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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Red Oak	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interviews, family interviews, staff interviews, hospital document review and provider interview, the facility failed to provide quality nursing care by not completing an assessment or intervention when a resident had low oxygen saturation (Resident #16) and for a resident who was coughing/spitting up blood (Resident #41) for 2 of 3 residents reviewed. The facility reported a census of 34 residents.Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #16 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #16 had diagnoses of chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, anxiety, paroxysmal atrial fibrillation and sleep related hypoventilation in conditions classified elsewhere. The Care Plan dated 12/8/25 for Resident #16 documented the resident has altered respiratory status related to sleep apnea, diagnosis of hypoxic respiratory failure and COPD. The care plan directed staff to monitor for signs and symptoms (s/s) of respiratory distress and report to her provider as needed: increased respirations, decreased pulse oximetry, increased heart rate, restlessness, diaphoresis, headaches, lethargy, confusion. Review of Resident #16's April 2026 Medication Administration Records - Treatment Administration Records (MAR-TAR) documented physician's orders for albuterol sulfate nebulization solution 2.5mg / 3mL give one dose inhaled orally via nebulizer every 24 hours as needed for dyspnea document oxygen saturation, pulse, respirations and lung sounds pre and post administration, albuterol-budesonide inhalation aerosol 2 puff inhaled orally every 6 hours as needed for wheezing and oxygen at 2LPM per nasal cannula via oxygen concentrator or tank to maintain saturation above 92% every shift for shortness of breath. Review of Resident #16's April 2026 MAR-TAR lacked documentation as needed albuterol sulfate nebulization solution or albuterol-budesonide inhalation aerosol were administered. Review of Resident #16's electronic health record (EHR) titled, Progress Notes documented the following: On 4/15/26 at 10:50 AM a call was placed to Resident #16's primary care physician's nurse regarding residents' oxygen saturation. Left a message with a call back number. On 4/15/26 at 12:04 PM, a return call from Resident #16's primary care physician's (PCP) nurse regarding Resident #16 unsure of what could be going on. Notified that vitals are stable and oxygen saturation was fine at that time that resident was laying down with BiPAP on. PCP was notified to see if he can stop and see the resident tomorrow. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/15/26 at 10:41 PM Resident #16 called 911 thinking she was at another place of residence and the person beside her had a stroke. 911 called the facility saying she called them and 2 ambulance employees arrived at the facility. Resident #16 was taken to the hospital. Husband was notified. DON was notified. On 4/16/26 at 1:06 AM, the hospital was called in reference to Resident #16 for an update. The resident had an exacerbation of CHF. The resident was being transferred to another hospital for care. The Progress Notes for Resident #16 lacked documentation of a comprehensive respiratory assessment on 4/15/26. Review of Resident #16's EHR titled, Oxygen Saturation Summary documented on 4/15/26 at 4:29 AM Resident #16 had an oxygen saturation of 96% on room air, on 4/15/26 at 8:11 AM Resident #16 had an oxygen saturation of 90% on BiPAP, on 4/15/26 at 10:55 AM Resident #16 had an oxygen saturation of 93% on BiPAP and on 4/15/26 at 7:32 AM Resident #16 had an oxygen saturation of 93% on BiPAP. Review of Resident #16's EHR dated 4/15/26 titled, Assessments documented the only assessments completed on 4/15/26 were weekly skin assessment and infection assessment. Neither assessment documented a respiratory assessment. Review of Resident #16's document dated on 4/15/26 at 10:04 PM titled, Prehospital Care Report documented Fire Department was initially dispatched to Resident #16's previous residence for a report of a female possibly experiencing a stroke. Unit 115 responded emergent and arrived on scene without incident or delay. Upon arrival, EMS personnel knocked on multiple apartment doors and announced their presence; however, no residents reported calling 911. Dispatch then updated EMS that Resident #16 was located at the current skilled nursing facility. Unit 115 responded to the facility and arrived without delay. Upon arrival at the skilled nursing facility, EMS attempted entry. Staff members were visible at the nursing station observing the entrance. EMS knocked, and staff opened the door. When questioned about the situation, one staff member stated, I don't know, I just got here, and later added, Well, she's been like this all day. EMS requested staff to direct them to the patient. As EMS approached the patient's room, audible screams for help were heard. A housekeeping staff member was observed entering the room asking if everything was okay. EMS entered shortly after. The patient was found lying supine in a bed, alert enough to visually track EMS personnel upon entry. The patient appeared pale and cool to the touch, with an altered mental status. The patient expressed confusion and stated concern about a lady that fell in the corner, the patient was informed there was no one else there. EMS and nursing staff briefly stepped into the hallway for clarification. Nursing staff reported the patient had been in this condition throughout the day and were unsure why 911 had been called. Initial vital signs revealed oxygen saturation levels in the high 60s to low 70s. The patient consented to transport. The patient was transferred to the EMS stretcher, secured, and moved to the ambulance. Once inside, a full set of vital signs was obtained, including blood pressure. CPAP was initiated with high-flow oxygen at 5 cm H2O PEEP. Due to continued respiratory distress and minimal improvement in oxygen saturation, PEEP was increased to 7.5 cm H2O, resulting in a slight improvement to 82%. Due to continued shortness of breath, PEEP was further increased to 10 cm H2O. Auscultation of lung sounds revealed rales in the bilateral lower lobes. The patient has a significant medical history including COPD, CHF, and diabetes. Transport to the receiving facility was initiated. The Prehospital Report further documented at 10:27 Resident #16 had a blood pressure of 154/78, a pulse of 101, respirations of 36 and oxygen saturation of 62% on room air. Review of Resident #16's hospital report provided by the facility with a date of 4/16/26 documented (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #16 was transferred to the hospital for possible pneumonia, possible CHF exacerbation, rales and rhonchi bilaterally. Chest x-ray showed possible pneumonia. Resident #16 was hallucinating but was alert and oriented x 3. Resident #16 explained she was at the emergency department (ED) because her breathing felt heavy. Resident #16 explained she has had heavy breathing for about a week. Resident #16 stated she was not usually wheezy but had noticed wheezes over the past couple days. Oxygen saturations reported in the 70's at the nursing facility. On 4/20/26 at 2:15 PM Staff Y, Medical Personnel Ambulance Crew stated the 911 call center was notified at 10:03 PM on 4/15/26 and arrived at the facility to Resident #16 at 10:19 PM. Staff Y explained Resident #16 was on her bipap and had low oxygen saturation of 62% on the bipap and respirations of 36. Staff Y said Resident #16 stated she was getting tired of breathing so hard and Staff Y asked if Resident #16 stopped breathing if he could place a tube to help and she said yes. Staff Y stated he had previous interactions with Resident #16 at her house and this was not her normal. Staff Y explained Resident #16 appeared hypoxic as she was confused. Staff Y explained Resident #16 was taken to the in town Emergency Department (ED) and she was then transferred to another hospital ED for a higher level of care than what the original hospital could provide. Staff Y explained she turned Resident #16 onto their oxygen with cpap and ended up going to 5 then 7.5 cm of water then at 10 for Positive End-Expiratory Pressure (PEEP) setting. On 4/21/26 at 3:50 PM Staff G, Registered Nurse (RN) acknowledged she did have interactions with Resident #16. Staff G stated Resident #16 was alert and oriented but before she was sent to the hospital she was hallucinating a little bit. Staff G stated Resident #16's hallucinations were seeing people that were not in the room. Staff G explained Resident #16 was not sent out on her shift. Staff G stated she thought that Resident #16 called 911 herself. Staff G stated Resident #16 was alert and oriented for most of the shift with a couple of hallucinations. Staff G explained when therapy sat Resident #16 up on the side of the bed she could not get enough air. Staff G stated Resident #16's oxygen saturation was checked and it was 68% and at that time she was put back on her bipap. Staff G explained Resident #16 was on the bipap prior to sitting up. Staff G stated therapy was in the room about 10:30 AM on 4/15/26. Staff G stated she was Resident #16's nurse that morning. Staff G explained once the bipap was applied Resident #16's oxygen saturation increased within a couple of minutes. Staff G stated she completed an assessment but did not remember if she documented the assessment. Staff G stated the assessment would probably be in the progress notes. Staff G explained guaifenesin was given because Resident #16 had complaints of a cough. Staff G stated she did not know how long Resident #16 had been complaining of a cough. Staff G stated Staff Z, RN had administered the medication for the cough and stated Resident #16 had been complaining of a cough. Staff G stated she called Resident #16's Primary Care Physician's (PCP) office and spoke with a nurse about the oxygen level. Staff G stated the nurse said to keep monitoring and if it did not seem it was getting better to send her out to the ED. Staff G said the nurse explained for her to utilize breathing treatments and supplemental oxygen as needed. She stated she did not give any breathing treatments because she was fine before she left. Staff G stated she continuously checked her oxygen saturation and listened to her lungs but did not think she charted it. Staff G stated she thought she should have charted the oxygen saturation and lung sounds. Staff G stated Resident #16 was supposed to wear her bipap when she was in bed and the oxygen was on then. Staff G stated at 8:11 AM on 4/15/24 she did not increase the oxygen with the 90% oxygen saturation noted. Staff G stated Resident #16 at 90% was a concern because she typically ran higher. Staff G stated that 90% did prompt her to increase the oxygen to 2.5 L but she did not document it or call the physician for orders. Staff G stated she could have got an order but she would have notified the physician. Staff G stated she did notify the physician for the increase to 2.5L of oxygen on the bipap. Staff G stated at that time she did retake the oxygen and did not document the results. Staff G stated the oxygen level had (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	increased to 94% at that time. Staff G stated Resident #16 was not showing any signs of respiratory distress once on the bipap she was just fine. Staff G stated she stayed in bed that day but that was not abnormal. Staff G said Resident #16's husband was at the nursing home that morning. Staff G explained Resident #16 was not requesting to be sent out of the facility at that time. Staff G stated the physician called back and that was when she was told to monitor. Staff G stated the as needed medication use would be prompted if the oxygen was ineffective. Staff G stated she would transfer to the hospital if she was unable to maintain an appropriate oxygen level with what they had available. Staff G stated she did not show any signs and symptoms she needed to be sent to the hospital that day. On 4/21/26 at 10:35 PM Staff H, Licensed Practical Nurse (LPN) stated she was familiar with Resident #16. Staff H stated she had cared for Resident #16. Staff H said she worked with Resident #16 on the night of 4/15/26. Staff H stated she was called by the ambulance crew that they were coming to the facility because Resident #16 called them. Staff H stated the ambulance crew told her that Resident #16 called and told the ambulance crew someone by her was having a stroke. Staff H stated she had not seen Resident #16 that evening. Staff H stated Staff K was the female nurse that was on duty the shift prior. Staff H explained Staff K, RN never said a word about her or any concerns with Resident #16. Staff H said she had no report there were concerns with Resident #16 earlier that day. Staff H stated if she found a resident with the oxygen saturation under 80% she would complete an assessment. Staff H stated the assessment would consist of the oxygen level, look at antibiotic, stress level, head of bed, and lung sounds. Staff H stated Resident #16 wore a bipap that had oxygen from the concentrator. Staff H stated the ambulance guys entered the room and she removed the bipap when they entered the room. Staff H stated she did not remember what the oxygen level that the ambulance driver obtained. Staff H explained Resident #16 became short of breath the moment she removed the bipap. Staff H stated she had worked with Resident #16 on Sunday. Staff H explained Resident #16 was not ill, short of breath and did not require any as needed medication. Staff H stated she would apply the oxygen and utilize the as needed Albuterol and follow the documentation recommendation. On 4/22/26 at 9:31 AM Staff AA, Physician's clinic nurse stated she told the nurse at the facility a steroid or antibiotics could be started but if further trouble the facility should transfer Resident #16 to the ED. The clinic nurse stated the nurse at the facility never told her that Resident #16 had an oxygen saturation of 68%. The clinic nurse stated the facility staff were having trouble keeping Resident #16's oxygen saturation above the 90's. She stated the facility nurse explained Resident #16's oxygen saturation was only 80's. The clinic nurse stated the facility nurse explained once the bipap was on Resident #16's oxygen saturation was stabilized at 90%. She stated she explained that Resident #16 did have an as needed order for oxygen. The clinic nurse stated when she called the facility back the nurse explained that Resident #16 was stable and using oxygen. She explained if she was notified that Resident #16 had an oxygen saturation of 68% the physician would have probably had said she needed to be evaluated in the ED. The clinic nurse stated Staff G's initial voice mail sounded like she was a little concerned. She stated the supplemental oxygen would be utilized when she was not asleep. She stated she did not think Resident #16 needed to be in bed wearing the bipap all day. The clinic nurse stated when she verified the orders from the nursing home she verified there was as needed oxygen and Staff G was reminded that it could be utilized and it was there for a reason. The clinic nurse stated the as needed oxygen should have been utilized, or the as needed nebulizer treatment, or the hand held inhaler. On 4/22/26 at 10:43 AM Resident #16's husband acknowledged he was at the hospital with Resident #16 at that time and would be returning 4/23/26. Resident #16's husband stated Resident #16 left the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	faciity on 4/15/23. He explained Resident #16 had pneumonia and it was bad. He stated Resident #16 had pressure on her heart and had to get rid of fluid. Resident #16's husband explained Resident #16 was telling the nurses at the facility on 4/15/26 that she had a fluid overload problem. He stated they gave her compression gloves and arms. Resident #16's husband stated the facility nurses did not seem concerned about it. He stated Resident #16 was telling them that she was not feeling good that day. Resident #16's husband stated they wanted Resident #16 to go to therapy and do 45 minutes worth of therapy. He stated Resident #16 was gasping for air so bad that she was seeing things. Resident #16's husband explained his wife told him the facility staff were not answering her call so she called 911. He stated Resident #16 had felt ill for several days and that she had told staff she felt ill every day. Resident #16's husband stated the nurses really did not do any assessments on his wife during those days. He said he was not at the facility when Resident #16 was transferred to the Emergency Department (ED). Resident #16's husband stated Staff H, Registered Nurse (RN) called him and said Resident #16 was going to the hospital. He explained he was at the facility around 9:30 AM - 10:00 AM and left at around 8 pm on 4/15/26. He stated he did not remember any nurse completing an assessment on his wife the whole day of 4/15/26. He explained the facility nurses did not offer Resident #16 an as needed breathing treatment or increase her oxygen. Resident #16's Husband stated it did appear his wife was struggling to breath and did not have the air to do what they wanted her to do. He stated his wife's oxygen was never checked. Resident #16's husband said Staff D, Certified Nurse Assistant (CNA) and Staff X, Physical Therapy were in the room when his wife was struggling to breathe. He explained that Staff D said let's put her back to bed. Resident #16's husband said Resident #16 was just sitting on the side of the bed and she could not even get out of bed. He stated he did not ask for her to go to the hospital. He stated Resident #16 was hallucinating while he was sitting there in the room. He acknowledged Resident #16 had never had hallucinations prior to that day. Resident #16's husband stated he was worried for his wife but he was not a medical person he relied on the nursing judgement of the nurses at the facility. He stated she had edema in her legs that was so tight that he had to apply lotion because they itched. Resident #16's husband stated Resident #16 had swelling in her hands as well. He stated it was not common for her to have that much swelling. Resident #16's husband stated Staff H told him that his wife was being transferred to the hospital, she was hallucinating and he might want to get up there as soon as he could. On 4/22/26 at 10:43 AM Resident #16 acknowledged she was at the hospital and there were plans for her to return home tomorrow 4/23/26. Resident #16 said she left the faciity on 4/15/26 to the emergency room. Resident #16 said she had pneumonia and it was bad. Resident #16 explained she told the nurses at the facility that she had a fluid overload problem on the day of 4/15/26. Resident #16 said the nursing staff gave her compression gloves and compression sleeves. Resident #16 stated the facility nurses did not seem concerned about it. Resident #16 said she told them she was not feeling good that day. Resident #16 stated the staff wanted her to go to therapy and do 45 minutes of therapy that day. Resident #16 said she could not even get up, she finally told them to stop and her body told her that she cannot do this anymore. Resident #16 said there were 4 of them there and they finally put her back to bed. Resident #16 said she was gasping for air so bad that she was seeing things. Resident #16 said the facility staff were not answering her call light so she called 911. Resident #16 stated she felt ill for several days. Resident #16 stated she had told staff she felt ill every day. Resident #16 explained the nurses at the facility really did not do any assessments when she said she was ill. Resident #16 stated she did not remember the exact oxygen level but it was probably in the 70's because she was seeing things. Resident #16 stated she had so much fluid on her chest that her heart could not beat appropriately. Resident #16 explained on 4/15/26 when she said she could not breath very well the nursing staff did not offer her a breathing treatment or increase her oxygen. Resident #16 stated it felt like she was struggling to breath and gasping for air. Resident #16 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	stated she was hallucinating that a nurse was hot, took her clothes off and fell behind the chair. Resident #16 explained she was sucking for air so she just called 911. Resident #16 stated she did not remember that much from the rest of the day because she was out of it. On 4/22/26 at 11:42 AM Resident #16's Primary Care Physician explained oxygen levels in the 60's was a very big concern and if Resident #16's oxygen saturation was that low she should have been transferred to the ED. The Physician stated one of Resident #16's as needed respiratory medications should have been utilized. He stated he should have been notified of oxygen saturation in the 60's. He stated he was not made aware Resident #16 had oxygen saturation levels in the 60's. He stated he expected if the resident's oxygen level was in the 60's or the 70's he would expect to have been notified of the vitals and current vitals. He stated if Resident #16 was transferred to the ED earlier; she might not have been as ill but it would not have prevented the hospitalization and would not have changed the outcome. The Physician acknowledged knowledge of Resident #16's diagnoses and history. He stated if the ambulance was not called when it was the mortality rate of Resident #16 would have increased but it would be difficult to determine if death would have occurred before being noticed by other facility staff. He stated Resident #16 did not have hallucinations that he was aware of. He stated hallucinations from hypoxia made logical sense. On 4/22/26 at 3:27 PM Staff K, RN stated she worked with Resident #16 daily. Staff K stated when she was at the facility, she was always on the far west hall with Resident #16. Staff K stated she worked with Resident #16 the day of 4/15/26. Staff K stated Resident #16 was fine that day. Staff K stated Resident #16 took her medications and was not confused at all. Staff K stated Resident #16 was in bed most of that day. Staff K stated that was kind of normal for her. Staff K stated Resident #16's husband was usually at the facility with her. Staff K stated he was at the facility that day. Staff K explained Staff E did not mention any concerns about Resident #16 at shift change with the shift report. Staff K stated she did not complete any assessment on Resident #16 that day. Staff K acknowledged she did not check a pulse, oxygen saturation level or lung sounds on 4/15/26. Staff K stated she had mentioned that the physician was notified of Resident #16's oxygen saturation level was lower and she had been in bed all day. Staff K stated Staff G did not mention any oxygen saturation percent to her. Staff K stated if there was low oxygen saturation levels or difficulties breathing, she would utilize the as needed nebulizer treatment and or the inhaler. Staff K stated Resident #16 did not appear any different than any other day. Staff K stated if Resident #16 had an oxygen saturation level of 68% she would turn on the oxygen from the concentrator from the nasal cannula and send her out immediately to the ED. Staff K stated she would not keep any resident at the facility with oxygen levels in the 60's or 70's. Staff K stated she would have documented an assessment for sure. On 4/22/26 at 3:54 PM the Director of Nursing (DON) stated she was working on 4/15/26 and had interactions with her every day. The DON explained any time Resident #16 had therapy she does not want to go to therapy. The DON explained therapy staff came out and got Staff G and noted her oxygen saturation was low. The DON stated Staff G should have done a better job documenting what intervention was in place for the oxygen level of 90% at 8:10 AM. The DON stated she would expect the as needed albuterol would have been utilized and would have been documented if the resident refused and that was not documented. The DON stated if the oxygen level was low it should have been documented in the vitals or progress notes. The DON stated at times Resident #16 had behaviors and would take her bipap mask off and that would drop her oxygen. The DON stated Staff G noted a low oxygen level of 68%, put the bipap on and her oxygen level stabilized; she did not think it would require the transfer to the ED. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 4/23/26 at 11:28 AM Staff D, Certified Nurse Assistant (CNA) acknowledged he worked with Resident #16 frequently. Staff D explained Resident #16 would have him write a note and hang it on the door because she had a migraine and did not want to do therapy. Staff D stated him and one of the therapy girls tried to get Resident #16 up on 4/15/26. Staff D stated Staff G offered her the portable oxygen tank but she did not want it. Staff D stated before they even stood her up she said you guys are making me do stuff I do not want to do. Staff D stated Resident #16 said she could not breathe and that it was around 10:00 AM or 11:00 AM that day. Staff D stated they laid her back down and she seemed fine. Staff D stated she went to the hospital that evening. Staff D stated other than her insisting she wanted to lay down and saying she was having a difficult time breathing she did not have any other complaints. Staff D stated he did not remember if the vitals were good or bad. Staff D stated he thought that her oxygen was low because she could not breathe well but did not remember the exact number. Staff D stated Resident #16's husband was not in the room at that time. Staff D stated therapy had asked him to help because sometimes they need a second person to help. Staff D explained when Staff G came in Resident #16 said she was having a difficult time breathing. Staff D stated Resident #16 was talking alright. Staff D explained Resident #16 was talking very slowly but seemed really weak and really tired. Staff D stated that time it might be because she could not breathe. Staff D stated she did take long deep breaths between words and that was when Staff G offered her the portable concentrator. Staff D stated he had to do other tasks and was not sure if Staff G completed an assessment he did not see. Staff D explained Resident #16 stayed in bed all day on 4/15/26 and usually does not eat breakfast but usually eats lunch. Staff D said Resident #16 did not eat the day before and did not eat lunch that day. Staff D said Resident #16 stayed in bed 2 days in a row was very unusual. Staff D said she never stayed in bed for 2 days and that was not normal for her. Staff D stated Resident #16 had not had hallucinations in the past except after surgery with anesthesia. Staff D stated she would complain of migraines. Staff D stated Resident #16 had not ever complained about difficulties breathing until that day. On 4/23/26 at 12:42 PM Staff V, Registered Nurse (RN) / Infection Preventionist (IP) stated he had worked the floor as a nurse and had been on the overnight shift for the last 6 months. Staff V explained if a resident had an oxygen saturation of 80% he would ask the resident for subjective data like if it was difficult to breathe or how they felt. Staff V explained he would then obtain vital signs. Staff V stated if the resident's oxygen saturation was lower than 80% the physician would probably want the resident sent to the Emergency Department (ED). Staff V explained he would attempt to utilize an as needed medication if there was an order such as a nebulizer treatment, an inhaler or oxygen. Staff V stated if the resident's oxygen saturation was 70% he would complete all of that in the room and if the resident was coherent he would ask the resident for subjective data. Staff V explained might need to call 911 and get an order from the physician at the same time. Staff V explained a resident could be sent out without a physician order in an emergency. Staff V said a resident with an oxygen saturation of 68 would be an emergency and that resident would have been sent to the ED. Staff V stated even if he was able to get the resident to baseline he would definitely let the physician know the oxygen saturation level of 68 percent because it might change the outcome of what the physician might want done. Staff V explained an oxygen saturation of 68% would indicate more of a potential issue than just low oxygen saturation. 2. Resident #41's Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of high blood pressure, pneumonia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (irregular heart beat). It revealed the resident was independent with eating, required setup assistance with personal hygiene, was dependent with toileting hygiene, bathing, and footwear, and required maximal assistance with all other Activities of Daily Living (continued on next page)

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Good Samaritan - 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 0684 Level of Harm - Actual harm Residents Affected - Few	(ADLs) and mobility. It also revealed he was short of breath with activity and lying flat but not while at rest. It further revealed he received an anticoagulant (blood-thinner) medication during the 7-day look-back period. The Electronic Health Record (EHR) included a physician's active order dated 2/28/25 for apixaban oral tablet 5 MG; 1 tablet by mouth every morning and at bedtime related to atrial fibrillation. The Care Plan revised 1/08/26 included altered respiratory status/difficulty breathing related to COPD and directed staff to monitor for signs and symptoms of respiratory distress and report to the health care provider PRN (as needed): increased respirations, decreased blood-oxygen level, increased heart rate, restlessness, diaphoresis (sweating), headaches, lethargy, confusion, hemoptysis (coughing up blood), cough, pleuritic pain (sharp, stabbing chest pain that worsens with breathing, coughing, or sneezing). A subsequent Care Plan revision on 1/09/26 included anticoagulant medication use and directed staff to report observations of blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs to the nurse. Another subsequent revision on 3/17/26 indicated the resident had pneumonia that resolved 3/17/26. A document titled Fax Communication to Physician dated 3/30/26 at 8:05 AM marked Response Required indicated Staff E, Registered Nurse (RN) faxed the resident's physician the following information: re