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	12/05/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, resident and family interviews, staff interviews and record review the facility failed to treat each resident with respect and dignity during care for 1 of 1 resident reviewed. Resident #8 reported that a staff member refused to put him to bed until he went to the bathroom, then she tried to pry his hand off of the mechanical lift. The facility reported a census of 42 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #8 was admitted to the facility on [DATE]. He had a Brief Interview for Mental Status (BIMS) score of 15 (intact cognitive ability.) Resident #8 did not exhibit verbal or physical behavioral symptoms toward others nor did he reject care from staff. The resident required substantial assistance with toileting, lower body dressing, showers, sit to stand, and toilet transfers. His diagnoses included; lymphedema, muscle weakness, need for assistance with personal care, depression and chronic pain. The Care Plan for Resident #8, updated on 4/26/24, showed that he had a communication problem related to a hearing deficit, staff were to turn off the television during cares and speak clearly and slowly. Resident #8 had impaired mobility, was unable to ambulate and required extensive assistance for toilet use. Staff transferred him with the use of a mechanical lift; Sit to Stand, at times, he was able to pivot transfer to and from the toilet and wheelchair. The resident had bladder incontinence, chronic pain and he was on diuretic therapy related to edema. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/02/24 at 12:13 PM, observed Resident #8 sitting in a wheel chair in his room watching television. He was wearing shorts, and was found to have swelling in his legs and feet. When asked if the staff were treating him respectfully, Resident #8 said that there was just one staff member that he'd had trouble with. I needed to go to the bathroom. He went on to said that he put his call light one evening around 6:30 and when he didn't get help, he transferred himself from the wheel chair to the toilet. Later that evening, when he was ready to go to bed, he put his call light on again and Staff G brought the mechanical lift, Sit to Stand in the room. She told him she wouldn't transfer him to bed until he first went to the bathroom. She tried to pull my arm off the lift, and argued that she was not going to transfer him to bed until he went to the bathroom. The resident said that he needed to put his feet up because he had a lot of swelling and he just wanted to be put in bed. Resident #8 was holding onto the arms of the Sit to Stand machine and Staff G tried to get his hand off by prying and pulling on his fingers. The resident said that Staff G got on the walkie and asked for help. Soon after, another aide came into the room and put him in bed. He said that the Administrator, and the DON failed to come and talk to him about the allegations. On 12/02/24 at 12:51 PM, a family member (FM) for Resident #8 said that the resident told her that he thought his rights had been violated. He told her that on the evening of 11/8/24 he put his call light on at around 6:30 PM. Staff G came in and said that it would be a while before she could help him and then left the room. He took himself to the bathroom and then put the light back on when he was ready to go to bed. Staff G came back into the room around 7:45 PM and said that she wanted him to go to the bathroom first, and would not transfer him until he went to bathroom. The FM said that Resident #8 told her, she tried to pull his hands off the lift. The FM wrote up a grievance on 11/9 and called the facility on 11/11 to tell the Social Worker (SW) that she did not want Staff G to take care of the Resident #8 until the incident had been investigated. She found out on 11/13 that Staff G had been in his room on 11/12. The FM said that she did not get a call back from the facility or talk to the DON or Administrator about the incident until about a week later. On 12/3/24 at 10:10 AM, Staff C Licensed Practical Nurse (LPN) said that she was the nurse working the evening of 11/8/24. She said that she gave Resident #8 his medications earlier that evening and there wasn't anything unusual about him at that time. Around bedtime, Staff D came and told her that Resident #8 and Staff G weren't getting a long, so she put the resident to bed herself. She hadn't learned about the details of the incident until the following day from the FM. A couple of days later, she had gone into the resident's room and talked to Resident #8 and the FM and they described what happened. The FM said that it seemed that the administration wasn't doing anything about it and Staff G hadn't been suspended. Staff C said that she had not been interviewed by Administrator or the DON about the events of that evening. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/24 at 12:22 PM, Staff D, CNA was getting ready to leave for supper break on the evening of 11/8/24 when she got a message on the Walkie-Talkie that Staff G needed assistance in the room for Resident #8. Staff D said that she went to the resident's room could tell there was tension. Usually, Resident #8 would be friendly and talkative but he was upset, and his facial expressions showed he was angry. Staff D asked what was going on and Staff G responded that Resident #8 was being difficult and rude. The resident did not say anything. She asked Staff G to leave the room and continued with his care, and asked him if everything was okay. Staff D said that he did not want to talk about it. The Sit to Stand was in front of the resident who was sitting in his wheel chair. His feet were on the lift, and the sling was hooked up to the machine. She said that she asked him if he needed to use the bathroom and he responded that he had gone earlier and just wanted to get into bed. The resident didn't need anything else. he goes to restroom every couple of hours. Staff D said that neither the DON nor the Administrator interviewed her related to this incident. On 12/03/24 at 2:38 PM, the DON said that she learned about the incident between Resident #8 and Staff G the following day, 11/9/24. The resident didn't have any marks on his hands and arms and Staff G didn't work with him over that weekend so she dealt with it on Monday, 11/11/24. She said that she trusted the nurses on duty and none of them expressed concerns of suspected abuse. The DON maintained that she had interviewed Staff C and Staff D and she did not report the incident to the state authorities or complete an incident report because the resident did not have any marks, and they didn't believe that it rose to the level of abuse. On 12/3/24 at 5:02 PM, the DON said they did not talk to the resident about the incident, but had relied on the Social Worker to complete an interview and had assumed that she had. She said that she hadn't talked to Resident #8 specifically about the interactions with Staff G, but the resident was not shy about coming to them with concerns. On 12/04/24 at 8:08 AM, the Social Worker (SW) said that she was responsible for resident grievances. She said that the department heads along with DON and Administrator determined if/when the issues had been resolved. She said that it was over the weekend that the FM for Resident #8 completed a grievance so she dealt with it on the following Monday (11/11/24). The SW acknowledged that she hadn't actually talked to the FM, and didn't talk to Resident #8 about the situation until 11/19/24 at which time he said that it was just a moment of frustration. The SW said that she gave the grievance to the DON, and then Staff G had been interviewed by the DON. On 12/04/24 at 9:21 AM, Staff A RN, said that the FM for Resident #8 told her about an incident the previous evening and she directed her to fill out the grievance form. Staff A and Staff F were in the Resident's room providing care while the FM discussed the detailed with the resident. Staff A said she didn't see any marks on the resident's hands or arms. The resident said that he just wanted to go to bed and didn't need to use the restroom. The resident told Staff A that she grabbed his arm and forcefully pulled his hand off the lift. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/04/24 at 9:51 AM, Staff F, Registered Nurse (RN), said that she provided care to Resident #8 on the morning of 11/9/24. The FM was in with the resident and she and Staff A, RN came in the middle of the conversation. They talked about an incident that happened the night before and the FM was examining the resident's hands. Staff F also looked over his hands and didn't see any marks or bruises. The resident said that Staff G wanted him to go to the bathroom and he had already gone. Staff G got upset and left. He did mention she had walked by the room a couple of times while his call light was on. Watched her walk by the room. He said she forcefully moved his hand off the sit and stand and he thought there were scratches. Staff F said that the resident was grumpy that morning because he hadn't slept well. The FM said she was going to talk to the DON and SW about the details. Staff F said that she did not get interviewed by the DON or Administrator regarding this situation. The backside of the grievance form also included a second, hand-written note, dated 11/11/24, signed by the DON. The note indicated that the DON spoke to Staff G, and the CNA admitted that on the evening of 11/8, Resident #8 wanted to go to bed but she tried to get him to go to the bathroom so he wouldn't need to get up shortly thereafter. He told her that he already went to the bathroom and he just wanted to get into bed. They argued a little and he told Staff G to get the nurse. She called for help and tried to remove the lift from the room but the resident held on to the lift. She told him she couldn't leave it in the room for safety reasons and tried to remove his left hand, with no luck, then tried to remove the other. A second CNA came into the room and took over the cares. The DON discussed with Staff G that she should not have tried to pry his hand off of the lift. Staff G agreed that she would refrain from providing cares to resident #8, unless necessary. According to a Grievance Log summary that included a list of resident grievances, on 11/9/24 the grievance for Resident #8 concerning CNA problems had been resolved. According to a form titled: Suggestion or Concern, dated 6/19/24. Resident #8 reported to a family member that the evening before, he put on his call light to get assistance to the bathroom and Staff G wanted him to use the urinal. The resident did not like to use the urinal because he was concerned that he would make a mess in the chair. He was able to get assistance from a different staff member.

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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** 41785 Based on clinical record review, staff interview and policy review, the facility failed to provide a resident and family with adequate notification of financial responsibility when Medicare Part A services were scheduled to be discontinued for 1 of 3 residents reviewed (Resident #32). The facility reported a census of 42 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #32 had a Brief Interview for Mental Status (BIMS) score of 1 (severe cognitive deficit.) He had diagnoses that included; cancer, anemia, renal insufficiency and Cerebrovascular Accident (CVA). The Care Plan updated on 2/8/24, showed that Resident #32 had self-care performance deficits related to acute transverse myelitis in demyelinating disease of the central nervous system. He required one staff assistance with ambulation, toileting and transfers. According to the census tab in the electronic record, on 9/16/24 Resident #32 qualified for Medicare A services and on 9/24/24, he was self pay. The chart lacked a Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055. On 12/03/24 at 1:17 PM, the Social Worker (SW) said that therapy services had initiated the paperwork to discharge Resident #32 from Medicare Part A. The resident was not cognitive enough to participate or make decisions. The SW was unable to locate a 10055 form and did not see where the information had been offered or signed by the family. According to the facility policy, dated 2/14/23, titled: Advance Beneficiary Notice of Non-Coverage (ABN). The advance Beneficiary Notice of Noncoverage informs the beneficiary of potential none-coverage and shift of financial liability for those items or services, if Medicare denied the claim. The Medicare Administrative Contractor may hold any provider financially liable who either failed to give notice when required or gave an valid notice. The ABN must be issued prior to delivery of the service in question. The provider must allow enough time for the beneficiary to make an informed decision on whether or not to receive the service in question and accept potential financial liability.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on observation, interview and record review the facility failed to ensure that residents consented to the use of a restraint and obtained a physician's order for the restraint, for 1 of 1 resident reviewed. Resident #33 had a diagnoses of epilepsy and profound intellectual disabilities with limited mobility. Staff were using bilateral foot straps on her wheel chair for safety; they failed to get consent from the family and physician orders. The facility reported a census of 40 residents. Findings include: According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #33 had a Brief Interview for Mental Status (BIMS) score that required staff completion and indicated severe impairment. The resident was totally dependent on staff for transfers, dressing, locomotion, and hygiene. She used a wheelchair for mobility. The MDS indicated that the resident had a trunk restraint used daily on her wheelchair. The MDS did not reference the foot restraints. The Care Plan updated on 6/3/24 showed that Resident #33 had epilepsy with limited mobility, she was chair fast, did not ambulate, and required the use of a dependent non weight bearing mechanical lift for transfers. The document identified a Focus Area of physical restraints in the wheelchair related to epilepsy exhibited by seizure activity. The Interventions for staff guidance included: discussion and recording with the family the risks and benefits of the restraint, application of a seatbelt every time the resident uses the wheelchair and releasing every 2 hours, and monitor/document to the health care provider any changes regarding the effectiveness of the restraint. The Care Plan did not reference the foot restraints. The Physician Orders revealed an order dated 1/10/24 for a seatbelt in current tilt in space wheelchair for safety related to epilepsy. The seatbelt will be released when repositioned in bed every 2 hours. Review of Resident #33's Consent Documents noted a signed consent by the resident's Power of Attorney for the use of a seatbelt on the tilt in space wheelchair. The document did not reflect the use of foot restraints. Observation on 12/2/24 at 12:41 PM revealed Resident #33 positioned in a tilt in space wheelchair with a seatbelt and bilateral foot restraints. Observation on 12/2/24 at 6:33 AM revealed Staff H, Certified Nursing Assistant (CNA), and Staff J, CNA, completing a transfer of Resident #33 from her bed to the tilt in space wheelchair using a dependent mechanical non weight bearing lift. Upon positioning in the wheelchair, Staff H fastened the seatbelt and foot straps. On 12/4/24 at 1:50 PM the Director of Nursing (DON) stated a restraint is considered anything that inhibits any body part from movement. The DON further stated a restraint needs to be released every 2 hours and requires physician orders and consent. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 1:54 PM the MDS Coordinator with the DON stated when Resident #33 transferred to the facility from a State Facility the resident had the foot straps and seatbelt in place on the tilt in space wheelchair. The MDS Coordinator stated consent and orders were not obtained for the foot straps upon entry as it was not thought to be a restraint as the resident could not reach her feet. The MDS Coordinator did acknowledge that anything that restricted a resident's movement would be considered a restraint. The DON and MDS Coordinator revealed the foot straps were released every 2 hours with the seat belt as the resident was repositioned from wheelchair to bed every 2 hours. The facility provided document, Restraints - R/S, LTC, Therapy and Rehab Policy, reviewed/revised 10/29/24 revealed a physical restraint is any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement. Examples of restraints contained in the document included leg or ankle restraints,and waist belt or safety belt if the resident was unable to remove them. The document further revealed the facility should receive consent for the restraint, physician's order, remove every 2 hours, and document in the Care Plan.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628 Based on clinical record review, staff interviews, and policy review the facility failed to obtain bed hold notifications for 2 of 2 residents (Residents #3, Resident #20) reviewed. The facility reported a census of 40 residents. Findings Include: 1. Review of Resident #3's Minimum Data Set (MDS) assessment dated [DATE] revealed a most recent reentry date from a short-term general hospital on 5/14/24. Review of Resident #3's Clinical Census in the Electronic Health Record (EHR) provided a Paid Hospital Leave from 5/11/24 to 5/14/24. Review of the Progress Notes in the EHR dated 5/11/24 revealed Resident #3 fell while at home and was transferred to the hospital where she was admitted with a right fractured hip. Review of the Notice of Transfer Form to Long Term Care Ombudsman for 5/24 revealed Resident #3 was transferred to the hospital on 5/11/24. On 12/4/24 at 12:05 PM Staff E, Social Worker, indicated the facility did not have a signed bed hold for the resident. The staff stated she was not present when the resident left the facility for completion of the document. 2. Review of Resident #20's MDS dated [DATE] revealed a most recent reentry date from a short-term general hospital on 10/24/24. Review of Resident #20's Clinical Census in the EHR provided a No Pay Hospital Leave from 10/19/24 to 10/24/24. Review of the Progress Notes in the EHR dated 10/19/24 at 10:43 AM revealed the resident was found on the floor in the living room. The Emergency Management System (EMS) and Primary Care Physician (PCP) were notified and the resident was transferred to the hospital. The resident was admitted with a right hip fracture. Review of the Notice of Transfer Form to Long Term Care Ombudsman for 10/24 revealed Resident #20 was transferred on 10/19/24 to the hospital. On 12/4/24 at 12:05 PM Staff E, Social Worker, indicated the facility did not have a signed bed hold for the resident. The staff stated she was not present when the resident left the facility for completion of the document and a nurse was supposed to complete the document. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/4/24 at 2:00 PM the Director of Nursing (DON) stated bed holds were primarily completed by Social Services or other administrative personnel. The DON stated charge nurses have not completed bed holds in the past but could be trained to complete them. When asked about the process after hours, the DON indicated it had been discussed but no clear answer/plan had been developed. The DON acknowledged in both instances a bed hold should have been completed. On 12/4/24 at 2:15 PM the Administrator stated nurses (charge) could likely complete the bed hold forms after hours, and they could contact the Social Worker or other administrative personnel for assistance. The facility provided document, Bed-Hold Policy, reviewed/revised 12/7/23, revealed that the facility is to ensure the resident/resident ' s representative is made aware of the bed hold and reserve bed payment policy before and upon transfer to the hospital. The document further revealed that in the case of an emergency transfer the Notice of Bed-Hold Policy is sent with other papers accompanying the resident to the hospital, and should be provided to a family member/representative within 24 hours of transfer. The policy indicated the document should be mailed if the family member or representative does not come to the facility to receive a copy. The document provided that the charge nurse is responsible for completion of notification procedures if the Social Worker/designee is not available, and the Social Worker/designee will contact the resident/representative regarding the decision for holding a bed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to practice safe transfer techniques for 1 of 3 residents reviewed. On 12/3/24, Staff I transferred Resident #36 to and from the toilet without the use of a gait belt. The facility reported a census of 42 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #36 had a Brief Interview for Mental Status (BIMS) score of 4 (severe cognitive deficit.) He required partial assistance for bed to chair and toilet transfers, and he was occasionally incontinent of urine and always continent of bowel. His diagnoses included, cancer, Anemia, renal insufficiency, Non-Alzheimer's Dementia and anxiety disorder. The care plan updated on 5/3/24, showed that Resident #36 had falls related to poor balance and unsteady gait on 4/18, 5/12, 8/15, 9/11, 9/25 and 9/29. An audio monitor was used to alert staff of any movement for safety. He had limited weight bearing ability due to a right patella fracture, required one person assist with toilet use, transfers and he did not use his call light due to decreased cognitive ability. Staff were directed to use assistive devices with transfers. In an observation on 12/03/24 at 6:57 AM, Staff I, Certified Nurse Aide (CNA), pushed Resident #36 down the hallway and to his restroom in a wheel chair. The resident was very anxious to go the bathroom and as he tried to rise out of the wheel chair, Staff I grabbed onto his right arm and pants to stand him up. When he was done on the toilet, she grabbed his arm and shirt to help him stand. He couldn't bear weight for long and sat down quickly into the wheelchair, on his side with left hip on the seat. The CNA then pushed him out of the bathroom and assisted him to sit up straight in the wheel chair. On 12/05/24 at 6:28 AM, Staff H, CNA, said that the residents have their own gait belts kept in the room or sometimes in the pocket on the back of the wheel chairs. On 12/05/24 at 8:35 AM, The Director of Nursing (DON) said that she expected staff to follow the care plan and know how a resident was to be transferred. She said that staff were taught to use a gait belt with every transfer where a resident required the assistance of staff for transfers and ambulation. According to the facility policy titled: Gait-Transfer Belt, last reviewed on 5/2/24, The purpose of gait belt use was to safely stabilize a transfer, to ambulate with residents and to aid resident in maintaining balance. The gait belts were used with assisted ambulation unless medically contraindicated.