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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
	165207	A. Building B. Wing	03/20/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49990 Based on clinical record review, resident and staff interview, the facility failed to implement or follow through with advanced directives per resident directive upon admission for 1 of 21 residents reviewed (Resident #206). The facility reported a census of 49. Findings include: The entry Minimum Data Set (MDS) dated [DATE] indicated Resident #206 entered the facility on [DATE]. The Care Plan for Resident #206, implemented [DATE] did not document if the resident wanted cardiopulmonary resuscitation (CPR) should he require it. A review of clinical records and files on [DATE] showed they failed to document Resident #206 had a code status or advanced directive of any kind. His Electronic Health Record (EHR) lacked documentation the resident required CPR and did not indicate the resident was indicated as a do not resuscitate (DNR). In an interview on [DATE] at 3:54 PM with Resident #206, he was asked directly if he wanted CPR in the event he should need it. He was able to voice that yes, he wants CPR. In an interview on [DATE] at 4:09 PM with the Director of Nursing (DON), she stated she was unaware the resident's code status was not present in the EHR. She stated staff are instructed to check the EHR to determine code status should a resident require CPR.

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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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** 46875 Based on clinical record review, staff interview and policy review the facility failed to develop a care plan to address risk factors and interventions for 3 out of 21 residents (Resident #10, #16, #31) reviewed for comprehensive care plans. The facility reported a census of 49 residents. Findings include: 1. Resident #10's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Resident #10's MDS included diagnoses of diabetes mellitus, non-alzheimer's dementia, anxiety and depression. The MDS documented Resident #10 was taking insulin injections during the 7 day look back period. A Physician Order dated 9/25/24 directed staff to obtain a FSBS (Finger Stick Blood Sugar) daily in the morning related to type 2 diabetes mellitus. A Physician Order dated 10/14/24 directed staff to administer Basaglar Insulin 100 unit/ml (milliliter) to inject 14 units subcutaneously (fatty tissue below the skin) one time a day related to type 2 diabetes mellitus. Review of the Care Plan dated 9/12/24 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 to the Physician, signs/symptoms to monitor for related to hyper/hypoglycemia (high/low blood sugars), and potential adverse reactions/complications. 2. Resident #16's MDS assessment dated [DATE] identified a BIMS score of 03, indicating severe cognitive impairment. Resident #16's MDS included diagnoses of non-alzheimer's dementia, seizure disorder, anxiety, depression, psychotic disorder and intellectual disabilities. The MDS documented Resident #16 was taking antipsychotic and antidepressant medications during the 7 day look back period. A Physician Order dated 4/24/23 directed staff to administer Sertraline HCL (antidepressant medication) 100 MG (milligrams) one time a day for depression related to emotional lability. A Physician Order dated 6/3/24 directed staff to administer Seroquel (antipsychotic medication) 50 MG three times a day related to delusional disorders. Review of the Care Plan with a target date of 10/29/24 revealed the antidepressant and antipsychotic medication, potential side effects and what to monitor for while taking the high risk medication was not addressed on the comprehensive care plan. On 3/19/25 at 4:15 PM, the DON (Director of Nursing) reported she would expect high risk medications and side effects to be addressed on the care plan. 47079 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The MDS for Resident #31 dated 2/4/25 revealed a BIMS of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), Non-Alzheimer's Dementia, unspecified dementia with agitation, and depression. It also revealed the resident sometimes felt lonely or isolated from those around him and received antipsychotic (AP) and antidepressant (AD) medications during the last 7 days. On 3/17/25 at 1:35 PM, Resident #31's spouse stated the resident took medication for behavior concerns. The Electronic Health Record (EHR) included a Physician's Order for an antidepressant medication dated 6/4/24, escitalopram oxalate 10 mg by mouth one time a day for depression. It did not identify the resident's target behaviors that required an antidepressant. The Progress Notes did not identify target behaviors for depression. The Care Plan revised 2/12/25 included the resident's antidepressant medication use but did not include the resident's individualized target behaviors for staff to monitor nor the non-pharmacological interventions for staff to attempt if the behaviors were observed. On 3/18/25 at 3:44 PM, Staff A, Registered Nurse (RN) stated she believed the resident's target behaviors should be in the Care Plan. She was not able to locate the resident's antidepressant medication target behaviors nor any individualized, non-pharmacological interventions in the resident's Care Plan. On 3/18/25 at 4:53 PM, the Director of Nursing (DON) stated the observed target behaviors for a scheduled anti-depressant should be documented in a Mood & Behavior titled Progress Note. She also stated the resident's target behaviors should be in the Indications for Use box. She further stated attempted non-pharmacological interventions should be documented in the Progress Notes. On 3/18/25 at 5:22 PM, the DON was not able to locate the antidepressant medication target behaviors in the Care Plan. A policy titled Care Plan - Rehab / Skilled & Long-Term Care, Therapy and Rehab revised 12/02/24 indicated 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. It also indicated the plan of care will be modified to reflect the care currently required/provided for the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49990 Based on direct observation, clinical record review, and staff interview, the facility failed to provide adequate oral cares for 2 of 2 residents reviewed (Resident #22, #24). The facility reported a census of 49. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #22, dated 12/9/2024, documented the resident's Brief Interview for Mental Status (BIMS) score as 00, indicating the resident was rarely/never understood. It documented the resident required substantial/maximal assistance to perform oral hygiene. The Care Plan for Resident #22, last revised 12/15/2024, documented the resident had his own teeth. It instructed staff to assist the resident with oral cares every AM and PM shift. Review of the Plan of Care Response History, printed 3/20/2025 at 10:08 AM, contained no documentation of oral cares performed in the last 30 days, the maximum look back period of the plan of care response history. 2. The MDS for Resident #24, dated 1/29/2025, documented the residents BIMS score as 03, indicating severely impaired cognition. It documented Resident #24 was fully dependent on staff to perform oral cares. The Care Plan for Resident #24, last revised on 7/22/2024, directed staff to provide oral cares twice daily or after each meal as recommended by the dental hygienist. In a direct observation on 3/18/2025 at 8:18 AM revealed Resident #24 to be missing several teeth, and the teeth that were visible were stained and appeared to have a layer of film on them. Review of the Plan of Care Response History, printed on 3/20/2025 at 9:39 AM, documented only three instances of oral hygiene performed within the 30-day lookback period. In the evening of 3/18/2025, the morning of 3/19/2025, and the evening of 3/19/2024. In an interview on 3/20/2025 at 11:07 AM with Staff I, Certified Medication Aide (CMA), she stated the only place they document oral cares is in the Electronic Health Record (EHR). She stated she documents cares like oral cares twice daily unless it indicates otherwise. In an interview on 3/20/2025 at 11:18 AM with Staff F, Certified Nurse Aide (CNA), she confirmed that oral cares are documented in the EHR, and that oral care documentation is typically required once per shift. She stated that if there was no documentation of oral cares, she would assume it was not done. In an interview on 3/20/2025 at 11:21 AM with Staff G, Registered Nurse (RN), she confirmed it is the CNAs responsibility to document oral cares as indicated in the EHR. She further stated that if it wasn't documented it wasn't done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/20/2025 at 11:32 AM with Staff H, RN, she confirmed oral cares for Resident's #22 and #24 should be documented twice daily as indicated by their plan of care. In an interview on 3/18/2025 at 5:57 PM with the Director of Nursing (DON), she acknowledged there was no documentation of oral cares for Resident #24 or #22. She stated there had been a mistake made when entering the care tasks for the residents and they were entered to be documented as needed, instead of a scheduled task to be done daily.

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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** 46875 Based on clinical record review, staff interviews, observations, and policy review, the facility failed to provide adequate nursing supervision to prevent accident and injuries for 1 of 3 residents reviewed for falls (Resident #46). The facility also failed to ensure a wander guard (a monitoring bracelet with activated alarm when exiting) was working for resident safety on a daily basis for 1 of 1 resident reviewed for risk for elopement (Resident #49). The facility reported a census of 49 residents. Findings include: 1. Resident #46's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 04, indicating severe cognitive impairment. The MDS identified Resident #46 required supervision/touching assistance with bed mobility and ambulation. The MDS identified Resident #46 required partial/moderate assistance for transfers. Resident #46's MDS included diagnoses of non-alzheimer's dementia, depression, hypothyroidism and other abnormalities of gait and mobility. The Care Plan dated 7/8/24 revealed Resident #46 had an ADL (activities of daily living) self care performance deficit related to dementia. The Care Plan directed staff to transfer and ambulate Resident #46 with one assistance and a gait belt. A Fall Risk Evaluation dated 7/6/24 documented Resident #46's fall risk score was a 20 which indicated he was at high risk for falls. A Progress Note dated 11/7/24 title Communication/Visit with Physician documented Resident #46 was unsteady with increased weakness at times and requested an order for Physical Therapy (PT) to evaluate and treat. Review of the clinical record revealed there was no follow up regarding the request and the order for PT was not obtained. A Progress Note dated 12/6/24 documented Resident #46 was very sleepy throughout the day, requiring assistance of two staff members at times due to lethargy. The clinical record lacked any further follow ups or assessments. A Progress Note dated 12/9/24 at 12:15 AM documented CNA (certified nursing assistant) summoned RN (Registered Nurse) to Resident #46's room. CNA reported she had assisted Resident #46 to the bathroom and had walked him to the closet to get new clothes when he became unsteady and she lowered him to the floor. CNA reported Resident #46 said his leg was broken. The note documented upon the nurse arrival, Resident #46 was lying on the floor, flat on his back parallel to the closet and dresser and head was behind the bedroom door. Resident #46's right leg was externally rotated and he was unable to point his foot up or pull leg up. Resident #46 complained of pain to the right hip. A pillow was placed under Resident #46's right knee/leg and behind his head for comfort. A Progress Note dated 12/9/24 at 1:43 AM documented Resident #46 was transported to the emergency department (ED) at 12:55 AM for evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note dated 12/9/24 at 2:55 AM documented the facility received a phone call from the ED reporting Resident #46 had a right femur fracture. The ED Triage Notes dated 12/9/24 documented Resident #46 was brought to the ED via ambulance after reporting right hip pain and being lowered to the floor. Staff from the nursing home reported Resident #46 was ambulating and had a sudden onset of severe right hip pain so was lowered to the floor. Staff reported slight shortening and rotation of the right leg. The Hospital x-ray of the right hip dated 12/9/24 documented the impression of a nondisplaced intertrochanteric fracture of the right femur. The Hospital History and Physical dated 12/9/24 documented Resident #46 was admitted due to the right femur fracture and would undergo surgery to repair the fracture. A handwritten statement from Staff C, CNA dated 12/9/24 documented she assisted Resident #46 to the bathroom then she walked him to the closet to get clean clothes and he became unsteady so lowered him to the floor. The facility 5 day Summary/Root Cause Analysis dated 12/13/24 documented Staff D, RN was summoned to the memory car unit by Staff C, CNA. Staff C reported Resident #46 wavered/lost balance while picking out clothes at the closet and she intervened by lowering Resident #46 to the floor. Staff D reported that during the fall investigation and further conversation with Staff C, Resident #46 had been complaining of pain to his right leg off and on throughout the shift, most recently as they ambulated from the bathroom, several feet to the closet. The investigation documented the root cause of the fall was Resident #46 had been complaining of right leg pain prior to fall. The facility investigation documented the following facility interventions: -Educate CNAs to report any resident complaints of pain to the charge nurse. -Educate the Nurses to assess any resident reports of pain and document their assessment, interventions, and new orders. -Educate nursing staff that if a resident was unsteady or complains of pain, assist the resident to a safe surface (chair or bed), then bring them outfits from the closet to choose from, rather than having the resident stand at the closet where space is limited. -Review with nursing staff the Safe Resident Handling Program Overview R/S, LTC Policy. -Review Nursing Related Assessments Policy with the Nurses Review of the facility 5 day investigation did not indicate how Staff C, CNA lowered Resident #46 to the floor or if a gait belt was used as directed on the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 3:45 PM, the Nurse Manager reported she received a call from Staff D, RN and she came to the facility. The Nurse Manager reported the staff did not move Resident #46 because he was in pain. She reported she observed him sitting on his bottom by the dresser/closet. She reported she did not recall if Resident #46 was wearing a gait belt or not. She reported she interviewed Staff C, CNA and she had made the motion with her two hands like she was holding on to something when she lowered Resident #46 to the floor so she had assumed Staff C was using a gait belt. When asked about the request for therapy orders on 11/7/24, the Nurse Manager reported that the Nurse Practitioner did not respond to the request until 12/10 and Resident #46 was in the hospital. On 3/18/25 at 3:45 PM, the DON was present with interview with the Nurse Manager and reported Staff C, CNA did not tell the charge nurse until after the fall that Resident #46 had complained of right leg pain. The DON reported the facility questioned if the pain contributed to the fall or if the fracture happened/caused the fall. The DON reported she was not sure if Staff C was using a gait belt or not at the time of the incident. The DON said she educated all nurses and CNAs on reporting and assessing pain. When asked if the Resident #46 had a history of right leg pain, she said not that she was aware of. She reported there had been no previous falls prior to 12/9/24. On 3/19/25 at 11:04 AM, Staff D, RN said she was out in the main area and Staff C CNA called for assistance due to Resident #46 had fallen. She said when she arrived to the room she couldn't get the door opened very far as Resident #46 was lying behind the door. She said Staff C and Resident #46 reported they were walking back from the bathroom to the closet to get clothes, Resident #46 complained of pain in his right leg and Staff C lowered Resident #46 to the floor (sat him down and then laid back). Staff D reported Resident #46 said he felt like something was broken and complained his right hip hurt. She said there was external rotation and he was not able to pick up his right leg or point his toes. She said she called for an ambulance and the Nurse Manager. She said the Nurse Manager came to the facility before the ambulance got there. When asked if Resident #46 was wearing a gait belt, Staff D reported she could not say for sure if he had a gait belt on or not. She said she did not recall taking the gait belt off Resident #46 when he was transferred onto the gurney. Staff D reported Resident #46 required assistance of one staff member and a walker for ambulation. Staff D reported the pain in the right leg was new for Resident #46 and started when he was walking from the BR over to the closet. She said the pain was not reported before the fall. Staff D reported there was not a lot of space between the bathroom and closet, probably about 10 steps. Staff D reported she felt like something happened prior to the fall, she said Resident #46 had pain, then became unsteady and then sat on the floor. She reported Resident #46 told her he sat on the floor as he was having pain while walking and that the pain started prior to being on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 11:49 AM, Staff C, CNA reported she was working the night Resident #46 broke his leg. She reported when she entered the room, Resident #46 was standing up with his walker. She said she asked him if he needed to go to the bathroom and he did. She reported she walked Resident #46 to the bathroom and he sat down on the toilet and urinated. She reported when he was done, she walked him to the closet to pick out new clothes and he got wobbly, so she lowered him to the floor using the back of his pants and his regular belt. Staff C reported Resident #46 did not have a gait belt on when she lowered him to the floor. Staff C reported Resident #46 would get up on his own sometimes and walk around. She reported Resident #46 was already standing up so she walked him to the bathroom and did not put on the gait belt. When asked why she did not put the gait belt on after Resident #46 was sitting on the toilet, she said she did not think about it but should have put the gait belt on him. She reported when she lowered Resident #46 to the floor it was gentle and not hard. Staff C reported she would have had to lower Resident #46 to the floor even if he had the gait belt on. She reported when Resident #46 sat down on the floor, he complained that his leg hurt. When asked if Resident #46 had voiced any complaints of pain prior to the fall, she said he may have but did not recall for sure. Staff C reported after the fall, she was educated if a patient wanted to change their clothes, to have them sit on the bed or chair then get the clothes and assist them that way. On 3/19/24 at 4:15 PM, the DON (Director of Nursing) reported she would expect the staff to follow the care plan when transferring or ambulating a resident. She reported if Resident #46 was already standing up, she would expect the staff to assist the resident and then attempt to apply the gait belt once the resident was in a safe place (sitting down). A facility policy titled Gait- Transfer Belt date reviewed/revised 5/2/25 documented the purpose of the gait belt was to safely stabilize a transfer, to ambulate with a resident and to aid residents in maintaining balance. The policy documented gait belts are used with assisted ambulation and are never used as a lifting device, only for stabilization. The policy further directed staff not to use the pants/slacks belt as a gait (transfer) belt as upward movement of the belt can cause male residents severe pain. 2. Resident #49's MDS dated [DATE] identified a BIMS score of 03, indicating severe cognitive impairment. The MDS identified Resident #49 was independent with bed mobility, transfers and ambulation. Resident #49's MDS included diagnoses of Alzheimer's, non-alzheimer's dementia, anxiety, depression, and post traumatic stress disorder. The MDS documented Resident #49 used a wander/elopement alarm daily. The Care Plan dated 9/5/25 revealed Resident #49 had behavioral symptoms related to wandering and a potential for elopement related to Alzheimer 's disease. The Care Plan directed the following interventions: -Check wander guard placement every shift. -Wander guard used to alert staff to resident's movements. -Check wander guard functionality every shift to ensure wander guard is in working order. -Educate families to use the sign in/sign out sheet at nurses station. -Ensure that exit door alarms are in working order. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Order dated 9/6/24 directed staff to check Resident #49's wander guard bracelet function daily. An Elopement Risk assessment dated [DATE] documented Resident #49 was at risk for elopement. A Progress Note dated 3/3/25 documented Resident #49 was independent with mobility and usually steady when doing so. The note documented Resident #49 was followed by Psychiatric ARNP (Advanced Registered Nurse Practitioner) for behaviors and anxiety as she had been noted to put herself on the floor, continued with pacing, attempted to get out doors and hitting staff. On 3/17/25 at 11:46 AM, observed Resident #49 pacing hallway, walking up and down quickly with no assistive device, wander guard in place to right ankle. Resident #49 told staff that she hates it here. A Progress Note on 3/17/25 documented Resident #49 upset that she cannot leave the facility and go home. Resident #46 started becoming agitated by other residents around her and staff intervened to allow her to have space. Resident #49 began hitting the window attempting to get out repeatedly stating I want to leave. Let me out of here Resident #49 very difficult to redirect and pacing quickly up and down the hall. Review of the September 2024 to March 2025 MAR (Medication Administration Records) and TAR (Treatment Administration Records) lacked documentation Resident #49's wander guard was being checked for placement and function. On 3/18/25 at 11:30 AM, Staff E, RN (Registered Nurse) verified Resident #49's wander guard was not documented on the MAR or TAR. She reported the Physician Order was put in the electronic medical record incorrectly so the order was not pulling over to the MAR or TAR for signature. Staff E reported she would correct the order. On 3/18/25 at 2:40 PM, the DON reported it was an expectation for the staff to check and document the placement of the wander guard daily and functioning of the wander guard twice a day on the TAR. The DON reported the facility had extra bands and devices so if the battery was to die, the staff would get a new device and band. A facility policy titled Alarms- Bed, Chair and Door date reviewed/revised 9/25/24 documented bracelet alarms are to be checked daily to see if the alarm was functional and nursing was responsible for visually checking for placement of the alarm daily.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interview and facility policy review, the facility failed to complete a gradual dose reduction (GDR) for 1 out of 5 residents reviewed for unnecessary medications, (Resident #21). The facility also failed to include nonpharmacological interventions and targeted behaviors for which staff were to monitor and/or redirect for 1 out 5 residents (Resident #31). The facility reported a census of 49 residents. Findings include: 1. Resident #21's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 01, indicating severe cognitive impairment. The MDS identified Resident #21 was independent transfers and ambulation. Resident #21's MDS included diagnoses of Alzheimer's, non-alzheimer's dementia, seizure disorder, and psychotic disorder. The MDS documented Resident #21 was taking an antipsychotic medication during the 7 day look back period. The Care Plan with a target date 9/17/24 documented Resident #21 received Seroquel medication with FDA (Food and Drug Administration) boxed warnings (most serious safety warning issued for a prescription drug). The Care Plan directed staff to consult with pharmacy and healthcare providers to consider dosage reduction when clinically appropriate. A Physician Order dated 4/20/23 directed staff to administer Seroquel (antipsychotic medication) 50 MG (milligrams) two times a day related to adjustment disorder with mixed anxiety and depressed mood. Review of the clinical record lacked documentation that a gradual dose reduction (GDR) had been attempted for the Seroquel in the last year. The clinical record lacked documentation of a clinical rationale from a Physician on why the antipsychotic medication was continued without a GDR. On 3/19/25 at 6:45 PM, the DON (Director of Nursing) verified the facility had not done a GDR on the Seroquel since July 2023. On 3/20/25 at 7:53 AM, the DON reported the expectation of the facility was that upon initiating a psychotropic medication, a gradual dose reduction should be attempted within the first year in two separate quarters, at least one month separating the attempts. The DON reported that upon attempting a GDR, and the resident experiences increased symptoms, or the physician does not feel a GDR would be beneficial or would be contraindicated due to symptoms, that the Physician and the facility had documentation to support this including targeted behaviors being exhibited. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165207	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Holstein		STREET ADDRESS, CITY, STATE, ZIP CODE: 505 West Second Street Holstein, IA 51025	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled Psychotropic Medications date reviewed/revised 12/30/24 documented that the residents would be free of any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. The policy directed gradual dose reductions must be done according to federal regulations. The policy documented the purpose of tapering medication was to find an optimal dose or to determine if continued use of the medication was benefiting the resident. Tapering may be indicated when the resident s clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved and/or nonpharmacological intervention have been effective in reducing the symptoms. The policy indicated within the first year an antipsychotic medication was started, the facility must attempt a GDR in two separate quarters with at least one month between attempts, unless clinical contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. The policy documented clinically contraindicated meant the following: a. The resident's target symptoms returned or worsened after the most recent attempt at a GDR. b. The Physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 47079 2. The MDS dated [DATE] revealed a BIMS of 02 out of 15 which indicated severely impaired cognition. It included diagnoses of Chronic Kidney Disease (CKD), Diabetes Mellitus (DM), Non-Alzheimer's Dementia, unspecified dementia with agitation, and depression. It also revealed the resident sometimes felt lonely or isolated from those around him and received antipsychotic (AP) and antidepressant (AD) medications during the last 7 days. On 3/17/25 at 1:35 PM, Resident #31's spouse stated the resident took medication for behavior concerns. The Electronic Health Record (EHR) included a Physician's Order for an antidepressant medication dated 6/04/24, escitalopram oxalate 10 mg by mouth one time a day for depression. It did not identify the resident's target behaviors that required an antidepressant. The Progress Notes did not identify target behaviors for depression. The Mood Task did not include documented observations of any of the following listed components nor identify them as depression-related target behaviors. a) Trouble falling or staying asleep, or sleeping too much b) Feels bad about self or is failure; let self/family down c) Moving or speaking so slowly that other people notice d) Fidgety or restless; moving around more than usual e) States life is not worth living or wishes for death (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f) Attempts to harm self g) Being short tempered, easily annoyed h) Little interest or pleasure in doing things i) Feeling or appearing down, depressed or hopeless j) Feeling tired or having little energy k) Poor appetite or overeating l) Trouble concentrating (e.g. reading newspaper, watching tv) The Care Plan revised 2/12/25 included the resident's antidepressant medication use but did not include the resident's individualized target behaviors for staff to monitor nor the non-pharmacological interventions for staff to attempt if the behaviors were observed. On 3/18/25 at 3:44 PM, Staff A, Registered Nurse (RN) stated she believed the resident's target behaviors should be in the Care Plan. She was not able to locate the resident's antidepressant target behaviors nor any non-pharmacological interventions in the resident's Care Plan. On 3/18/25 at 3:53 PM, Staff B, Certified Nursing Aide (CNA) stated CNAs document resident behaviors in the EHR's Point-of-Care (POC) component. On 3/18/25 at 4:53 PM, the Director of Nursing (DON) stated the target behaviors for a scheduled anti-depressant should be documented in a Mood & Behavior titled Progress Note. She also stated the resident's target behaviors should be in the Indications for Use box. She further stated non-pharmacological interventions should be documented in the Progress Notes. On 3/18/25 at 5:22 PM, the DON was not able to locate exhibited behaviors in the POC documentation. A policy titled Psychotropic Medications - Rehab / Skilled revised 12/30/24 indicated Based on a comprehensive assessment of a resident, the location must ensure that: a) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. b) Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. It also indicated if the reduction committee determines that initiating a medication is warranted, then the committee nurse will ensure the following is completed: a) Contact the physician and describe the behavior, attempted interventions and behavior committee recommendations. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Obtain an order for an appropriate medication, in an appropriate dose and corresponding diagnosis, as well as medical symptom from the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49990 Based on direct observation, staff observation, and facility document review, the facility failed to serve food to residents in a safe and hygienic manner. The facility reported a census of 49. Findings include: A direct observation on 3/17/2025 at 12:21 PM revealed Staff J, Registered Nurse (RN), assisting two residents simultaneously with eating assistance. There was no witnessed hand hygiene as she transferred from resident to resident. A continued observation on 3/17/2025 at 12:22 PM revealed Staff J appearing to touch their face before continuing to assist both residents with eating, no hand hygiene was performed. A direct observation on 3/18/2025 at 12:31 PM revealed Staff J, RN, offer eating assistance to two residents again. No hand hygiene was observed as she switched from resident to resident. A direct observation on 3/18/2025 at 12:39 PM revealed Staff K, Certified Nurse Aide (CNA), assisting a resident to take a bite of a cake. While assisting the resident to take a bite of the cake she appeared to make direct contact with the tines of the fork, and then assisted the resident in taking another bite of cake. In an interview on 3/20/2025 at 11:07 AM with Staff I, Certified Medication Aide (CMA), she stated the facility instructs them to not assist two residents with eating at the same time. If they do, they must sanitize or wash their hands in between each bite the residents take. In an interview on 3/20/2025 at 11:18 AM with Staff F, Certified Nurse Aide (CNA), she stated they are not supposed to feed two residents at the same time. She stated that they are not allowed to touch the tines of forks, and would need to replace it if she did. In an interview on 3/20/2025 at 11:21 AM with Staff G, Registered Nurse (RN), she stated the facility directs them not to feed two residents at the same time, but if she were to do so she would be required to wash or use hand sanitizer between helping each individual resident. She also stated if she made direct contact with the eating surface of a utensil she should replace it. In an interview on 3/18/2025 at 4:09 PM with the Director of Nursing (DON), she stated her expectation is for staff members to feed only one resident at a time or to cleanse their hands every time they switch between residents. She further stated that if direct contact were made with the eating surface of a utensil, such as the tines of a fork, a new fork would be required to be provided. Review of a facility provided document titled Infection Prevention and Control Program, last revised 12/02/2024, states the facility uses standard precautions for all residents, regardless of suspected or confirmed diagnoses, and that those standard precautions include proper hand hygiene.