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	09/03/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical document review, observation, resident interview, staff interview, and policy review the facility failed to provide a professional standard of quality by not following physician orders for 1 of 3 residents reviewed (Resident #2). The facility reported a census of 37 residents. Findings include:Review of the Minimum Data Set (MDS) for Resident #2 dated 6/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS further revealed diagnoses of quadriplegia, seizure disorder, anxiety, and respiratory failure.Review of the Electronic Healthcare Record (EHR) page titled, Physician's Orders revealed an order for the lower extremities to be 1. washed with soap and water, 2. irrigate with normal saline, 3. apply skin prep to periwound, 4. apply nickel thick medicated cream, 5. Saline moistened fluffed gauze, 6. Cover with dry gauze, 7. Secure with rolled gauze and tape every day and evening shift for wound care with a start date of 7/21/25. The page further revealed an order for compression socks on in the morning and off in the evening for edema with a start date of 7/21/25.Review of a facility provided document titled, Provider Orders Form dated 7/21/25 revealed an order for compression hose as ordered by vascular.Review of a facility provided document titled, Clinic Referral dated 7/21/25 revealed an entry from an outside physician stating Resident #2 would need to start wearing compression stockings daily and to follow up as necessary. Review of another facility provided document titled, Certified Wound Care Nurse Assessment and Recommendations with a date of 8/20/25 revealed a note stating that Resident #2 reported not getting his new compression stockings, and that the wound nurse would reach out to the facility. Interview 9/2/25 at 2:35 PM with an outside provider revealed that she has been seeing Resident #2 since May of this year. The outside provider further revealed that Resident #2 was seen by vascular at an outside facility, and that Resident #2 has not had his stockings in the last 3 weeks that she has seen the resident. The provider then revealed that if Resident #2 was wearing his stockings as ordered wounds would be healing better on the lower legs. Observation 9/2/25 at 2:50 PM revealed Resident #2 to not be wearing compression stockings bilaterally to the lower extremities. Interview 9/2/25 at 2:57 PM with Resident #2 revealed that he does not have any stockings. Resident #2 revealed that stockings were ordered, and when they came in on August 29th or so of this year they were the wrong size. Resident #2 then revealed that if offered some stockings he would have put them on with the condition of his legs. Review of the Treatment Administration Record for the months of July, and August of 2025 revealed that between the dates of 7/21/25 through 8/31/25 compression stockings were documented that Resident #2 refused them 25 times, they were put on 6 times, and were unavailable 30 times. Interview 9/2/25 at 3:07 PM with Staff B Licensed Practical Nurse (LPN) stated that staff sometimes get click happy when entering/documenting on the Medication Administration Record (MAR), and may not be completing treatments as ordered. Staff stated she may be guilty as well as entering stockings donned when they were not. Staff B then revealed Resident #2 wanted specific stockings as the physician wanted a specific brand.Interview 9/2/25 at 3:15 PM with Staff C Registered Nurse RN revealed Resident #2 is very particular with his treatments, and that as far as Resident #2's compression stocking's he wanted to order his own. Staff C then revealed that Resident #2 did get some stockings in but they were the wrong size, and sent them back. Staff C further revealed that she would expect someone to follow up with the physician who ordered the stockings to be notified that they were not being worn. Interview 9/2/25 at 3:27 PM with Staff D LPN revealed that Resident #2 supposedly ordered his own compression stockings, and when they came in they did not fit. Staff D then revealed that she would expect that with a physician's order staff would follow up with the provider whether that be the primary care provider or the clinic that prescribed them if the supplies had not come in. Interview 9/2/25 at 4:15 PM with the Director of Nursing (DON) revealed that orders should be followed as written, and if the facility or resident was not wearing or did not have compression stockings that the facility should have followed up with the physician who ordered them.Review of a facility provided policy titled, Physician/Practitioner Orders with a revision date of 4/6/25 revealed:a. Physician/Practitioner orders are a critical component to providing quality care to residents. Accurate processing of physician/practitioner orders is important. The nursing services and health information management departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. Teamwork and communication between the two departments is essential.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, observation, staff interviews and policy review the facility failed to protect a resident from a possible accident and injury by not following the prevention of fall interventions for 1 of 3 residents (#5). The facility failed to protect the resident with the completion of 3 movements using a dependent non-weight bearing mechanical lift with only 1 staff present. The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) for Resident #5 dated 8/19/25 identified a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment The document revealed the resident required total staff assistance for toileting hygiene and significant/maximal staff assistance for lower body dressing, sit to stand, chair/bed-to-chair transfer and toilet transfers. The document provided the resident was dependent for manual wheelchair mobility. The document provided the resident's diagnoses included cerebrovascular accident, Non-Alzheimer's Dementia and coronary artery disease. Resident #5's Care Plan printed 9/2/25 contained a focus area related to activities of daily living (ADL) with interventions of toileting with 2 staff assist and transfers with 2 staff assist with total lift using medium (yellow) sling. The document contained an additional focus area of impaired cognitive function/dementia and thought processes. Interventions for this focus area included reduction of distractions by turning off the television, radio, breaking tasks into single components, and providing simple direction sentences. The document contained a focus area of Enhanced Barrier Precautions (EBP) related to a pressure ulcer with interventions of applying/removing gown and gloves while performing high contact areas of transferring, checking and changing.On 9/2/25 at 12:00 PM observed an EBP sign on Resident #5's door, a storage container labeled EBP supplies and a disposal container for used products. On 9/2/25 at 3:15 PM observed Staff A, Certified Nurse Assistant (CNA), complete transfer and toileting tasks with Resident #5. The staff took a dependent mechanical non-weight bearing lift into the resident's room and told the resident she was going to get up, use the bathroom, and get into her wheelchair (w/c). The staff completed hand hygiene, donned gloves and approached the resident who was seated on her recliner. The staff prepared the resident for the transfer and toileting by lowering adaptive pants and placing the sling under the resident. Staff A connected the resident to the dependent lift. The staff then picked up a wash basin that was sitting on an arm chair, took it to the bathroom, and returned with a plastic bag in it. The staff proceeded to lift the resident from the recliner, place the wash basin on the recliner, lowered the resident onto the basin, told the resident she could go potty, and placed her blanket over her lap. While Resident #5 was sitting on the wash basin, the staff obtained peri care supplies and a clean brief. When the resident indicated she was finished, the staff lifted the resident off of the basin, completed peri cares and initiated the clean brief. Staff A proceeded to move the resident using the dependent mechanical non-weight bearing lift to the resident's w/c. The staff lowered the resident onto the w/c and completed the dressing tasks. On 9/2/25 at 12:44 PM Staff E, Clinical Care Coordinator, stated Resident #5 used a sit to stand/weight bearing lift in the bathroom. The staff stated if a dependent mechanical non-weight bearing lift was used with the resident a bedside commode was used. On 9/2/25 at 2:50 PM Staff B, Licensed Practical Nurse (LPN), stated the resident transfers with a dependent non-weight bearing mechanical lift and transfers to a bedside commode for toileting. On 9/2/25 at 3:08 PM Staff A stated the resident used a dependent non-weight bearing mechanical lift for transfers and used a commode pot.On 9/2/25 at 3:30 PM Staff A acknowledged there should have been 2 staff present for the use of the dependent non-weight bearing lift. When asked about EBP, the staff stated she utilized gloves. The staff stated Resident #5 was the only resident who utilized a non-weight bearing lift and completed toileting tasks. The staff stated that's how they had always toileted the resident when using the lift. On 9/3/25 at 8:30 AM Staff F, CNA, stated there should be 2 staff present when operating a dependent non-weight bearing mechanical lift. On 9/3/25 at 9:10 AM Staff G, CNA, stated there should be 2 staff present and engaged to use the dependent non-weight bearing lift. The staff stated the 2 staff work together hooking the sling to the lift, ensuring the loops match on both sides, stop and do a time out to ensure safety, the staff ensure no one turns their back on the resident, and work as a team to move the resident from one location to the next. On 9/2/25 at 3:45 PM the Director of Nursing (DON) stated that staff should utilize PPE as required with EBP for all direct contact cares, including transfers and toileting. The staff expected that 2 staff should be present during the use of non-weight bearing lift and transfers. The staff acknowledged a resident was never left alone when connected to the lift and completing toileting tasks.On 9/2/25 at 4:00 PM the Administrator concurred 2 staff should be used with the use of non-weight bearing mechanical lift. The facility's Safe Resident Handling