STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165192	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Estherville	1646 Fifth Avenue North Estherville, IA 51334

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review, the facility failed to store food items according to professional standards and discard food items after product recommended date. The facility identified a census of 46 residents.Findings include: An initial kitchen tour conducted on 1/12/26 at 10:30 AM, of the kitchen revealed the following items were stored in the kitchen's refrigerator ready for service:a. Bag of shredded lettuce- turning brown- dated 1/2/26b. Container of breaded chicken- dated 1/4/26c. Container of fruit cocktail- dated 1/3/26d. Container of tomato sauce-dated 1/2/26e. Container of egg salad- open with used by date of 12/29/25f. Low Fat Cottage Cheese- 5 lbs- use by 11/11/25g. Mildly Thick Orange Juice - open with no lid and not dated. The directions on the container documented after opening may be kept up to 7 days under refrigeration.h. Angel food cake inside a plastic bag- Not datedIn addition, observation revealed a tray of dinner buns on a rack that were not covered.On 1/12/26 at 10:48 AM, the Certified Dietary Manager (CDM) reported left overs are good for 3 days then discarded otherwise they go by the expiration date on the food item. The facility policy titled Food-Supply-Food and Nutrition Services dated 3/7/25 documented the purpose of the policy was to ensure food was stored properly. The policy documented left over food items to be used within 7 days per food code and food items that have a use by date are checked on a regular basis and discarded when expired.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to complete a gradual dose reduction (GDR) for 1 of 5 residents (Resident #8) reviewed for unnecessary medications. The facility reported a census of 46 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] identified a Staff Assessment for Mental Status indicating severely impaired cognition. The MDS included diagnosis of non-Alzheimer's dementia, depression, frontotemporal cognitive disorder, adjustment disorder with depressed mood and emotional lability. The MDS documented Resident #8 was taking high risk medication that included antipsychotic and antianxiety medications. The Clinical Record revealed Resident #8 was admitted to the facility on [DATE].The Care Plan with a target date of 3/10/26 revealed Resident #8 was on an antipsychotic medication related to dementia with behavioral symptoms and an antianxiety medication related to adjustment issues and anxiety disorder. The care plan directed staff to consult with pharmacy and health care providers to consider dosage reduction when clinically appropriate.The January 2026 Medication Administration Record (MAR) directed staff to administer the following medications:1. Lorazepam (antianxiety medication) 0.5 mg (milligrams) one tablet one time a day in the morning with a start date of 12/24/24. 2. Lorazepam 0.5 mg one tablet one time a day at bedtime with a start date of 12/27/24.3. Olanzapine (antipsychotic medication) 2.5 mg one tablet two times a day with a start date 11/12/24. Review of the Clinical Record revealed one GDR completed on 9/17/25 for the routine Lorazepam and Olanzapine with no changes being made. The clinical record lacked a second GDR being completed in 2 separate quarters within the first year of admission. On 1/15/26 at 1:30 PM, the Director of Nursing (DON) verified there was only one GDR completed for the Olanzapine and routine Lorazepam on 9/17/25. The DON said she called the pharmacist and the pharmacist could not locate the second GDR. The DON agreed it was an expectation to complete two GDRs within the first year, in two separate quarters with a month in between.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinic record review, staff interviews, and policy review. The facility failed to develop a care plan to address risk factors and interventions for 2 of 13 residents reviewed. (Residents #7, and #10) for Comprehensive Care Plans. The facility reported a census of 46. Findings include: 1. Resident #7's Minimum Data Set (MDS) assessment dated for 11/3/2025 identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of traumatic brain injury (TBI), hypertension (high blood pressure), and depression. Resident #4's January 2026 MAR's listed the following orders:Oxygen at 4 Liters Per Minute (LPM) per nasal cannula, via O2 concentrator and/or tank. Titrate as tolerates, wean oxygen as patient tolerates tube and O2 sats 90% every shift for hypoxia. The Care Plan with an initiated date of 5/5/25 failed to develop a care plan for oxygen therapy. 2. Resident #10's Minimum Data Set (MDS) assessment dated for 12/8/2025 identified a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. The MDS included diagnoses of hypertension (high blood pressure), renal insufficiency, and diabetes mellitus.Resident #10's January 2026 MAR's listed the following orders:Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 100 Unit/ML - inject 25 unit subcutaneously two times a day for Diabetes.Insulin Aspart Injection Solution 100 unit/ML - inject 14 unit subcutaneously before meals for Diabetes.Insulin Aspart Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 200 - 250 = 4 units; 251 - 300 = 7 units; 301 - 350 = 10 units; 351 - 400 = 13 units; 401 - 450 = 16 units >451 call Dr. [NAME]., subcutaneously four times a day for DiabetesThe Care Plan with an initiated date of 8/26/25, lacked direction regarding the treatment and management of type 2 diabetes mellitus and insulin usage. The Care Plan lacked risk factors and interventions regarding blood sugar monitoring and parameters on when to report the Physician, signs/symptoms to monitor for related to hyper/hypoglycemia (high/low blood sugars), and potential adverse reactions/complications.The facility policy titled Care Plan - R/S, LTC, Therapy and Rehab with a revised date of 12/1/25 revealed the purpose to develop a comprehensive care plan using an interdisciplinary team approach and to provide guidance to the interdisciplinary team in developing the initial care plan. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders. The comprehensive plan of care will be finalized during an interdisciplinary care team conference no later than seven days after completion of the comprehensive resident assessment. This plan of care will be modified to reflect the care currently required/provided for the resident. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services.On 1/15/26 at 10:00 a.m. the Director of Nursing acknowledged the care plans did not address the oxygen therapy and lacked treatment and management of diabetic mellitus.

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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** Based on clinical record review, staff interviews, and policy review, the facility failed to provide care and services according to accepted standards of clinical practice for 1 of 13 residents reviewed (Resident #2) for Physician orders. The facility reported a census of 46 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #2 was dependent on staff for lower body dressing. The MDS included diagnoses of hypertension (high blood pressure), heart failure (heart does not pump enough blood), chronic kidney disease, type 2 diabetes mellitus, and morbid obesity. The Care Plan with a target date of 2/10/26 revealed Resident #2 had skin integrity issues with open wounds on bilateral lower extremities (BLE) related to a fall. The care plan directed staff to monitor location, size and treatment of the skin injury. The care plan lacked direction regarding ace wraps or compression to lower the BLE. The Progress Note dated 11/12/25 revealed Resident #2 was seen for an initial ET (enterostomal therapy) nurse consultation due to BLE injuries related to a fall on 10/27/25. The ET nurse recommended the following:1. Topical care to the left lower extremity (LLE) wound on bath days and PRN (as needed) with dislodgement or soilage. Cleanse wound and periwound with Vashe (wound cleanser) and gauze. Dry with gauze. Apply Triad (hydrophilic paste) to the wound base. Gently fill depth with a strip of CMC fiber (highly absorbent dressing). Secure with a foam border dressing. 2. Topical care to the right lower extremity (RLE) wound daily and PRN with dislodgement or soilage. Cleanse wound and periwound with Vashe wound cleanser and gauze. Dry with gauze. Apply Triad to wound base. Gently fill depth with a strip of CMC fiber. Secure with a silicone super absorbent dressing. 3. Apply gradual compression to BLE daily (on in the morning and off at bed time). Beginning at base of toes with a 4 inch ace wrap and transition to 6 inch ace wrap to complete wrapping to base of the knees. The Progress Note dated 11/14/25 revealed Resident #2's Physician agreed with the ET Nurse recommendations. The November 2025 Treatment Administration Record (TAR) revealed the treatment order for the RLE was not transcribed correctly to the TAR on 11/14/25. The RLE treatment was transcribed to the TAR to be completed on bath days (Tuesday and Friday) and not daily as the Physician order was written. The TAR revealed the treatment to the RLE was not completed on 11/15 and 11/16. The Clinical Record revealed Resident #2 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. The Progress Note dated 12/2/25 revealed the ET Nurse evaluated Resident #2's BLE wounds and recommended to restart the gradual compression to BLE daily (on in the morning and off at bed time). Beginning at base of toes with a 4 inch ace wrap and transition to 6 inch ace wrap to complete wrapping to base of the knees. The Physician agreed with the recommendations on 12/2/25. The December 2025 TAR revealed the ace wraps were not signed off indicating Resident #2 did not wear the ace wraps according to the Physician order on the following dates: 12/8, 12/9, 12/10, 12/13, 12/14, 12/15, 12/16, 12/23 and 12/30. On 1/14/26 at 1:30 PM, the Director of Nursing (DON) and the facility wound nurse acknowledged the daily treatment for the RLE was not transcribed correctly to the November TAR. The DON reported she would expect treatments to be transcribed correctly and implemented per Physician order. The DON reported she would expect staff to follow the physician order for the ace wraps and document the administration or refusals on the TAR. The facility policy titled Physician/Practitioner Orders dated 4/6/25 documented the purpose of the policy was to provide individualized care to each resident by obtaining appropriate, accurate and timely physician/practitioner orders and to provide a procedure that facilitates the timely and accurate processing of the orders. The policy directed orders must be obtained for wound care including product to be used, when to change and when to reassess.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 2 residents reviewed (Resident #2) for falls. The facility reported a census of 46 residents. Findings include: Resident #2's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #2 was dependent on staff for all transfers. The MDS included diagnoses of hypertension (high blood pressure), heart failure (heart does not pump enough blood), chronic kidney disease, type 2 diabetes mellitus, and morbid obesity. The Care Plan initiated on 8/11/25 revealed Resident #2 had an Activity of Daily Living (ADL) self care performance deficit related to weakness and limited mobility. The care plan intervention revised on 9/20/25 directed staff to use a mechanical sit to stand lift with assist of 2 with transfers or sit to stand with assist of 2 staff members, walker and gait belt depending on resident's fluctuating level of consciousness. An incident report (IR) titled Resident Event dated 9/20/25 at 10:30 AM revealed Resident #2 had fallen on the floor when one staff member was transferring Resident #2 from the recliner to commode using a mechanical sit to stand lift. The IR documented Resident #2 let go of the bars and slipped out of the sling onto the floor. The clinical record documented the intervention was to use the mechanical sit to stand lift with assistance of 2 staff members instead of one. An IR titled Resident Event dated 10/9/25 documented a Registered Nurse (RN) was called to Resident #2's room due to Resident #2 almost slipped out of the lift. The note documented Resident #2 was readjusted with the lift sling placed correctly and assisted onto the commode. According to the note, the RN told the CNA (Certified Nursing Assistant) not to transfer Resident #2 on her own and to call for help when she was finished on the commode. The RN was called back urgently to Resident #2's room and noted Resident #2 on the floor. The CNA reported when she went to transfer Resident #2, she went limp and was assisted to the ground. On 1/14/26 at 10:45 AM, Staff A, CNA reported she assisted Resident #2 on and off the commode using the mechanical sit to stand lift by herself. Staff A said when she went to get Resident #2 off the commode to go to the wheelchair she went limp and was not standing. She said Resident #2 could not hold onto the bar of the lift. She said she lowered Resident #2 to the floor by putting her hands under her armpits. On 1/14/26 at 11:09 AM, Staff B, RN reported when she entered the room, Resident #2 was on the commode but not safely. She said she had to help reposition Resident #2 so she could go to the bathroom. She said Resident #2's sling was not applied correctly. She said the sling was loose and Staff A was using the blue and green loop. Staff B said she corrected the harness and provided education to Staff A. She said she told Staff A to stay with Resident #2 and not to leave her. Staff B said she told Staff A to radio her when Resident #2 was ready to get off the commode and she would come back to help with the transfer. Staff B said she told Staff A not to get Resident #2 up by herself. Staff B said the next radio contact from Staff A was reporting Resident #2 was on the floor. Staff B said she went to the room and observed Resident #2 was on the floor and Staff A was in a panic. She said Staff A was the only person in the room. She said Staff A reported Resident #2 had gone limp. She said when she got to the room Resident #2 was talking to her. She said she told Staff A not to use the mechanical sit to stand lift again and to use the full body mechanical lift. On 1/14/26 at 1:00 PM, the Director of Nursing (DON) reported the intervention for the fall on 10/9/25 was verbal education with Staff A. The DON reported she did not document the education that was given. The DON reported she would expect the staff to follow the care plan. The facility policy titled Safe Resident Handling Program dated 12/12/25 documented the goal was to maintain a safe living and working environment for residents and employees. The policy directed the caregivers to perform a time out safety stop while the resident is in a sling or harness and still over the surface of the bed or chair to ensure that all straps are secure before moving away (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the surface. This was to be completed once the straps are taut, but before the resident leaves a surface. The facility policy titled Care Plan dated 12/1/25 documented the purpose of the policy was to develop a comprehensive care plan using an interdisciplinary approach. The policy documented the plan of care would be modified to reflect the care currently required and provided for the resident. The care plan will address the relationship of items or services required and facility responsibility for providing these services.