Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165205	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Lemars	1140 Lincoln Street NE Le Mars, IA 51031

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to revise and update Care Plans to include and address high risk medications and side effects to watch for in 2 out of 15 sampled residents reviewed for Comprehensive Care Plans (Resident #17 & #30). The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #17 documented diagnoses of diabetes mellitus and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Review of the April 2024 Medication Administration Record (MAR) revealed the following orders: a. Insulin Glargine-Lixisenatide (diabetic medication) with a start date of 7/12/23. Review of the MDS dated [DATE] revealed diabetic medication and insulin injection taken 7 out of 7 days in the look back period. Review of the Medication Review Report signed 3/13/24 revealed the following orders: a. Insulin Glargine-Lixisenatide with a start date of 7/12/23. Review of the Care Plan undated lacked information regarding the usage and side effects of insulin injections. 2. The MDS assessment dated [DATE] for Resident #30 documented diagnoses of diabetes mellitus, edema and hypertension. The MDS showed a Brief Interview for Mental Status (BIMS) score of 13 indicating no cognitive impairment. Review of the April 2024 MAR revealed the following orders: a. Lasix with a start date of 1/25/24. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Lemars		STREET ADDRESS, CITY, STATE, ZIP CODE 1140 Lincoln Street NE Le Mars, IA 51031	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Lantus Insulin (diabetic medication) with a start date of 2/15/24 with a discontinuation date of 4/8/24. c. Tresiba (diabetic medication) with a start date of 4/9/24. Review of the MDS dated [DATE] revealed diabetic medication and insulin injection taken 7 out of 7 days in the look back period. Review of the Medication Review Report signed 3/13/24 revealed the following orders: a. Lasix with a start date of 1/25/24. b. Lantus Insulin with a start date of 2/15/24. c. Tresiba on hold. Review of facility provided policy titled Comprehensive Care Plan and Care Conference with a reviewed date of 12/4/23 revealed the purpose of the policy is to provide an ongoing method of assessing, implementing, evaluating and updating the resident's Care Plan to help maintain the resident's highest practicable level of function, including culturally competent and trauma informed care. Interview on 04/10/24 at 01:11 p.m., with the Director of Nursing (DON) revealed insulin and diuretic medication should be on the Care Plan.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on observation, document review, resident interview, and staff interview the facility failed to provide nursing staff to assure residents safety by not adequately responding to call lights in a timely manner. The facility reported a census of 61 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #8 documented a Brief Interview for Mental Status (BIMS) of 13 indicating no cognitive impairment. Review of document titled, Resident Listing Report revealed Resident #8 resided in 213. On 4/10/24 at 7:55 AM a continuous observation of room [ROOM NUMBER]'s call light revealed at 7:55 AM call light was on and at 8:30 AM call light was shut off. On 4/10/24 at 8:11 AM Resident #8 stated his call light was turned on because he wanted his butt scooted over in bed. Resident #8 stated he wanted help transferring into bed. Resident #8 stated he had grown tired of waiting and transferred himself into bed. Resident #8 stated in the morning sometimes it would take longer than 15 minutes for staff to answer the call lights. Resident #8 stated he could read the clock in the room and knew how long it took the staff to answer his call light. Resident #8 stated it was 8:13 AM at that time. Review of document titled, Device Activity Report dated 4/10/24 reported on 4/10/24 the call light for room [ROOM NUMBER] was shut off after 21 minutes and 51 seconds at 12:16 AM, 4/10/24 at 5:10 AM the call light was shut after 24 minutes, 4/10/24 at 7:12 AM the call light was shut off after 16 minutes and 37 seconds, and 4/10/24 8:30 AM the call light was shut off after 36 minutes and 35 seconds. 2. The MDS dated [DATE] for Resident #59 documented a BIMS of 15 indicating no cognitive impairment. Review of document titled, Resident Listing Report revealed Resident #59 resided in room [ROOM NUMBER]. On 4/10/24 at 7:55 AM a continuous observation of room [ROOM NUMBER]'s call light revealed at 8:02 AM call light was on and at 8:31 AM call light was shut off. On 4/10/24 at 8:24 AM Resident #59 stated he wanted to go to the bathroom. Resident #59 stated the call light had been on for a bit but they are usually good about answering the call light. Review of document titled, Device Activity Report dated 4/10/24 reported on 4/10/24 the call light for room [ROOM NUMBER] was shut off after 28 minutes and 35 seconds at 8:31 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 1:39 PM Staff A, Certified Nursing Assistant (CNA) stated call lights would be answered in no more than 3-5 minutes. Staff A stated sometimes it could take longer than 3-5 minutes depending on if someone had fallen or what was going on at the time. Staff A stated no one had fallen the morning of 4/10/24 from her hall. Staff A stated the facility's expectation was that call lights would be answered in less than 15 minutes. On 4/10/24 at 1:52 PM the DON stated the residents did not really complain about how long the call lights are on prior to answering. The DON stated it was hard to answer them all at times under 15 minutes, but she was aware this was the regulation. The DON stated Resident #8 never needed anything urgent. The DON stated the standard was 15 minutes and the staff is educated on that all the time. The DON stated mornings at the facility were busy. Review of policy titled, Call light reviewed 8/1/23 documented when a resident's call light is observed/heard, go to the residents room promptly and respond to resident's request as soon as possible.