

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Red Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observation, interview and record review the facility failed to provide oral cares for 1 of 3 residents reviewed (Resident #28). The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>According to the Minimum Data Set (MDS) dated [DATE], Resident #28 had a Brief Interview for Mental Status (BIMS) score of 7 (moderate cognitive deficit.) He was totally dependent on staff for showering, dressing, personal hygiene and toileting.</p> <p>The Care Plan dated on 12/16/24, for Resident #28 showed that he had impaired cognitive functioning related to dementia and he was non-ambulatory. The resident required staff assistance of 1 for oral cares, shaving and grooming.</p> <p>A review of the clinical record; Point of Care History, Oral Care Provided for a 30 day history showed that Resident #28 did not have any oral cares provided in that timeframe.</p> <p>The History and Physical report from the hospital, dated 3/2/25 at 3:32 PM, showed that Resident #28 presented from the emergency room with pneumonia, urinary tract infection, suspected deep tissue injury of unknown depth of heel and a sacral wound. Once the resident arrived on the floor of the hospital, he was noted to have crusty skin in the corners of his mouth with yellow film build up in his mouth and teeth.</p> <p>On 4/17/25 at 7:25 AM, it was discovered that there were no tooth brushes in the bathroom cabinet. Staff L, Certified Nurse Aide (CNA) and Staff M, CNA said that they would help Resident #28 with oral care but they weren't sure where his toothbrush was. They looked around and found one in the top drawer of his dresser and a small tube of toothpaste.</p> <p>On 4/17/25 at 9:09 AM, the Director of Nursing (DON) said that staff were expected to set up the tooth brush and encourage the resident to brush his own teeth. She would expect that it would be documented.</p> <p>A facility policy titled: Denture and Oral Care last reviewed on 4/6/25 the purpose of the policy was to ensure good oral hygiene and maintain healthy condition of teeth and oral cavity. Staff were to document care in the Point of Care in the Electronic Medical Record (POC/EMR).</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observations, resident interview, staff interview and physician interview, record review, and facility policy review the facility failed to provide adequate pressure ulcer care for 2 of 3 residents reviewed (Resident #39, #28). Resident #39 had a Stage IV pressure on his coccyx and staff failed to complete the treatments as ordered. He was found to have 3 areas of skin breakdown that staff failed to document and measure. Resident #28 had a Stage II pressure on his buttocks and was found to be without the ordered dressing. The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers:</p> <p>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.</p> <p>Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an intact or open/ruptured blister.</p> <p>Stage III 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.</p> <p>Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar.</p> <p>Unstageable Ulcer: inability to see the wound bed.</p> <p>1. According to the Minimum Data Set (MDS) dated [DATE], Resident #28 had a Brief Interview for Mental Status (BIMS) score of 7 (moderate cognitive deficit). He was totally dependent on staff for showering, dressing, personal hygiene and toileting. He had one, stage 2 pressure, and one stage 2 pressure that was present upon readmission. The MDS dated [DATE], showed that the resident had one, Stage I pressure injury at that time.</p> <p>The Care Plan updated on 12/16/24, for Resident #28 showed that he had impaired cognitive functioning related to dementia and he was non-ambulatory. He had a suprapubic urinary catheter. Staff were to monitor for cloudiness, output, foul smelling urine. He had the potential for pressure ulcer development and on 3/11/25 he had a stage 2 pressure to coccyx and a pressure on his heel they were noted to be present upon hospital return on 3/7/25.</p> <p>A Wound Data Collection (WDC) document dated 4/9/25 at 7:02 AM, showed that Resident #28 had an unstageable ulcer on the left heel that measured 2 centimeters (cm) x 3 cm. The wound was being treated with Betadine.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The WDC dated 4/9/25 at 7:04 AM, showed that Resident #28 had a Stage II wound on the right buttocks measuring 2 cm. x 2.3 cm. and a depth of 0.2 cm. There was no dressing present at the time of the assessment and the resident did not voice complaints of pain related to the wound. Dressing description; Mepilex.</p> <p>According to the Clinical Physician Orders, Resident #28 had an order dated 3/10/25 at 11:00 AM, to apply Mepilex dressing to open area right buttocks, change every 3 days and as needed when soiled.</p> <p>During an observation on 4/15/25 at 12:48 PM, Staff E, Certified Nurse Aide (CNA) and Staff F CNA, prepared to provide incontinence cares for Resident #28. The resident was laying in bed and was wearing gripper socks. Staff E removed his socks and revealed a large red spot on the bottom of his left heel. It looked to have Betadine on, and around the spot. When the CNA's removed the residents brief and rolled him onto his right side, to clean him, the resident flinched and said ouch as they wiped an open area on the right buttock bottom. Staff F questioned if the resident should have some cream applied to the area and Staff E said that he should have a dressing on it and she would inform the nurse that he needed the treatment completed.</p> <p>The Medication Administration Record and Treatment Administration Record (MAR/TAR), printed on 4/15/25 at 12:52 PM, showed that the treatment order for Mepilex dressing to the open area of the right buttocks had been completed at 10:26 AM that morning.</p> <p>A review of the history of skin breakdown for Resident #28 revealed a Skin Observation document dated 2/24/25 at 10:00 AM, showed that a skin check had been completed that day with no skin conditions observed/skin conditions resolved.</p> <p>The nursing notes on 3/2/25 at 9:24 AM, showed that Resident #28 was transferred to the emergency room at 7:13 AM that morning.</p> <p>The History and Physical report from the hospital, dated 3/2/25 at 3:32 PM, showed that Resident #28 presented from the emergency room with pneumonia, urinary tract infection, suspected deep tissue injury of unknown depth of heel and a sacral wound. Once the resident arrived on the floor of the hospital, his brief was removed, and he was found to have small open skin areas in the groin and scrotum, a possible Stage II wound in the sacral area, and a large deep tissue injury to the left heel.</p> <p>The Wound Care Progress Note, final report from the hospital, recorded on 3/6/25, showed that Resident #28 was found to have an unstageable suspected deep tissue injury of the left heel and a pressure ulcer Stage II of the right buttocks. Both present upon admission to the hospital.</p> <p>On 4/17/25 at 6:50 AM, the Director of Nursing (DON) maintained that Resident #28 had no skin issues when he went into the hospital on 3/2/25. She said the skin nurse did an assessment on the resident the day that he went out to the emergency room , and there was nothing in the notes about the heel or open area on his buttocks. The DON said that the resident was in the emergency room all day and these issues developed during that time before he was admitted to the hospital.</p> <p>On 4/17/25 at 9:05 AM the DON said that the patch probably fell off after the treatment nurse put it on earlier that day. She said she would expect that a new spot would be noted and measured. Measurements are expected once a week.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 10:09 AM the Physician for Resident #28 said that without having seen the wounds that were described in the ED at first thought, one would think there would be something the staff would have seen on his heel or stage II on his buttocks. Without having seen them, he just couldn't say for sure. He added that overall he is happy with their wound care here.</p> <p>2. The MDS dated [DATE], for Resident #39, showed that he was admitted to the facility on [DATE] and he had a BIMS score of 13 (moderate cognitive deficit). The resident was always incontinent of urine and frequently incontinent of bowel. His diagnoses include: malnutrition, Chronic Obstructive Pulmonary Disease (COPD) and a Stage 4 pressure ulcer of the sacral region.</p> <p>The Care Plan dated 3/3/25, showed that Resident #39 had self-care performance deficits related to malnutrition and weakness. He was bedfast most of the time and non-ambulatory. Resident #39 was dependent for all bed mobility, dependent for toilet use and hygiene. He was incontinent of bowel and bladder and he required 2 staff assistance for transfers with a mechanical lift. He had the potential for pressure ulcer development. Staff were to notify the nurse immediately of any new areas of skin breakdown: redness, blisters or discoloration. Assess and monitor wound healing and report improvements and/or decline. The resident required Enhanced Barrier Precautions (EBP) related to stage 4 pressure injury to sacrum.</p> <p>The WDC dated 4/8/25 at 12:06 PM for Resident #39 showed that he had a Stage IV wound on sacrum measuring 2 cm. x 1.7 cm. with a depth of 0.5 cm. The wound had minimum drainage, serosanguinous in color with no odor. Undermining or Tunneling Depth was 0.8 cm. at 6:00 and 12:00.</p> <p>On 4/16/25 at 10:14 AM, Staff C Certified Nurse Aide (CNA) and Staff D, CNA, prepared to transfer Resident #39 to the shower chair for a shower. The resident was in bed on his back, his legs supported with a pillow at the knees and he was wearing heel protectors. The resident had a scabbed wound on the back of his left calf and the right calf had a dark spot in the area of where the legs had been resting on the pillow. Further up on the left thigh here were two separate open areas. When asked if those skin issues were documented, Staff D responded that those were old spots that had been there for a while. Staff C and Staff D turned the resident onto his left side. He had a dressing patch on his coccyx that was not dated and was soiled. With gloved hands, Staff C (aide) peeled the dressing off and pulled the packing out of the wound and threw it away. The wound had a large opening that immediately started to bleed and dripped down his side onto the bed.</p> <p>On 4/16/25 at 10:52 AM, Staff D pushed the resident back to his room after his shower. The wound was left open through the shower and the lift sling was still soiled with blood on the back. The resident was transferred back to the bed for the wound treatment. Staff G, Treatment Nurse, provided the wound treatment including measurements and packing. Staff G was not sure if the other skin issues had been documented. She later said that a skin observation had been completed on 4/12/25 and included the other skin breakdown.</p> <p>A Skin Observation document dated 4/12/25 at 12:48 PM, showed an area on outer aspect of the left knee scabbed and right knee outer aspect of right knee scabbed. The chart lacked measurements, description, or reference to the two open areas on the left leg. The Assessments tab lacked follow up documentation of the three areas observed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MAR/TAR for March and April for Resident #39 showed an order for Wound care dated 3/6/25 at 7:00 PM to cleanse with wound cleanser, pack wound/undermining with normal saline soaked gauze, cover with foam dressing twice a day (BID) and as needed (PRN) every morning and at bedtime. The TAR showed that on March 6th, 14th, 17th and 19th the evening treatment was not completed. The charting for the evening treatment was left blank on the 7th, 8th, 9th, 12th, 15th, 18th, 21st, 22nd, 23rd, 26th, 28th, 29th, 30th, 31st, and April 12th and 13th.</p> <p>On 4/17/25 at 10:11 AM the Physician said he would be more concerned with the wound having been exposed to the Hoyer sling then being open in the shower. He stated it is probably not best practice to have put him on the sling.</p> <p>A facility policy titled: Pressure Ulcer/Wound Care Resource Packet, dated 6/5/24 showed that a Wound Data Collection UDA was required for documenting daily monitoring, was required at least weekly when skin integrity was impaired or an open area was present, and was required to be used daily and with every treatment for documenting observations.</p> <p>The facility must ensure that a resident having pressure sores received necessary treatment and series to promote healing, prevent infection and prevent new sores from developing.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785</p> <p>Based on observations, staff interviews, record review and facility policy review the facility failed to establish and implement interventions to prevent falls and injuries for 2 of 3 residents reviewed. Resident #20 had a history of confusion and many falls. She tripped on the pedals of the wheelchair on 3/1/25 and staff failed to follow through with an intervention to remove those pedals from the wheelchair when not in use. On 4/2/15 the resident again tripped on the wheel chair pedals, fell and sustained head trauma. Resident #6 had many falls and the facility failed to evaluate for risks and hazards and failed to implement interventions for every fall. The facility reported a census of 43 residents.</p> <p>Findings include:</p> <p>1. According to the Minimum Data Set (MDS) dated [DATE], Resident #20 had a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive deficit). She required supervision with eating, dressing and hygiene and toilet transfers. The resident had two or more falls with injury since admission. She was admitted to the facility on [DATE].</p> <p>The Care Plan (CP) updated on 4/17/25, showed that Resident #20 was at risk for falls related to confusion, incontinence, osteoporosis, syncope and medication use. The CP listed 11 falls from 1/1/25 through 4/2/25. The resident had self-care performance deficit related to dementia, she was able to ambulate with seated walked, gait belt and assistance of one and she was able to transfer with the assistance of one staff. The resident had behavior symptoms related to dementia, a history of exit seeking and verbal aggression. On 4/7/25 Resident #20 was admitted to Hospice Services after an alteration in neurological status related to head injury with traumatic cerebral hemorrhage.</p> <p>On 4/15/25 at 10:03 AM, observed Resident #20 sitting in her wheelchair with Hospice staff in the dayroom. She had a tall back wheelchair; her feet were on the pedals and it was slightly tilted. There was an open sore on the right side of her face, her forehead and cheek had bruising in various stages of healing. The resident was very calm and the Hospice staff person said that she was just getting to know the resident and she had been told that Resident #20 had days of agitation.</p> <p>The Care Plan (CP) and Fall Scene Huddle Worksheet (FSHW) contained the following information related to falls since January:</p> <p>a. Fall on 1/9/25 the CP included an intervention to check frequently during shifts. The FSHW lacked a root cause or intervention.</p> <p>b. Fall on 1/25/25 unwitnessed in her room no intervention on the CP. FSHW intervention included wearing gripper socks 24 hours a day.</p> <p>c. Falls on 1/26 and 1/27/25 unwitnessed in her room, no interventions listed on the CP. FSHW included a medication change.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>d. Fall on 2/28/25 intervention on the CP not to leave the resident in the room unattended with foot rest on recliner up. FSHW included a root cause of trying to transfer out of the recliner.</p> <p>e. Fall on 3/1/25 the CP included an intervention to keep in view of staff. The FSHW included the root cause to be that she tripped on the foot pedals of the wheel chair, fall with abrasion to head. The corrective actions taken to prevent recurrence of this incident was to remove the pedals when not in use and all staff would complete the corrective action.</p> <p>f. Falls on 3/6 and 3/7/25 CP intervention was to check often (repeat intervention from 1/9) frequently leave door open. 3/7/25 fall in room when up independently with contusion to head. CP intervention to leave door to room open and check often. No FSHW document.</p> <p>g. Fall on 3/16/25 no intervention added on CP. FSHW documentation; found on floor in another resident's room. Confusion, intervention to keep light on in the bathroom.</p> <p>h. Fall on 4/2/25 in the morning, slid from wheel chair no injury no team meeting</p> <p>i. Fall on 4/2/25 late afternoon. CP included; the resident got up out of wheel chair independently, intervention to remove pedals from the WC unless staff pushing resident in chair. FSHW root cause resident attempting to stand up and tripped over wheel chair pedal. She had been fidgeting with pedals on WC all day, talking to people not there</p> <p>The Nursing Progress Notes for the resident included the following:</p> <p>a. On 3/1/25 at 10:38 AM the resident was sitting at the nurse's station, the Certified Nurse Aide (CNA) saw the resident attempt to get up from wheel chair, became unbalanced, swayed backward, unable to clear foot pedals on the wheel chair falling to the floor and obtained a 5-centimeter (cm) x 3 cm. laceration.</p> <p>b. On 4/2/25 at 1:03 PM, the resident was sitting in common area in wheelchair looking at a magazine, she tore a page out and was taking to someone, and slid to the edge of the wheelchair seat and then slow motion went to the floor, did not hit her head. The pedals were on the wheelchair. She was assessed and sat back it the wheelchair then taken to the front nurse's station.</p> <p>c. On 4/2/25 at 5:54 PM, the resident was sitting in chapel in her wheelchair attempting to get up and she tripped over the pedal on the wheelchair and fell and hit her head. Large amount of blood. Emergency service called and sent to the emergency room .</p> <p>d. On 4/2/25 at 8:50 PM, call to the hospital and told that she had a brain bleed and was being transferred to a larger hospital.</p> <p>e. On 4/5/25 at 1:36 PM, returned to facility from hospital. Scattered bruising on bilateral upper extremities abrasion on right forehead measuring 3 cm. x 1.5 cm.</p> <p>The Incident Reports included the following:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>a. 4/2/25 at 10:37 AM the resident was in her wheelchair by the nurses station. She had been messing with the pedals on the wheelchair and talking to someone. She had a picture from a magazine in her hand and scooted to the edge of the wheelchair seat and slid to the floor.</p> <p>b. 4/2/25 at 4:30 PM the resident was getting up out of the wheelchair. The nurse tried to get to her but the resident tripped over the pedals before she could get to her. She fell and hit her head.</p> <p>On 4/16/25 at 1:36 PM, Staff K, CNA, said that she was working on 4/2/25 when Resident #20 fell in the chapel. She and another CNA were taking the residents to the chapel to wait for the dining room to open. There was a nurse in the area and it was about 4:00 PM. Resident #20 said that she was cold so they got her a blanket. Staff K said that she had been more agitated and the night before they found her walking down the hallway on her own. She said there had been a time when they used chair alarms but they were no longer able to use them. The resident would also climb out of bed and it helped to have a bed pad that would alarm but they don't have that any more either. Staff K said they usually have two staff in the dining room to monitor residents.</p> <p>On 4/16/25 at 1:44 PM, Staff H, CNA said that she was working on 4/2/25 when Resident #20 fell . That evening, there was a nurse and about 6-7 residents' in the chapel waiting to be taken into the dining room. She said that she was talking to another resident and next thing she knew, Resident #20 was on the floor. Foot pedals on the wheel chair were down and she was covered with a blanket.</p> <p>On 4/16/25 at 2:15 PM, Staff B Licensed Practical Nurse (LPN) said that she was the only one in the chapel that afternoon and she was passing pills. When she saw the resident getting up, she had some pills in her hands and couldn't get to her fast enough to prevent her from falling. She said the resident had been messing around the pedals earlier in the day.</p> <p>On 4/16/25 at 3:03 PM, the Director of Nursing (DON) said that having just one person in the chapel when the residents were waiting to go into the dining room was enough because the CNAs were in and out as they assisted the other residents. She said that after falls, they had a stand-up meeting with the team and come up with ideas on what they can do differently and add those interventions to the care plan.</p> <p>41783</p> <p>2. The MDS assessment dated [DATE] for Resident #6 documented she scored 12 on the BIMS indicating she has moderately impaired cognition. The MDS documented she was independent with transfers and walking 10 feet. The MDS documented she required supervision or touching assistance for walking 50 feet with two turns. The MDS documented she had diagnoses to include arthritis, dementia, multiple fractures of ribs and syncope and collapse.</p> <p>The Care Plan dated 1/2/24 documented the following fall focus for Resident #6:</p> <p>The resident has had an actual fall (prior to admit) with fracture to right arm R/T Poor balance, Dementia.</p> <p>10/3/24 fall in room without injury.</p> <p>10/5/24 fall in room when carrying items while pushing walker.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>10/15/24 fall in room with 3 left rib fractures.</p> <p>12/28/24 fall from obstacle in room.</p> <p>2/3/25 fall in room when lost balance.</p> <p>4/11/25 fall in dining room when slipped on floor.</p> <p>Date Initiated: 1/2/2024 Revision on: 4/14/2025</p> <p>The Care Plan lacked documentation of the fall that occurred on 1/2/25 and any new interventions.</p> <p>The Progress Notes for the resident documented the following:</p> <p>On 1/2/25 at 7:05 PM Late Entry: As leaving room across the hall from resident room (her door was open) heard her yell at her radio, which was on the floor and watched her walk up to it and kick it. She went to kick it again and fell to her buttocks. She did not hit her head. Asked her to wait a minute while got someone to help get her up, she kicked at me, said it was all my fault and I wasn't to touch her. When CNA arrived, we attempted to help her up and she fought us scratching, pulling our clothes and refused to stand.</p> <p>On 1/2/25 at 7:05 PM Late Entry: She refused vitals (VS). When we thought she might be calmer (720pm) we were able to help her to bed, she continued to yell at us both and told us to take her to the huskow (slang for jail?). As we were leaving she put her hands above her head in the air and purposely slid easily to her floor, yelling leave me alone for good, I don't need any help from you and your people. Eventually we were able to get her up in the Hoyer without difficulty and transferred her to bed. No VS were able to be obtained.</p> <p>The Progress Notes lacked any other documentation regarding the fall on 1/2/25.</p> <p>On 4/16/25 at 11:50 AM the DON stated the facility does not have an incident report for the fall on 1/2/25. She stated the nurse at the time missed it. She stated it was crazy at the time of the fall, the resident was uncooperative and that affected their ability to assess her.</p> <p>Review of the clinical record and the chart lacked a Falls Tool assessment for the fall on 1/2/25.</p> <p>During an interview on 4/16/25 at 12:09 PM the DON stated they don't do a drill down to find the root cause at the time of the fall. She stated they discuss them the next morning at daily huddle with all staff and if there are reasons for the fall with recommendations that come out of that meeting then the MDS Coordinator will update the care plan and put those interventions in place. Upon asking, the DON provided the Falls Scene Huddle Worksheet for all of Resident #6's falls except she did not provide one for the fall that occurred on 1/2/25.</p> <p>The facility policy with the revised date 4/8/25 titled Fall Prevention and Management documented the following:</p> <p>Purpose:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Red Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Alix Avenue Red Oak, IA 51566	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-To promote resident well-being by developing and implementing a fall prevention and management program.</p> <p>-To identify risk factors and implement interventions before a fall occurs.</p> <p>-To give prompt treatment after a fall occurs.</p> <p>-To provide guidance for documentation.</p> <p>Policy for fallen resident:</p> <p>6. A nurse must observe the resident and perform a full body exam to determine if there may be suspected injury and direct whether to move the resident.</p> <p>f. Complete Fall Scene Huddle Worksheet.</p> <p>8. If the resident is stable, call available employees to the scene of the fall and begin the investigation using the Fall Scene Huddle Worksheet.</p> <p>9. After the initial documentation of the incident in the SAFE Event Reporting application (Incident Report), if there is a need for additional documentation, this will be done in the Progress Notes.</p> <p>11. Complete the Falls Tool if not done in the post fall huddle.</p> <p>16. Review and update the Care Plan with any changes/new interventions.</p> <p>18. Continue to monitor condition and the effectiveness of the interventions.</p>