STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Holstein	505 West Second Street Holstein, IA 51025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to ensure accurate accounting of Scheduled II medications for 2 of 6 residents (#3 and #4). The facility also failed to ensure that medications were securely locked in the cart and storage room. The facility reported a census of 57 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #3 had a Brief Interview for Mental Status (BIMS) score of 2 (severe cognitive deficit). The resident was totally dependent on staff for eating, toileting, dressing. Her diagnoses included cancer, anemia, anxiety disorder, secondary malignant neoplasm of brain, adult failure to thrive. The Care Plan updated on [DATE] showed Resident #3 had alteration in gastrointestinal status related to malignant neoplasm on the abdomen. She had communication problem related to difficulty forming words and self-care deficit related to weakness. The resident was on high risk medications prescribed for pain, depression and anxiety. The following orders were found on the Medication Administration Record (MAR): a. An order dated [DATE] at 12:15 PM for morphine tablet 15 milligram (ml) give 1 tablet every 2 hours as needed for pain. b. An order dated [DATE] at 3:45 PM for 0.5 of Ativan to use as needed (PRN) for anxiety. c. An order dated [DATE] at 5:00 PM for a scheduled 0.5 mg Ativan 4 times a day. According to the Individual Resident Narcotic Record (IRNR) showed from the 27th of May through 31st of May the tabs were administered 18 times, the MAR showed in the same timeframe that the medication was administered just 14 times. Staff used the same IRNR sheet for the scheduled and the PRN Ativan. On [DATE]th, the IRNR showed that the Ativan used 4 times and the MAR showed that it was used 5 times. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) The MDS for Resident #4, dated [DATE], showed a BIMS score of 14 (intact cognitive ability). The resident was independent with eating, toileting and dressing, transfers and walking. Diagnoses included anemia, anxiety, depression and Chronic Obstructive Pulmonary Disease (COPD). The Care Plan updated on [DATE] showed the resident had altered cardiovascular status and at risk for potential fluid imbalance overload. She had sleep disturbance and insomnia and often had difficulty falling asleep. She had chronic pain syndrome. Resident #4 had an order dated [DATE] at 8:00 PM for lorazepam 0.5 mg twice a day for anxiety, and an order dated [DATE] at 4:00 PM for Pregabalin 200 mg two times a day related to rheumatoid arthritis. According to the IRNR, on [DATE] at 7:34 PM Resident #4 had 3 Ativan tabs remaining. The IRNR for Pregabalin 200 mg showed on [DATE] that there was 1 tab remaining. On [DATE] at 7:58 AM, Staff D, Nursing Supervisor said that she was unsure why there were left over pills for Resident #4 and when there was a changeover with a refill of pills, she investigated when the count was off and would destroy the extra. On [DATE] at 9:42 AM the Director of Nurse stated that she witnessed the medications being destroyed and that it was their process to destroy left over medications so they could start a new narcotic sheet with the number of tabs that were delivered. She acknowledged the 3 Ativan tabs and 1 Pregabalin tab were destroyed and she witnessed that process. 3) In an observation on [DATE] it was discovered the Controlled Drug Count Record for June, (used to verify that all narcotics had been counted at shift change) lacked two nurse initials on the 3rd, 6th and 11th of June. Staff A, Licensed Practical Nurse, had pre-signed for the beginning of her shift at 11:00PM, and the end of her shift at on [DATE]. 4) On [DATE] at 5:30 AM, Staff B, Certified Nurse Aide (CNA) was gathering laundry in the 300 hallway. The medication cart was sitting near the nurse's station with a key attached to a ring of other keys was in the narcotic drawer. The medication room door was propped open. There were no staff in the area supervising the medication cart or room. According to the facility policy titled: Medications: Acquisition Receiving Dispensing and Storage reviewed on [DATE]. An employee would be responsible for receipt of medications and once medications are received, they would be secured in the appropriate storage areas. Medications would be stored in locked medication cart. Staff would routinely check for expired medication and necessary disposal would be done in accordance with state/pharmacy regulations. Controlled drug would be reconciled at least daily through appropriate system of records of recipe and disposition.