance of staff when moving out of her chair/bed and with walking. Staff A stood in the doorway while she tried to get up but would not come to help her. Resident #2 indicated she told Staff A she needed help and her doctor had filled out paperwork that stated this. Resident #2 also stated she was using the restroom before she had to leave the facility for an appointment. She activated her bathroom light and could hear Staff A talking outside of her room but would not come in to assist her off the toilet and assist her with getting ready for her appointment. Resident #2's daughter came in for her appointment and had to assist her off the toilet to get ready for the appointment. They ended up being late that day. When Staff A came in to Resident #2's room the next day, she asked Staff A why she did not help her when she heard her talking outside of her room, Staff A did not say anything. Resident #2 indicated she has not had further issues since Staff A was let go. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165189	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Villisca	202 North Central Avenue Villisca, IA 50864

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 9/24/24 at 1:55 PM the DON stated when she got here Resident #1 was out of the dining room. She indicated staff made a comment that Resident #1's nose was cricked so she pulled up his picture from his Electronic Health Record (EHR) and his nose was cricked in the picture as well. She did not notice any redness or bruising when she arrived. The ended up sending him to the ER because of other bruising that was noted during his head to toe assessment. She let Staff A know she was suspended pending investigation. She did not talk to Resident #1, the MDS Coordinator interviewed him. When they spoke to Staff A about the incident with Resident #1 Staff A stated she did not want to hurt him. She was washing his face and he was not letting her do so. Staff A stated she honestly did not see him bleeding. When asked what happened to his left pinky Staff A did not say anything to that. Staff A told them she was overstimulated that day. The DON indicated they had previously provided education to Staff A before and wanted to believe in her that things would change. The told her she needed to slow down with residents and ask for help. They had formally completed did some disciplinary actions for her attendance, behavior and performance. The DON was asked if Staff D was working that day, she indicated she was scheduled to work but called in. The DON stated Staff A never reported that Resident #1 had bruising to his chest that day. If he was having behaviors during his bath, she should have stepped away from the situation and asked for help. The facility provided a document titled Abuse and Neglect with a revision date of 7/22/24 documented the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies service the individual, family members or legal guardians, friends or other individuals. The resident has the right to be free from abuse. The facility provided a document titled Resident-Dignity with a revision date of 11/16/2023 documented the purpose of the policy was to maintain the dignity of all residents and to assist with respecting and ensuring resident rights. The location will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Ideas for maintaining a resident's dignity may include, but not be limited to: a. Grooming residents as they wish to be groomed f. Treating residents with respect