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	10/16/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, staff interviews, and policy review the facility failed to provide needed services in accordance with professional standards by receiving physician's orders to start physical therapy (PT) and occupational therapy (OT) and failed to start the orders for 1 of 3 residents (Resident #2). The facility reported a census of 37 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 documented a Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment. The MDS documented right below the knee amputation with right lower extremity prosthetic. Review of Resident #2's EHR document dated 8/4/25 titled, admission Orders to Nursing Home documented physician's orders for physical therapy and occupational therapy with rehab potential as fair. Review of document dated 9/3/25 titled, Physical Therapy PT Evaluation and Plan of Treatment documented certification period was 9/3/25 through 11/25/25. The document further explained physical therapy started 9/3/25.Review of document dated 9/3/25 titled, Occupational Therapy OT Evaluation and Plan of Treatment documented certification period was 9/3/25 through 11/25/25. The document further explained occupational therapy started 9/3/25.On 10/16/25 at 9:39 AM Staff C, Occupational Therapist Assistant stated Resident #2 was picked up for therapy in the beginning of September for improvement on standing, strengthening, and application of the prosthetic leg. Staff C explained the therapy department received an order on 8/27/25 to see Resident #2.On 10/16/25 at 11:30 AM the Director of Nursing (DON) acknowledged an order for Resident #2 dated 8/4/25 documented admission orders for physical therapy and occupational therapy. The DON acknowledged the orders were not followed and Resident #2 was not seen until 9/2/25 after Resident #2's primary care physician placed orders on 8/27/25 to be evaluated by PT and OT. The DON acknowledged Resident #2 should have been seen by PT and OT when orders were placed on 8/4/25. The DON stated the order was missed. On 10/16/25 at 1:14 PM the Administrator said the facility should have followed up better with the order for PT / OT for Resident #2. Review of policy revised 4/6/25 titled, Physician / Practitioner Orders - Rehab / Skilled documented the purpose was to provide individualized care to each resident by obtaining appropriate accurate and timely physician / practitioner orders. At the time of admission, the location will have physician orders for the resident to be admitted to a location. Each resident must remain under the care of a physician. The admitting orders are intended to provide guidance on appropriate resident care until a comprehensive assessment was conducted and the interdisciplinary care plan was developed. Required orders on admission include rehabilitation potential and therapy orders when appropriate.

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

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	10/16/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record review, Medication Administration Records - Treatment Administration Records (MAR-TAR) and staff interviews the facility failed to receive necessary treatment to prevent developing avoidable pressure ulcers for 1 of 3 residents reviewed (Resident #5). The facility reported a census of 37 residents.Finding include:The Minimum Data Set (MDS) dated [DATE] for Resident #5 documented a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The MDS documented diagnosis of two stage 2 pressure ulcers.Review of Resident #5's MAR-TAR documented a physician's order for daily wound data every day shift for wound observation. Right sacral region dressing change. Cleanse with soap and water, skin prep, med honey, cover with 2x3 or 4x4 proximal border foam dressing once a day for skin treatment started 5/9/25. Weekly skin observation one time a day every Thursday for skin observation.Review Resident #5's EHR's titled, Wound Data Collection from 5/5/25 - 5/31/25 documented no measurements of Resident #5's wound on the right sacral region.Review document titled Nurse's Notes for Resident #5 documented by Staff A, Certified Wound Nurse assessed Resident #5's wound on 5/8/25 and 6/3/25 with description and measurements. On 10/16/25 at 9:54 AM Staff A stated she was contracted for wound care and assessment for a pressure wound on Resident #5 right sacral region. Staff A stated Resident #5 was supposed to come to the wound clinic weekly. Staff A stated she spoke with Resident #5's daughter about weekly visits to the wound clinic. Staff A discovered Resident 5 was uncomfortable with coming to the clinic so Staff A started going to the facility. Staff A stated she visited on 5/15/25. Staff A stated every time she went to the facility Resident #5 would be lying on her side. Staff A stated the area on Resident #5's right sacral region was unavoidable. Staff A stated the dressing appeared to be changed as ordered.On 10/15/25 at 11:43 AM Staff B, Registered Nurse (RN) / wound nurse stated she had time off work from the last day of April of 2025. Staff B stated she returned in June. Staff B stated when she went on leave from the facility Resident #5's right sacral region only had a bruise and when she returned in June the area was open. On 10/16/25 at 11:30 AM the Director of Nursing (DON) stated Staff B was on medical leave the month of May. The DON explained Staff B completed the wound assessments with measurements weekly. The DON acknowledged wound assessment was not completed with measurements by the facility staff from 4/30/25 until 6/11/25. The DON stated Staff A from the wound clinic visited Resident #5 and completed a full assessment on 5/8, 5/15 and 6/3. The DON acknowledged Resident #5 did not have an assessment completed by RN with measurements and descriptions of the wound on Resident #5's right sacral region. The DON stated a wound assessment completed by an RN with measurements should have been completed weekly. The DON acknowledged the Staff A did not complete an assessment on Resident #5's right sacral region from 5/8 through 5/15 and 5/15 through 6/3. The DON explained an assessment with measurements should have been completed between these dates by a facility RN and that did not happen. On 10/16/25 at 1:14 PM the Administrator stated he would have expected an assessment with measurements completed weekly on all pressure ulcers. Review of policy revised 4/6/25 titled, Skin Assessment Pressure Ulcer Prevention and Documentation documented the purpose was to accurately document observations and assessments of residents. If a pressure ulcer was identified, cleanse the area prior to observations being made to allow the wound bed and depth to be more accurately observed. The Licensed nurse records the location of the area, the measurements, and the ulcer wound characteristics. The pressure ulcer should be assessed / evaluated at least weekly and documented on a Wound RN Assessment UDA.