STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Red Oak	201 Alix Avenue Red Oak, IA 51566

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37074 Based on clinical record review, staff interviews and family interviews the facility failed to notify 1 of 3 resident's (Resident #1) family when a bruise developed. The facility reported a census of 44 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/3/23 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she utilized a wheelchair, was always incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for the resident: heart failure, stroke, hemiplegia, and depression. The Care Plan focus area with an initiation date of 7/6/23 documented Resident #1 had activities of daily living self-care deficit due to limited mobility, limited range of motion, right sided weakness related to a stroke. The Care Plan documented she required substantial staff assistance with bed mobility and to use a repositioning/turn sheet. The Skin Observation form dated 11/5/23 at 10:35 AM documented by Staff A Registered Nurse (RN) a large purple bruise to Resident #1's right thigh, painful to touch. The Skin Observation form only included documentation on this date of the bruise to the resident's thigh. The Progress Note for Resident #1 documented on 11/6/23 at 6:16 AM Staff C Licensed Practical Nurse (LPN) called hospice due to a change in condition; resident pale and moaning. Noted to Resident #1's right upper thigh had a big black and blue mark and was hard to the touch. Hospice nurse will be coming to assess her, resident's daughter called and informed of the situation and will be coming in. The Progress Note only included documentation on this date about the mark to her right upper thigh. The family provided photos taken on 11/6/23 at 8:33 AM, of the bruising to Resident #1's right hip and upper thigh. The bruising to her right hip deep purple in color spreading to her outer mid-thigh. Throughout her hip and thigh pink/purple discoloration noted. On her upper thigh light blue bruising noted. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 10:00 AM the resident's daughter in law stated her and her husband had visited Resident #1 on Sunday, 11/5/23. On that day the resident stated she was in pain and staff had been giving her pain medication while they were there. When they asked where her pain was located, Resident #1 stated it felt like a bruise over a bruise on her hip. Her daughter in law denied looking at the area for any bruising. On 4/12/24 at 1:41 PM Resident #1's first emergency contact stated on that Saturday 11/5/23 she had talked to her mom on the phone about 9:00 to 9:30 PM. She could tell something was not right, she was in a lot of pain. Her mother indicated her right hip/side was hurting and reported she had a bruise there. The facility called her early the next morning to inform her about the residents decline but they did not notify her about any bruising. On 4/16/24 at 11:53 AM Staff C LPN stated the morning she sent Resident #1 out on 11/6/23 she could not remember much from that day. After her progress note was read to her, she indicated that was all she could remember but if that's what she wrote than the bruise it must have been there before that day. She indicated she called who needed to be called but could not recall who specifically. On 4/16/24 at 12:48 PM Staff A RN acknowledged she documented a bruise to Resident #1's right thigh in November. When asked what had happened she stated it was probably from the sling when they used the mechanical lift on her. Resident #1 had tender skin on her right side with no muscle tone as a result of her stroke. She indicated the bruise was about the size of her hand at that time and was the first time seeing it. When asked if she notified anyone of this bruising she could not recall, she also could not recall if she notified the resident's family. On 4/16/24 at 1:24 PM the Director of Nursing (DON) stated if the skin area of concerns was new then family should have been notified. During an email correspondent on 4/17/24 at 8:55 AM she indicated the facility doesn't really have a policy/procedure related to family notification.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37074 Based on clinical record review, staff interviews, family interview and facility policy review the facility failed to notify facility management timely when 1 of 3 residents (Resident #1) was found to have a bruise to her right hip/thigh on 11/5/23. Management not notified until 11/6/23. The facility reported a census of 44 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/3/23 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she utilized a wheelchair, was always incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for the resident: heart failure, stroke, hemiplegia, and depression. The Care Plan focus area with an initiation date of 7/6/23 documented Resident #1 had activities of daily living self-care deficit due to limited mobility, limited range of motion, right sided weakness related to a stroke. The Care Plan documented she required substantial staff assistance with bed mobility and to use a repositioning/turn sheet. The Skin Observation form dated 11/5/23 at 10:35 AM documented by Staff A Registered Nurse (RN) a large purple bruise to Resident #1's right thigh, was painful to touch. The Skin Observation form only included documentation of the bruise to the resident's thigh. The Progress Notes for Resident #1 on 11/6/23 at 6:16 AM, Staff C Licensed Practical Nurse (LPN) documented she called hospice due to a change in condition; resident pale and moaning. Noted to Resident #1's right upper thigh had a big black and blue mark and hard to the touch. Hospice nurse will be coming to assess her, resident's daughter called and informed of the situation and will be coming in. The Progress Note only included documentation about the mark to her right upper thigh. The family provided photos, taken on 11/6/23 at 8:33 AM, of the bruising to Resident #1's right hip and upper thigh. The bruising to her right hip deep purple in color spreading to her outer mid-thigh. Throughout her hip and thigh, pink/purple discoloration noted. On her upper thigh light blue bruising noted. On 4/16/24 at 11:53 AM Staff C Licensed Practical Nurse (LPN) stated the morning she sent Resident #1 to the hospital she could not recall seeing the bruising to her hip. After reading her progress note, she stated it had to have been there before that day. She did recall the family calling and requesting Staff B not to go in the resident's room alone. She tried to assure the family member she would not let him go in by himself. When asked if she reported this to anyone in management she believed she did but was unsure if she personally talked to someone. She added she may have given a note to the DON but she's not certain. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 12:48 PM Staff A RN acknowledged she documented a bruise to Resident #1's right thigh in November. When asked what had happened she stated it was probably from the sling they used with the mechanical lift. Resident #1 had tender skin on her right side with no muscle tone as a result of her stroke. She indicated the bruise was about the size of her hand at that time and as the first time seeing it. When asked if she notified facility management of this bruising she stated she probably mentioned it to the Director of Nursing (DON). On 4/16/24 at 1:24 PM the DON stated the overnight nurse notified her of the bruising on 11/6/23, the day they sent her to the emergency room (ER). When she read the progress note from that morning, she stated she was notified very early that morning. When asked if she saw the bruising she denied seeing it because Resident #1 was exiting the building at the same time she was coming in to work. When staff reported to her, it was described as discoloration like a blood clot, hard to the touch but it was not described as a bruise to her. She added when the nurse told her about it, she described it on her underside and it was purple in color. In an email correspondent on 4/17/24 at 8:55 AM she indicated they did not have an incident report for the injury the resident's right hip. The facility's Abuse and Neglect-Rehab/Skilled, Therapy and Rehab policy with a revision date of 7/6/2023 documented the follow purpose: to ensure all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported and investigated. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the Administrator. In the absence of the Administrator the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor or social services. The Procedure section documented: 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. A designated individual will complete the documentation.

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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** 37074 Based on observations, resident interview, family interview, staff interviews and facility policy review the facility staff failed to supervise medication administration by leaving 1 of 3 resident's (Resident #3) medication on their bed side table. The facility reported a census of 44 residents. Findings include: The annual Minimum Data Set (MDS) assessment tool with a reference date of 2/13/24 documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 4. A BIMS score of 4 suggested severe cognitive impairment. The MDS documented she did not reject care during the review period. The follow diagnoses were listed: Alzheimer's disease, Gastric Esophageal Reflux Disease (GERD), renal failure, thyroid, arthritis, dementia, mood disorder, and mixed incontinence. The Care Plan focus area with an initiation date of 2/24/23 documented Resident #3 had self care performance deficit related to Alzheimer's dementia and rheumatoid arthritis. The Physician's Orders revealed an order for calcium carbonate (TUMS) oral tablet chewable, 500 milligrams (mg) by mouth once a day for health maintenance. The record lacked an order for Resident #3 to self-administer medications. Observations revealed the following: a) On 4/11/24 at 1:50 PM a clear medication cup on the resident's bedside table contained a yellow tablet of what appeared to be TUMS. b) On 4/16/24 at 10:46 AM a clear medication cup on the resident's bedside table contained a light blue tablet of what appeared to be TUMS. Review of Resident #3's assessment tab in her clinical record revealed no Self-Administration of Medication assessment had been completed. On 4/12/24 at 8:42 AM Resident #3 stated when she receives her medications, staff would generally watch her take them. She added she does a pretty good job getting them all down. On 4/16/24 at 1:24 PM the Director of Nursing (DON) stated staff should watch residents take their medications. When she was informed of the calcium carbonate tablets being found in Resident #3's room on two different days she stated the order would need to read the resident could take the medication on their own. It's pretty easy to do, they would need to contact her doctor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/24 at 9:48 AM Resident #3's son indicated one day when he visited he found one pill on her bedside table but did not think anything of it. He visited a second time and found a medication cup full of pills. When he reported it to the medication aide, they told him it was her medications from the night before but this was at like 2:00 PM so he assumed they were her morning medications. He counted 10 pills in the medication cup. He took a photo of it and showed the Director of Nursing (DON). This was within the last 30 days. The DON assured him that she would talk to staff about this. This was about two weeks ago. He came in last Sunday to visit and found pills in her room that had not been taken yet. On 4/16/24 at 1:24 PM the Director of Nursing (DON) informed of finding TUMS in Resident #3's room on two different occasions. She stated staff should watch residents take their medications unless there was an order for them to take them on their own. If Resident #3 wanted to take the TUMS later they could call the physician to get an order for that. On 4/18/24 at 10:37 AM the DON stated she has not had issues with staff leaving medications in resident's rooms for them to take later nor has she had family members voice concerns. On 4/18/24 at 9:55 AM the Administrator stated he has not noticed medications being left in resident rooms but it had been an issue with past surveys. He stated he does [NAME] on staff about not putting medications in the medication cup and walking away. The facility's Resident Self-Administration of Medication policy with a revision date of 10/30/23 documented the purpose of this policy is to determine if the resident can safely self-administer medications, to identify which medications may be safely self-administered, and to provide residents who can do so safely with the opportunity to self-administer medications. PROCEDURE: The first six steps should be completed before obtaining a physician's order. 1. Complete the Resident Self-Administration of Medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do this safely. It is also recommended that the initial MDS be completed prior to this review. Areas of the MDS that may impact the team's decision include B, C, D, E and J. A query could be used by the team to review MDS coding on these and other areas. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to self-administer medication(s). When responding to question 3 - numbers 2 through 6 will create a progress note for Teaching - Resident/Family. 3. The interdisciplinary team will also determine where medications will be stored. This can be at the nurses' station, in a locked medication cart, a locked compartment or locked drawer in the resident's room. If the medication is stored at the resident's bedside, an additional key must be kept by nursing employees. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering at all times. 5. The interdisciplinary team will determine who will document the medication administration (e.g., the resident or the nursing employees). If the resident will be documenting his or her medication, it is recommended that the Resident Self-Administration Record be used and scanned into the medical record. 6. The interdisciplinary team's determination that the resident can safely self-administer medications must be documented in the Resident Self-Administration of Medication UDA. 7. A physician's order must be obtained prior to the resident self-administering medications. a. The order must be specific to the medications being self-administered. Update with new orders as needed. 8 . The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of administration, if applicable. Document quarterly on PN - Care Plan Review. 9. The resident's ability to continue to safely self-administer medication must be reviewed during the care planning process. It is recommended that this be done at least quarterly and with any significant change. If the resident is no longer able to self-administer medications safely, the physician must be notified, and medication will then be administered by nursing employees. 10. All medications that the resident stores in his or her room must be reconciled (counted or observed for amount used, e.g., ointments and inhalers) and documented by a licensed nurse at least weekly on the MAR. 11. Medication errors made by the resident during self-administration are not to be counted in the location's medication error rate. 12. Some states have specific rules regarding self-administration of medications. Please check your state regulations for additional information. Periodic verification with the individual state regulations is encouraged due to potential changes.

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	165191	A. Building B. Wing	04/18/2024

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37074 Based on clinical record review, hospice documentation review and staff, family and hospice staff interview the facility failed to assess and intervene timely for a bruise for 1 of 3 resident (Resident #1) reviewed. The facility reported a census of 44 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/3/23 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she utilized a wheelchair, was always incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for the resident: heart failure, stroke, hemiplegia, and depression. The Care Plan focus area with an initiation date of 7/6/23 documented Resident #1 had activities of daily living self-care deficit due to limited mobility, limited range of motion, right sided weakness related to a stroke. The care plan documented she required substantial staff assistance with bed mobility and to use a repositioning/turn sheet. Review of hospice coordination notes from 5/23/23 through 11/7/23 revealed no documentation of the brusing. On 4/12/24 at 10:00 AM the resident's daughter in law stated her and her husband had visited Resident #1 on Sunday, 11/5/23 and the resident stated she was in pain and staff had been giving her pain medication while they were there. When they asked where her pain was located, Resident #1 stated it felt like a bruise over a bruise on her hip. Her daughter in law denied looking at the area for any bruising. The Skin Observation form dated 11/5/23 at 10:35 AM documented by Staff A Registered Nurse (RN) a large purple bruise to Resident #1's right thigh, painful to touch. This was the only skin observation related to the bruise to the resident's thigh. On 4/12/24 at 1:41 PM Resident #1's first emergency contact stated on that Saturday 11/5/23 she had talked to her mom on the phone about 9:00 to 9:30 PM. She could tell something was not right, she was in a lot of pain. Her mother indicated her right hip/side was hurting and reported she had a bruise there. She got a call early the next morning about her decline but staff never talked to her about any bruising. Review of Resident #1's record reviewed a progress note on 11/6/23 at 6:16 AM by Staff C Licensed Practical Nurse (LPN) documented she called hospice due to a change in condition; resident pale and moaning. Noted to Resident #1's right upper thigh had a big black and blue mark and was hard to the touch. Hospice nurse will be coming to assess her, resident's daughter called and informed of the situation and will be coming in. This was the only progress note about the mark to her right upper thigh. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The family provided photos, that were taken on 11/6/23 at 8:33 AM, of the significant bruising to Resident #1's right hip and upper thigh. Noted bruising to her right hip deep purple in color spreading to her outer mid-thigh. Throughout her hip and thigh noted pink/purple discoloration and on her upper thigh light blue bruising. Color of bruising indicated different levels of healing. On 4/16/24 at 12:48 PM Staff A RN acknowledged she documented a bruise to Resident #1's right thigh in November. When asked what had happened she stated it was probably from the sling with they used the mechanical lift on her. Resident #1 had tender skin on her right side with no muscle tone as a result of her stroke. She indicted the bruise was about the size of her hand at that time and as the first time seeing it. On 4/16/24 at 11:53 AM Staff C LPN stated the morning she sent Resident #1 out on 11/6/23 stated she could not remember much from that day. After her progress note was read to her, she indicated that was all she could remember but if that's what she wrote than the bruise must have been there before that day. She indicated she called who needed to be called. On 4/16/24 at 6:59 PM Staff D Certified Nursing Assistant (CNA) stated Resident #1 had a decent sized bruise on her hip that bothered her during cares. When they would help her, they would try to avoid that area. When asked how long that bruise was there she stated about a month before she passed in November. She added the bruising started at her hip and extended down towards her leg but no one told her what had happened. Resident #1 only reported it being sore there but would not say anything else. When asked if she told anyone about it, she indicated she told nurses multiple times. They would look at it but could not recall the nurse's names. On 4/16/24 at 7:37 PM Staff E CNA stated when she would give Resident #1 her baths, she noticed some redness to her folds. When asked if she noticed any bruising, she stated she remembered seeing bruising but could not remember where. She indicated she noticed the bruising a few days in a row. When that happens, she is to call the nurse and they are to come assess the area in question. When Staff E noticed the bruising, she was like holy cow what happened there but again could not remember where the bruising was located, exactly. She wanted to say it was on her right side between her shoulder and knee, somewhere around there she believed. On 4/18/24 at 9:55 AM the Administrator stated all incidents are to be reported to managment as soon as possible so they can be investigated and all incident reports are to be completed within 24 hours. The Administrator stated he assumed nursing would have done skin assessments of the bruise and if it had been there that long then nurses should have been doing skin assessments all along. On 4/18/24 at 10:37 AM the Director of Nursing (DON) acknowledged if the CNAs noticed a bruise on the resident, told the nurses and the nurses notified it as well then, assessments should have been completed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 37074 Based on clinical record review, staff interviews, resident interview, family interview, hospice staff interview, and hospice agreement contract the facility failed to notify 1 of 3 resident's (Resident #1) hospice provider when they found a bruise on her right hip and thigh. The facility reported a census of 44 residents. Findings include: The quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/3/23 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented she utilized a wheelchair, was always incontinent of urine and frequently incontinent of bowel. The following diagnoses were listed for the resident: heart failure, stroke, hemiplegia, and depression. The Care Plan focus area with an initiation date of 7/6/23 documented Resident #1 had activities of daily living self-care deficit due to limited mobility, limited range of motion, right sided weakness related to a stroke. The Care Plan documented she required substantial staff assistance with bed mobility and to use a repositioning/turn sheet. The Skin Observation form dated 11/5/23 at 10:35 AM documented by Staff A Registered Nurse (RN) a large purple bruise to Resident #1's right thigh, painful to touch. The Skin Observation form only included documentation on this date of the bruise to the resident's thigh. The Progress Notes for Resident #1 on 11/6/23 at 6:16 AM by Staff C Licensed Practical Nurse (LPN) documented she called hospice due to a change in condition; resident pale and moaning. Noted to Resident #1's right upper thigh had a big black and blue mark and was hard to the touch. Hospice nurse will be coming to assess her, resident's daughter was called and informed of the situation and will be coming in. This was the only progress note about the mark to her right upper thigh. The family provided photos, taken on 11/6/23 at 8:33 AM, of the bruising to Resident #1's right hip and upper thigh. The bruising to her right hip deep purple in color spreading to her outer mid-thigh. Throughout her hip and thigh was pink/purple discoloration noted. On her upper thigh was light blue bruising. Review of hospice coordination notes from 5/23/23 through 11/7/23 revealed no documentation hospice notified of the bruise that was found on Resident #1's right hip/thigh. On 4/12/24 at 1:27 PM the Hospice (Licensed Practical Nurse) LPN that took care of Resident #1 stated she had noticed some bruising on her right lower leg. She remembered asking what had happened and was told she bumped it while they were using the mechanical lift for a transfer. She did not recall if Resident #1 had a fall during her time at the facility. During a follow-up email correspondence on 4/17/24 at 6:31 PM the hospice nurse was provided photos of the bruising on Resident #1's right hip/upper thigh. She indicated she knew about the bruising on her right upper ankle but did not know about that bruising on her hips or knees. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Red Oak	201 Alix Avenue Red Oak, IA 51566

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/24 at 12:48 PM Staff A RN acknowledged she documented a bruise to Resident #1's right thigh in November. When asked what had happened she stated it was probably from the sling when they used the mechanical lift on her. Resident #1 had tender skin on her right side with no muscle tone as a result of her stroke. She indicted the bruise was about the size of her hand at that time and as the first time seeing it. When asked if she notified hospice, she stated she would have told them when they came to the facility to visit the resident. On 4/18/24 at 10:37 AM the Director of Nursing (DON) stated if family is notified of the skin issue, there was no change in the resident's condition, and there was nothing wrong with the resident hospice would not need to be notified. The facility provided a document titled Hospice and Nursing Facility Services Agreement that was signed by the facility representative and hospice provider representative in 2016. The Agreement documented hospice and the facility shall communicate with one another regularly and as needed for each particular hospice resident. After every communication between hospice and the facility, each party shall document the communication in it's respective clinical records to ensure that the needs of the residents are met twenty four hours per day.