STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165211	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ottumwa	2035 Chester Avenue Ottumwa, IA 52501

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 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 observation, clinical record review, and staff and resident interview, the facility failed to implement and follow physician orders for application of an ace wrap for 1 of 3 residents reviewed (Resident #8). The facility reported a census of 92 residents. Findings include: Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 15 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicated intact cognition. The MDS revealed the resident had a diagnosis of heart failure. Clinical record review revealed an order dated 6/18/25 for an ace wrap to be applied to Resident #8's lower extremities in the morning and discontinued in the evening. Review of June, July and August 2025 Medication Administration Records found no documentation of ace wrap or compression stockings being used as ordered. Observation on 9/3/25 at 10:45 a.m. noted Resident #8 sat in his recliner with his feet elevated. Resident #8 wore socks and shoes, but no ace wrap or compression stockings as ordered. Resident #8 was queried about using ace wrap on his legs and he stated they did it once, but it hurt so bad that he had them remove it. In an interview on 9/3/25 at 10:50 a.m. Staff W, Registered Nurse, was queried whether the computer showed Resident #8 was to have ace wraps applied daily. Staff W brought up her computer and searched, but was unable to find it as a nursing task. In an interview on 9/3/25 at 11:00 a.m. the Director of Nursing (DON), was questioned whether Resident #8 was to have ace wrap applied to his lower extremities daily. The DON searched her computer and noted he had an order for it, but was uncertain where it would be documented as completed. In an interview on 9/3/25 at 11:15 a.m. the Assistant Director of Nursing (ADON) brought her computer in and was able to show where aides documented the task of putting on an taking off the ace wrap.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, clinical record review and staff interviews, facility staff failed to ensure prompt intervention to ensure supplemental oxygen was administered in accordance with physician orders and each resident's individual care plan for 2 of 3 residents reviewed (Resident #6, #7). The facility reported census of 92 residents. Findings include: 1.According to a Minimum Data Set (MDS) assessment with reference date 6/17/25, Resident #6 had a Brief Interview for Mental Status (BIMS) score 14 out of 15, which indicated intact cognitive status. Resident #6 required moderate assistance with transfers, mobility and dependent assistance with dressing, toilet use and personal hygiene needs and determined as having a catheter and occasional incontinence of bowel. Resident #6's diagnosis included Parkinson's, coronary artery disease, gastroesophageal reflux disease, malnutrition, benign prostatic hypertrophy, and a right femur neck fracture. According to physician orders, Resident #6 was to receive oxygen at 2-3 liters per minute for shortness of breath as needed to keep his oxygen saturation levels greater than 90%.During an observation on 8/21/25 at 11:40 a.m. Resident #6 sat in his wheelchair in the dining room waiting for lunch. He had an oxygen tank and wore a nasal cannula. The oxygen tank was either empty or near empty as the needle was in the red range on the tank gauge.During an observation on 8/21/25 at 3:20 p.m. Resident #6 attended an activity and remained in his wheelchair with oxygen on per nasal cannula, however his tank remained empty as the needle remained in the red range on the tank gauge.In an interview on 8/21/25 at 3:30 p.m. Staff L, Licensed Practical Nurse, was queried who was responsible to change out empty oxygen tanks. Staff L stated the nurses would change them out and typically relied on the aides to let them know when they were low or empty.In an interview on 8/21/25 at 3:40 p.m. the Director of Nursing (DON) was queried regarding whose responsibility it was to ensure residents oxygen tanks were kept full. The DON stated it was everyone's, noting if a tank was observed low or empty, nurses or aides could exchange the tank.2. According to a MDS with reference date 7/12/25, Resident #7 had a BIMS score 14 out of 15, which indicated intact cognitive status. Resident #7 required maximal to dependent assistance with transfers, mobility and dependent assistance with dressing, toilet use and personal hygiene needs and was determined as always incontinent of bladder and bowel. Resident #7's diagnosis included rheumatoid arthritis and gastroesophageal reflux disease.According to Resident #7's Plan of Care dated 10/8/24, Resident #7 required oxygen therapy related to hypoxia. Interventions initiated 10/8/24 included to monitor signs and symptoms of respiratory distress and report to the health care provider as needed, prevent abdomen compression and respiratory distress by routinely checking the resident's position so she does not slide down in bed, and oxygen therapy at 1-4 liters per minute per nasal cannula. According to physician orders, Resident #7 was to receive supplemental oxygen 1-4 liters per minute as needed to keep oxygen saturation levels great than 90%.During an observation on 8/21/25 at 11:40 a.m. Resident #7 sat in a wheelchair in the dining room waiting for lunch. She had an oxygen tank and was not wearing her nasal cannula. The oxygen tank was empty as the needle was in the red on the tank gauge.During an observation on 8/21/25 at 1:15 p.m. Resident #7 was propelled back to 200 unit and sat at a table. Resident #7's tank was exchanged and now had half full tank and she wore her nasal cannula.

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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. Based on observation, clinical record review and staff interview, the facility failed to use enhanced barrier precautions (EBP) during peri care for 1 of 3 residents who required EBP (Resident #6). The facility reported a census of 92 residents. Findings include: According to a Minimum Data Set (MDS) with a reference date of 6/17/25, Resident #6 had a Brief Interview for Mental Status (BIMS) score 14 out of 15, indicating intact cognitive status. Resident #6 required moderate assistance with transfers, mobility and dependent assistance with dressing, toilet use and personal hygiene needs and determined as having a catheter and occasional incontinence of bowel. Resident #6's diagnoses included Parkinson's, coronary artery disease, gastroesophageal reflux disease, malnutrition, benign prostatic hypertrophy, and a right femur neck fracture. The Care Plan initiated 7/1/25, revised on 7/22/25, revealed the following: The resident requires Enhanced Barrier Precautions (EBP) R/T (related to) indwelling catheter. The Intervention dated 7/22/25 revealed, [NAME] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing, device care and/or use, and wound care. Observation on 8/28/25 at 9:00 a.m. revealed upon entrance to Resident #6's room, Staff U, Certified Nurse Aide, was in the process of resident care. Staff U was observed at Resident #6's bedside, and only wore gloves and no gown per EBP protocols. Resident #6's brief was open as to appear she was preparing to complete peri care. A new brief sat at the foot of the bed. Staff U stopped what she was doing and left the room to get a supervisor. Upon returning to the room, Staff U donned gloves and a gown and stated she needed to empty the catheter bag. Staff U then stated there was no graduate and asked her supervisor to get one. Upon returning with the graduate, Staff U then stated she had no alcohol wipes and again asked her supervisor to get her some. Staff U then proceeded with emptying the catheter bag properly using aseptic technique. Staff U then doffed her gloves and gown and re-gloved. She pulled Resident #6's brief open, stated he was clean, and she had completed catheter care prior to this surveyor entering the room. Staff #6 left the old brief on and reattached it, continued to dress Resident #6, then transferred him into his wheelchair and to the dining room for breakfast.According to the facilities Enhanced Barrier Precaution policy, Enhanced Barrier Precautions expand the use of personal protective equipment beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug-resistant organisms (MDROs) to staff, hands and clothing.Enhanced barrier precautions are used for residents with chronic wounds (i.e., pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous statis ulcers) and residents with indwelling medical devices (i.e., central lines, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies), even if the resident is not known to be infected or colonized with an MDRO (Multidrug resistant organisms).