

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 07/03/2024
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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>47673</p> <p>Based on observations, staff interview, and policy review the facility failed to complete and post on a daily basis the nursing staffing data. The facility reported a census of 40 residents.</p> <p>Finding include:</p> <p>On 6/30/24 at 10:04 AM an observation of a document titled, Daily Staffing noted Saturday June 29th 2024 as the date.</p> <p>On 7/1/24 at 10:04 AM an observation of a document titled, Daily Staffing documented Saturday June 29th 2024 as the date.</p> <p>On 7/1/24 at 12:35 PM the DON stated Staff H licensed practical nurse (LPN) / Wound Nurse was the staff responsible for changing the staffing sheet. The DON stated she would have expected that the Daily Staffing Form would be changed out daily and that overnight nurses can print it as well.</p> <p>Review of document titled, Nursing Staff Daily Posting Requirements revised 2/28/24 documented the facility will post daily the current date, the total number and the actual hours worked by registered nurses, licensed practical nurses or licensed vocational nurses, certified medication assistants, certified nurse aides, and resident census with registry and pool staff members included.</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 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49628</p> <p>Based on clinical record review, resident interviews, observation, staff interviews, and policy review the facility failed to provide food at an appetizing temperature to 3 of 15 residents reviewed (Resident #31, #30 and #40). The facility reported a census of 29 residents.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14/15 indicating no cognitive impairment. The assessment section entitled Functional Abilities and Goals (GG) revealed Resident #31 was independent with eating.</p> <p>On 6/30/24 at 1:14 PM Resident #31 stated baked potatoes have been served raw and food is not always warm when it should be hot. The resident stated room trays are worse than food served in the dining room.</p> <p>Continuous observation on 6/30/24 beginning at 12:05 PM noted a cart with 3 room trays present. Between that time and 12:15 PM seven more meals were added to the cart. At 12:17 room delivery began by Staff A, Dietary Aide. Tray delivery service continued until the last tray at 12:33 PM. Requested Staff A to return the tray to the dining room for temperature check. At 12:35 PM Staff B, cook, took the temperatures of the food with the Dietary Manager (DM) present. The food items were on a plate inside of an insulated bottom and lid. The coleslaw registered 72.8 degrees and the pulled pork sandwich 106 degrees. A new tray was prepared for delivery. The temperatures of the food was requested with the coleslaw registered at 50 degrees and the pulled pork sandwich at 136.2 degrees. Staff B stated would need to do a substitution for the coleslaw.</p> <p>Observation on 7/1/24 at 12:20 PM found 2 trays on a meal cart for room tray delivery. Staff A placed additional room trays on the cart and left the dining area at 12:45 for delivery.</p> <p>On 6/30/24 at 12:37 PM Staff B stated cold foods should be served at or below 41 degrees and hot foods from the steam table above 135 degrees. The DM stated to prevent cold foods from getting warm may need to serve in Styrofoam containers versus on the warm plates with insulated covers. The DM stated room trays should not be sitting for over 10 minutes before delivery to the room.</p> <p>The facility policy, Food Temperature Monitoring - Food and Nutrition Services, dated 12/21/23 revealed that temperatures should be retaken periodically throughout the meal service to ensure foods are held below 41 degrees or above 135 degrees. The policy further revealed that test trays should be done periodically to ensure holding temperatures based on food safety.</p> <p>47673</p> <p>2. The MDS assessment dated [DATE] documented Resident #30 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/30/24 at 12:06 PM Resident #30 stated the food is frequently served cold, at least once a week. Resident #30 stated she ate every meal in her room. Resident #30 stated the facility had heated plates but the food might be cold being applied to the plates.</p> <p>3. The MDS dated [DATE] documented Resident #40 had a BIMS score of 15 indicating no cognitive impairment.</p> <p>On 6/30/24 on 1:11 PM Resident #40 stated the pork on the sandwich today at lunch was not hot. Resident #40 stated coleslaw was not cold. Resident #40 stated he did not eat too much of it. Resident #40 stated food is cold when it should be hot at times.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49628</p> <p>Based on observations, staff interviews, and policy reviews the facility failed to prepare, serve, distribute, and store food in accordance with professional standards. The facility reported a census of 40 residents.</p> <p>Findings include:</p> <p>Continuous observation on 6/30/24 starting at 10:38 AM noted the upright refrigerator/freezer combination in the kitchen to have a black fuzzy area on the ledge that had smaller dots/splotches spreading to the right and to the left. The refrigerator shelves had an uncovered dessert with whipped topping, an opened undated gallon of milk, 2 packages of pizza neither dated with one package not sealed, and an undated plastic bag with whipped cream inside of it. The walk in dry goods pantry had empty cardboard boxes/flats sitting on the floor, as well as condiment packages. The walk in refrigerator had a container of strawberries that had a white fuzzy appearance to it.</p> <p>Continuous observation on 7/1/24 starting at 11:18 AM of the kitchen and mealtime revealed the following:</p> <p>-The walk in refrigerator contained a package of strawberries with a white fuzzy appearance and discolored, soft strawberries.</p> <p>-Staff B, cook, washed his hands and began modification of 6 cornmeal muffins using a small processor. Staff donned gloves for removal of the wrappers from the muffins. After placing the muffins in the processor the staff removed the gloves and placed them next to the empty muffin flat on the counter where food preparation was taking place. The staff touched his face with his hand, placed the liner in the pan, and poured the pureed muffins into the lined pan. Staff B covered the pan and placed it in the refrigerator. The staff threw the empty muffin flat away and the dirty gloves were left on the food preparation counter.</p> <p>-During the meal service the staff placed the serving scoops and tongs on top of steam table lids and on serving counters when not in use. Staff B prepared a peanut butter and jelly sandwich for a resident on a food preparation counter. After washing his hands, staff B donned a single glove on his right hand. Using the non-gloved hand the staff obtained the bread, opened the wrapper. Using the gloved hand obtained the bread and placed it on the plastic wrap for the sandwich. The peanut butter lid was removed using the single non-gloved hand. Holding the bread with the gloved hand, applied the peanut butter with a spreader with the non gloved hand. Staff attempted removal of the lid of the jelly and needed to remove the glove to open. The staff then touched the sandwich, realized the error, stopped preparation and threw the sandwich away. The staff placed the dirty glove on the food preparation counter next to the bread. The staff donned a new glove without washing his hands. The staff used the gloved hand to obtain bread and hold during application of the peanut butter and jelly. The sandwich was wrapped in plastic wrap. The staff removed the glove and placed it on the counter with the other dirty glove next to the bread package.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/1/24 at 1:40 PM the Dietary Manager (DM) stated the refrigerators were cleaned weekly and there was a log of cleaning duties. The DM concurred the upright refrigerator had been dirty and contained items that were not marked and uncovered. The DM indicated that she had not looked at the walk-in refrigerator and was unaware of the strawberries with the fuzzy white appearance.</p> <p>On 7/2/24 at 1:42 PM the DM stated the process of using gloves included washing hands prior to application and immediately throwing them into the trash upon removal.</p> <p>The facility policy, Hand Hygiene - Enterprise, dated 3/29/22 revealed hand hygiene must be performed after removal of gloves regardless of the task completed.</p> <p>The facility policy, General Sanitation - Food and Nutrition, dated 6/25/24 revealed that food should be stored, prepared, distributed, and served under sanitary conditions. The policy further revealed the food preparation, kitchen, serving areas and dry storage are cleaned and sanitized on a regular basis.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47079</p> <p>Based on observation, record review, staff interview, and policy review, the facility failed to implement infection control practices to prevent cross contamination of invasive medical devices. The facility reported a census of 40 residents.</p> <p>Findings include:</p> <p>1. On 6/30/24 at 1:00 PM, observed Resident #11 sitting in his wheelchair with his indwelling catheter drainage bag hanging on an angled part of the wheelchair frame and the tubing lying on the floor.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated moderately impaired cognition. It included diagnoses of diabetes mellitus and obstructive uropathy (impaired urine flow). It also indicated the resident had an indwelling catheter and required supervision with toileting hygiene.</p> <p>The Care Plan dated 6/25/24 indicated the resident had potential for a urinary tract infection related to the indwelling catheter and directed staff to perform catheter care by a Certified Nursing Aide (CNA) every shift and as needed per facility protocol.</p> <p>The Electronic Health Record (EHR) progress notes dated 6/30/24 indicated the resident relied on staff for catheter care.</p> <p>On 7/01/24 at 1:17 PM, a catheter care observation revealed Staff D, CNA and Staff E, CNA performed hand hygiene (HH) and donned gloves. Staff D opened the resident's bathroom cabinet and got alcohol wipe packets. She opened the resident's closet and got a trash bag. She placed the alcohol wipe packets on the floor in front of the resident's wheelchair and put the urine container inside the plastic bag on the floor at the resident's feet. Staff E picked up the alcohol wipe packets off the floor, opened one alcohol packet, and handed the alcohol wipe to Staff D. Staff D grabbed the wipe with her right hand and wiped the resident's urine collection bag drain port. She used her right hand to unclamp the drain port and emptied the urine into the urine container. Staff E opened another alcohol packet, and handed the alcohol wipe to Staff D. Staff D grabbed the wipe with her right hand and wiped the resident's urine collection bag drain port then clamped it and secured it. She placed the urine collection drain bag inside a dignity bag and hung it to the underside frame of the resident's wheelchair.</p> <p>On 7/01/24 at 1:25 PM, Staff D stated she should've performed hand hygiene and changed gloves after emptying the resident's urine collection bag. Staff E stated she should've opened the alcohol packet and had Staff D grab the alcohol wipe directly from the packet.</p> <p>47673</p> <p>2. The MDS assessment dated [DATE] documented Resident #40 had a BIMS score of 15 indicating no cognitive impairment. The MDS documented Resident #40 had a surgically placed supra pubic catheter.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/24 at 1:42 PM Staff F Certified Nursing Assistant (CNA) and Staff G CNA completed hand hygiene, applied a gown, and applied gloves. Staff G applied a barrier to the ground and placed a graduated cylinder on the barrier. Staff G cleansed the catheter drainage tube with an alcohol wipe. Staff G emptied urine from the catheter leg bag. Staff F took the graduated cylinder to the toilet and emptied. Staff F removed his gloves and applied new gloves without performing hand hygiene. Staff F returned to the Resident #40 and stood the resident utilizing a gait belt. Staff G cleansed Resident #40's supra pubic stoma with a peri wipe. Staff G cleansed the catheter tubing. Staff F and Staff G then pulled Resident #40 ' s brief up, pulled his pants up, and sat Resident #40 back down in the recliner. Staff G removed the gloves, removed the gown, and completed hand hygiene in the room. Staff F removed the gown, removed gloves, opened the door, walked down the hall to the nurses station, entered the bathroom behind the nurses station, and completed hand hygiene.</p> <p>Review of policy titled, Infection Prevention: Hand Hygiene revised 3/29/22 documented that all employees in patient care areas will adhere to the 4 Moments of Hand Hygiene when entering a residents room, before clean task, after body fluid / glove removal, and exiting room.</p> <p>On 7/2/24 at 2:00 PM the DON stated the facility's expectation for hand hygiene would be after glove removal, before and after resident care, when entering or exiting a residents room, and between clean and dirty tasks.</p>