

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Algona		STREET ADDRESS, CITY, STATE, ZIP CODE 412 West Kennedy Street Algona, IA 50511	

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital clinical record review, staff interviews and policy review the facility failed to assure the resident with pressure ulcers received treatment and services, consistent with professional standards of practice to promote healing for 2 of 3 residents reviewed (Resident #1 and #2) for pressure ulcers. The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, with slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister. Stage III is full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue) which may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound. Other staging considerations include: Deep Tissue Pressure Injury (DTP): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent skin. These changes often precede skin color changes and discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. 1. Resident #1's Minimum Data Set (MDS) dated [DATE] assessment identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS identified Resident #1 required substantial/maximal assistance with bed mobility and all transfers. Resident #1's MDS included diagnoses of cancer, anemia, end stage renal disease, diabetes mellitus, morbid obesity and chronic pain. The MDS documented Resident #1 was at risk for developing pressure ulcers/injuries. The MDS documented the following skin and ulcer/injury and treatments: pressure reducing device for chair/bed and application of nonsurgical dressing. The Care Plan with a revision date of [DATE] indicated Resident #1 had actual impairment to skin integrity related to abrasion to buttocks evidence by need for treatment. The care plan directed staff to monitor location, size and treatment of skin injury and to report abnormalities, failure to heal, signs/symptoms of infection, and maceration to the health care provider. In addition the care plan documented Resident #1 required enhanced barrier precaution related to open wounds to bilateral heels and left upper buttocks. The Care Plan lacked interventions related to pressure ulcer prevention and treatment such as repositioning, turning or keeping Resident #1's heels floated or elevated off of a surface to reduce the risk for pressure ulcers and promote healing. The Braden Scale for Predicting Pressure Sore Risk documented the following scores (a lower score indicates higher risk): [DATE]- 18- Mild Risk [DATE]- 17- Mild Risk The Progress Note dated [DATE] documented a Nurse to Nurse Hospital Report indicated Resident #1 had Mepilex (foam dressing) treatments to her coccyx, labia and buttocks. The admission Skin Assessments (Wound RN Assessment and Wound Data Collection) dated [DATE] revealed the following information: A. Right buttock abrasion- full thickness, traumatic wound- measured 4 cm (centimeters) (length) x 1.6 cm (width), 25% epithelialized tissue and 75% granulation tissue. B. Left buttock abrasion- full thickness, traumatic wound- measured 1.2 cm x 1 cm, 25% epithelialized tissue and 75% granulation tissue. The Skin Assessments dated [DATE] for the right and left buttocks documented a treatment order to clean the areas with wound cleanser, apply Aquacel AG (antimicrobial dressing) and bordered Mepilex. Review of the June, July and [DATE] Treatment Administration Records (TAR) lacked documentation of a treatment being completed to the left buttock abrasion. The Progress Note dated [DATE] documented a blister was noted to Resident #1's left heel, betadine applied and a blue boot in the room. The clinical record lacked documentation Resident #1's family was notified of the area. The Wound Data Collection assessment dated [DATE] revealed an intact blister to the left heel that measured 5.7 cm x 3.5 cm with the surrounding skin erythematous/reddened. The assessment documented the treatment to the left heel was to apply betadine to the blister twice a day (BID). The Wound RN assessment dated [DATE] for the right buttocks revealed two abrasions with full thickness loss that measured 1 cm x 1 cm (lower wound) and 1</p>		