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	06/03/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative interview, staff interviews, and the facility policy, the facility failed to treat a resident in a dignified manner by placing him on a mattress in the common area when he is acting out for 1 of 3 residents (Resident #2) reviewed for dignity. The facility reported a census of 95 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderately impaired cognition. The MDS indicated no behaviors exhibited verbal, physical, utilized a manual wheelchair, and required substantial/maximal assistance to roll right and left, lying to sitting on side on side of bed, and chair/bed-to-chair transfer. The diagnoses list included depression, heart failure, repeated falls, and polyarthritis (arthritis in multiple locations). Review of Resident #2's Care Plan dated 4/7/26 revealed a Focus area to address The resident has behavior symptoms; calling the nurses station, the front desk, SS (Social Services) for every need he has. He is very tearful. He calls his wife frequently and then she calls the facility. Resident also yells out and uses profanity when he is not getting the attention he desires. Resident will also threaten to put himself on the floor. Interventions included, in part:a. When resident is trying to put self on floor, assist him so he does not fall. Allow him to be on the floor until he is ready to get up and sit in chair or go to bed. Allow him to lay on mattress if he will on the floor. Allow to sit on floor when he becomes belligerent, aggressive, and tries to hit. He will try to get out of chair when he is upset and is a harm to self or others. Revised: 5/10/26.During an interview on 5/28/26 at 2:03 PM, Resident #2's family member stated the facility puts Resident #2 on a mattress on the floor in the common area when Resident #2 had behaviors. The family member stated she didn't think it was right to keep the resident in the common area because the resident did have some pride left.Review of the electronic health record (EHR) revealed:a. Other Progress Note dated 5/10/26 at 3:35 PM: Resident behavior starting to yell out, states come on lets go. Using Hoyer (name brand of a mechanical body lift) assist 2 transferred to the floor with no difficulties, mattress on the floor to lay on. Yelling out lets go.b. Other Progress Note dated 5/10/26 at 8:00 PM: Resident sleeping on the floor. Using Hoyer assist of 2 transferred to w/c (wheelchair) bed, then into the recliner to eat and ate 25%. Taking medications without any problem. Transferred to floor using a hoyer when resident slapping a workers glasses out and states you will get tired of doing this.c. Other Progress Note dated 5/10/26 at 11:17 PM: Res (resident) remains laying on mattress in common area. Sleeping soundly without any signs of discomfort. Staff monitoring closely.d. Health Status Note dated 5/11/26 at 12:51 AM: Resident laying on mattress on floor in common area under direct supervision. Is asleep. Has been very confused this noc (night shift). Staff is worried to put resident in bed due to behaviors and worried about his safety so he is under one-on-one direct supervision. Monitoring resident closely. Remains total care with hygiene and incontinent care. Turning and repo resident.During an interview on 6/1/26 at 4:59 PM, Staff A, Certified Nurse Aide (CNA) queried on Resident #2 behaviors and being placed on a mattress in the common area and she stated never placed Resident #2 on a mattress in the common area because she thought it was a dignity issue. Staff A stated when the resident had behaviors, staff had helped him to (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor for safety concerns but if they gave the resident 15 minutes to calm down, the resident usually got back up.During an interview on 6/2/26 at 2:21 PM, Staff B, Registered Nurse (RN) asked about Resident #2 behaviors and the resident being placed on a mattress in the common area and Staff B stated she was not at the facility when it happened and she didn't think putting Resident #2 on a mattress in the common area was okay. Staff B stated she went to the case manager about it and stated the mattress should be in his room, not the common area.During an interview on 6/2/26 at 3:40 PM, Staff C, CNA queried on Resident #2 being placed on a mattress in the common area and Staff C stated she didn't think it was appropriate because a bunch of people were around. Staff C stated she would have hoyered Resident #2 to his room and if he wanted to be on the mattress in his room that would be better. During an interview on 6/2/26 at 4:00 PM, Staff D, Licensed Practical Nurse (LPN) stated she had put Resident #2 on a mattress in the common area 3 times when Resident #2 had behaviors until the resident calmed down. Staff D confirmed other residents were in the common area when this happened.During an interview on 6/2/26 at 4:16 PM, Staff E, LPN queried about Resident #2 being placed on a mattress in the common area and Staff E stated even if it was Care Planned Staff E didn't feel like it was appropriate and is a dignity issue. Staff E stated family and other people would know Resident #2 and he was well known in the community and it wouldn't be dignified.During an interview on 6/2/26 at 4:51 PM, Staff F, LPN stated she placed Resident #2 on the mattress in the common area because she thought it was more dignified than laying on the floor. Staff F stated Resident #2 would relax and fall asleep. Staff F stated the core team came together and decided to keep the mattress in the resident's room and if the resident was more comfortable on the floor, he could be on the floor in his room.During an interview on 6/2/26 at 5:04 PM, Staff J, LPN queried about Resident #2 laying on a mattress in the common area and Staff J stated she didn't agree with it and at times Staff J understood they couldn't take Resident #2 to his room but when he fell asleep, Staff J was told not to move him. Staff J stated she would come in at 6:00 PM and Resident #2 would be asleep on the mattress. Staff J stated she felt it was a dignity issue and verbalized it, but she was overridden. Staff J stated keeping Resident #2 in the common area would cause some of the other residents to stay up or have behaviors.During an interview on 6/2/26 at 5:25 PM, the Director of Nursing (DON) queried on Resident #2 being placed on the mattress in the common area and the DON stated when she heard about the situation, the DON got the feeling staff were desperate and worried about safety. The DON stated the common area can be congested and having a resident on the floor in the common area can also cause a safety concern for other residents and some residents might even try to help. The DON stated the facility didn't want anyone to feel they were not treated with dignity, and they wanted to keep them safe and provide cares like they were adults.Review of the facility policy titled Resident Dignity-Rehab/Skilled Policy dated 12/18/25 indicated the facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The procedure revealed treating residents with respect.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, policy review, and staff interview, the facility failed to notify the physician of a weight loss for 1 of 4 residents (Resident #4) reviewed for a change in condition. The facility reported a census of 95 residents.Findings included:The Minimum Data Set (MDS) assessment tool, dated 4/15/26, listed diagnoses for Resident #4 which included Alzheimer's disease, non-Alzheimer's dementia, and muscle weakness. The Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicated a severe cognitive impairment. Care Plan entries, dated 3/28/25, stated the resident met the criteria for malnutrition and directed staff to monitor for weight loss. The facility policy Nutrition and Hydration-Food and Nutrition, dated 4/27/26, stated the facility would routinely assess the resident's nutritional status and monitor nutritional risk. The facility carried out a systematic method for obtaining, verifying, and interpreting data to identify nutrition related problems. The facility notified the physician as appropriate in evaluating and managing causes of the resident's nutritional risks. Resident #4's Weight Summary included the following weights during the period of 12/6/26 to 5/15/26:a. 11/03/25 - 121.0 lbs (pounds)b. 1/05/26 - 122.2 lbsc. 2/04/26 -123.8 lbsd. 3/04/26 -125.0 lbse. 3/27/26 -126.0 lbsf. 4/07/26 - 124.4 lbsg. 4/19/26 - 125.2 lbsh. 5/01/26 - 127.6 lbsi. 5/15/26 - 128.0 lbsj. 5/22/26 -118.8 lbsStaff U, Licensed Practical Nurse (LPN) documented the resident's 5/22/26 weight.The resident experienced a weight loss of 9.2 lbs. during the 7-day period between 5/15/26 and 5/22/26, calculated as a loss of 7.9%.The facility lacked documentation of physician notification of the weight loss during the period of 5/22/26 to 6/2/26.On 6/2/26 at approximately 12:00 p.m., when queried regarding Resident 4's weight loss between the dates of 5/15/26 and 5/22/26, Staff U, LPN stated she did not report the loss to the physician because she did not believe it was a true weight loss. Shortly after the interview, Staff U stated staff reweighed the resident and she currently weighed 122.2 lbs. On 6/3/26 at 9:42 a.m., during a phone interview, the Staff S, Physician stated if there was a large weight loss, staff should reweigh the resident. He stated he would like staff to inform him of significant losses.On 6/3/26 at 12:05 p.m., Staff T, Registered Nurse (RN) Case Manager stated if there was a 10 lbs. weight loss in one week, staff should contact the physician.On 6/3/26 at approximately 4:00 p.m., the Director of Nursing (DON) stated they reweighed the resident's wheelchair today and this was the reason for the weight discrepancy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy review, resident and staff interviews, the facility failed to maintain a homelike environment due to dry wall tape falling from the ceiling in the sunroom, drywall scuffed off in 2 residents' rooms and the heat baseboard coming off the wall leaving a large crack for 2 of 3 residents reviewed for homelike environment (Resident #8 and Resident #13). The facility reported a census of 95 residents. Findings include:1. During an observation on 5/26/26 at 12:18 PM, a piece of drywall tape hung from the ceiling in the facility sunroom; and the drywall had a wet spot with bubbling from water damage. This observation remained unchanged on 5/27/26 at 9:46 AM, 5/28/26 at 1:04 PM, and 6/1/26 at 4:39 PM. 2. Review of Resident #8's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition.During an observation on 5/26/26 at 4:01 PM, the drywall in Resident #8 room scuffed by her recliner with multiple scratches.During an interview on 5/26/26 at 4:01 PM, Resident #8 stated the drywall tape hanging in the sunroom was due to leaks when it rained. Resident #8 stated maintenance wanted to cut out the scuffed drywall in her room out and put up a hard plastic piece rather than replaster it. Resident #8 stated maintenance was supposed to fix it a few months ago and Resident #8 didn't know when they were going to do it. Resident #8 stated it bothered her the way the wall looked when she had visitors.During an observation on 6/1/26 at 4:37 PM, Resident #8 wall near her recliner is still scuffed and has drywall powder on the floor near the wall. 3. Review of Resident #13's MDS assessment dated [DATE] revealed a BIMS score of15 out of 15, which indicated intact cognition. During an interview on 5/28/26 at 8:13 AM, Resident #13 stated he hoped maintenance would fix his electric baseboard heater because it was falling off the wall. Resident #13 said he told maintenance a month ago and maintenance said they would get to it, but they haven't yet.During an observation on 5/28/26 at 10:15 AM, Resident #13 baseboard was coming off the wall and the paint above the baseboard scuffed off in an approximately 1-foot x 1-foot section.During an interview on 6/2/26 at 10:50 AM, the Maintenance Supervisor queried on the ceiling in the 300-400 hall and the Maintenance Supervisor stated the roof got replaced a month ago. The Maintenance Supervisor stated it was on his list and they would do in house to save money. The Maintenance Supervisor stated the ceiling needed fixed for 8 months but they needed to fix the roof first.During an interview on 6/2/26 at 10:50 AM, the Maintenance Supervisor stated the goal was to fix Resident #8 wall with a plastic peel and stick made out of vinyl and he still needed to order it. The Maintenance Supervisor stated Resident #8 had brought it to his attention a couple of times in the last couple of months ago.During an interview on 6/2/26 at 10:50 AM, the Maintenance Supervisor stated he was aware of Resident #13 heat register and it needed specialty order and needed to order it. The Maintenance Supervisor stated he knew about it for about the last 6 months. The Maintenance Supervisor had a lot going on and something fell down the list and were forgotten about for a while.During an interview on 6/2/26 at 6:17 PM, the Administrator queried about the drywall tape in the sunroom hanging and the Administrator stated she was not aware of the drywall tape hanging. The Administrator stated the roof got fixed and the facility had water damage but only the bubbling. The Administrator queried about Resident #8 wall and the Administrator stated she would look into it. The Administrator asked about Resident #13 heating register and she thought maintenance ordered one because the heating registers were custom and she would look into it. The Administrator queried on when repairs needed completed and the Administrator stated it depended if they needed a contractor, and repairs need done timely.Review of the facility policy titled Resident Environment-R/S (Rehab/Skilled) Policy dated 12/29/25 revealed the center will provide a safe, clean, comfortable and homelike environment that allows the resident use of some personal belongings to the extent possible. Resident rooms will be designed and equipped for adequate nursing care, safety and comfort, as well as the following: Housekeeping and maintenance services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to check incontinent residents and change as needed every 2 hours for 2 of 4 residents (Resident #11 and Resident #15) reviewed for incontinent care; and failed to perform morning oral hygiene for 1 of 3 residents (Resident #11) for residents reviewed for oral hygiene. The facility reported a census of 95 residents. Findings include: 1. Review of Resident #15's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 3 out of 15, which indicated a severe cognitive impairment. The MDS indicated Resident #15 dependent with toileting hygiene, required substantial/maximal assistance with toilet transfer, and always incontinent of urine and frequently incontinent of bowel. The diagnoses list included Alzheimer's disease, renal insufficiency, and anxiety disorder. The MDS indicated the resident took a diuretic (commonly known as a water pill, medication that helps the kidney flush excess salt and water). Review of Resident #15's Care Plan revised 3/23/23, revealed a Focus area to address resident had an ADL (Activity of Daily Living) self-care performance deficit related to dementia. Interventions included, in part: TRANSFER: Resident is stand aid with assist x 1, TOILET USE: Resident requires stand aid with assist x1. During a continuous observation on 6/2/26 at 6:01 AM, Resident #15 sat in the common area, in a recliner. At 8:45 AM, Staff B, Registered Nurse (RN) came over and administered his morning medications. At 9:36 AM, Resident #15 served his breakfast. At 9:48 AM, Staff G, Certified Nurse Aide (CNA) asked the resident if he was still eating his breakfast. At 10:00 AM, Staff B completed a dressing change on Resident #15 arm. At 10:29 AM, the State Agency (SA) asked Staff C, CNA when the staff would get Resident #8 up and the Staff C stated pretty quick. At 10:32 AM, Staff C asked Resident #15 if he was ready to get up and Resident #15 said yes. At 10:37 AM, Staff C took Resident #15 into the shower room and when resident was being placed on the toilet, Resident #15 incontinent brief was saturated. Resident #15 sat in the recliner for a total of 2 hours and 26 minutes. During an interview on 6/2/26 at 3:13 PM, Staff G, CNA asked about incontinence cares for Resident #15 and Staff G stated incontinence cares needed done every 2 hours. Staff G stated night shift said Resident #15 was up late so they didn't bother him until he was ready to get up. Staff G stated Resident #15 urinates large volumes. During an interview on 6/2/26 at 3:40 PM, Staff C, CNA queried on incontinence cares for Resident #15 and she stated every 2 hours. Staff C stated Resident #15 had been up late last night and sometimes get mad when asked, but today she didn't have any problems. Staff C stated Resident #15 won't tell you if he has to go to the bathroom, Staff C would just ask if he wanted to go to the bathroom. Staff C confirmed his incontinent brief was full. During an interview on 6/2/26 at 4:00 PM, Staff D, Licensed Practical Nurse (LPN) stated residents needed taken to the bathroom or checked and changed every time they got up or at least every 2 hours. During an interview on 6/2/26 at 5:25 PM, the Director of Nursing (DON) informed Resident #15 not asked or checked and changed for over 4 hours and the DON stated Resident #15 needed toileting (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every 2 hours and every 2 hours was the standard for the facility. 2. Review of Resident #11's MDS assessment tool dated 4/30/26, diagnoses listed included urinary incontinence, arthritis, and diabetes. The MDS listed the resident's BIMS score as 14 out of 15, which indicated intact cognition. The MDS indicated the resident dependent for toilet hygiene, and required substantial to maximal assistance with oral hygiene. The MDS also documented Resident #11 occasionally incontinent. Review of Resident #11 Care Plan dated 4/24/26 revealed the following: a. A Focus area to address the resident has bladder incontinence. Intervention: BRIEF USE: Resident uses incontinence products. Check & change before & after meals & HS (bedtime) & PRN (as needed). b. A Focus area to address The resident has an ADL self-care performance deficit r/t decrease mobility and spinal stenosis. Intervention included, in part: ORAL CARE: Resident has her own teeth. PERSONAL HYGIENE: Resident requires assist x 1. During observations on 6/1/26: At 8:32 AM, Resident #11 sat in her wheelchair while in the dining room. The resident remained in the dining room while she ate breakfast and the DON wheeled her out to the common area at 9:09 AM. Resident #11 remained in the common area until 9:42 AM when Staff O, Activities Assistant wheeled the resident to the chapel. Resident #11remained in the chapel until 11:03AM when Staff N, RN Case Manager wheeled her back to the common area. The resident remained in the common area until 11:18 AM when Staff K, CNA wheeled her to the dining room. The resident ate lunch and remained in the dining room until 12:25 PM. when Staff C, CNA asked her if she wanted to lie down and wheeled her out to the common area. At 12:29 PM, Staff C wheeled the resident into her room and she and Staff K, CNA transferred the resident to bed at 12:33 PM. The staff unfastened the resident's brief and it was heavily soaked with urine. Both sides of the resident's buttocks and the back of both of her thighs were covered with deep red indentations. Staff completed incontinence cares and applied a new incontinent brief. Continuous observation revealed staff did not offer to assist the resident to lie down or complete incontinence cares from 8:32 AM until 12:33 PM, a total of 4 hours and 1 minute. On 6/2/26 at 7:02 AM, Staff M CNA stated she would check the resident's incontinent brief because at times she was confused and staff needed to ask her if she needed assistance with incontinence cares. During an interview on 6/1/26 at approximately 12:40 PM, Resident #11 stated staff did not brush her teeth. Observations on 6/2/26 revealed at 6:40 AM, Resident #11 laid in bed. Staff L, CNA and Staff M, CNA changed the resident's clothes and transferred her into the wheelchair. Staff M combed the resident's hair and then wheeled her out of the room into the day room. Staff L and Staff M did not complete oral cares while they assisted the resident to get ready for the day. At 7:40 AM, a staff member wheeled the resident to the dining room where she remained until 9:33 AM, when a staff wheeled her back to the common area. At 9:37 AM, staff wheeled the resident into the therapy room. As of 9:37 AM, staff had not offered to assist the resident with oral cares. During an interview on 6/2/26 at 9:44 AM, Staff L, CNA stated that she did not brush the resident's (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	teeth today as she wasn't sure if she had real teeth or dentures. During an interview on 6/3/26 at 1:42 PM, Staff N, RN Case Manager stated staff should check and change Resident #11. Staff N explained that due to Resident #11 having had a stroke, she could not always recognize that she was wet. Staff N stated the resident was incontinent even prior to admission when she was in assisted living. She stated staff should toilet residents in between meals. Staff N stated staff should complete oral cares in the morning. During an interview on 6/3/26 at 2:34 PM, the DON stated staff should check and change residents every 2 hours. She stated staff should complete oral cares when they get up and before bed. Review of the facility policy Perineal Care, dated 7/30/25, stated the purpose of perineal cares included the prevention of infection and odors. The policy directed staff regarding the method of performing incontinence care but did not provide a frequency with which staff should carry this out. The facility policy Denture and Oral Care, Dental Health Assessment, Dental Services, dated 3/30/26, instructed staff to assist residents with oral hygiene if they could not complete it themselves.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and the facility policy, the facility failed to perform weekly skin observations for residents at risk of pressure ulcers and ensure a physician order in place prior to completing a wound dressing change for 2 of 5 residents (Resident #2 and Resident #15) reviewed for assessment and intervention. The facility reported a census of 95 residents. Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderately impaired cognition. The diagnoses list included depression, heart failure, repeated falls, and polyarthritis (arthritis in multiple locations). The assessment identified the resident at risk of pressure ulcer development. The MDS indicated Resident #2 without pressure ulcers, venous and arterial ulcers, or other wounds and skin issues. The MDS identified 9/27/25 as the admission date for Resident #2.Review of Resident #2's Care Plan dated 4/23/26 revealed a Focus area to address The resident has potential for pressure development r/t (related to) obesity, impaired mobility, incontinence of bladder. Interventions included, in part: Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc, noted during baths and daily care. During an observation on 5/26/26 at 11:28 AM, Resident #2 sat in his wheelchair next to the nurse's station in the 200 hall. Multiple bruises noted on his left arm, bandages on his knees and on his left elbow.A review of the electronic health record (EHR) revealed a Physician Order dated 5/3/36 to Review of EHR Physician Orders Dated 5/3/26- Cleanse open area to left buttock with wound cleaner soaked 4x4s, pat dry with clean 4x4s, apply triad paste and cover with a mepilex daily and PRN until healed- one time a day for open area AND every 1 hours as needed.Review of May 2026 N Adv Skin Check notes in the EHR revealed;a. Note dated 5/1/26 assessed: Skin Issues: #001.Location: Right outer wrist. Issue type: Puncture; #002: Location: Left Dorsum Left Hand. Issue type: Skin tear; #003: Location: Left Dorsum Left Hand. Issue type: Skin tear.b. Note dated 5/5/26 assessed: Skin Issues: #001.Location: Right outer wrist. Issue type: Puncture; #002: Location: Left Dorsum Left Hand. Issue type: Skin tear; #003: Location: Left Dorsum Left Hand. Issue type: Skin tear.c. Note dated 5/19/26 assessed: Skin Issues: #001.Location: Right outer wrist. Issue type: Puncture; #002: Location: Left Dorsum Left Hand. Issue type: Skin tear; #003: Location: Left Dorsum Left Hand. Issue type: Skin tear.During an interview on 6/2/26 at 2:21 PM, Staff B, Registered Nurse (RN) queried Resident #2 orders for the wound on his bottom and Staff B stated she thought it was healed, but didn't look at it today. Staff B explained the Assistant Director of Nursing (ADON) completed the skin assessments.During an interview on 6/2/26 at 6:08 PM, the ADON stated she did not do the weekly skin assessments, the floor nurses were supposed to. The ADON stated schedules placed in each med room for mornings and evenings to do. The ADON queried about Resident #2 order for a wound on his bottom but the skin assessment not addressing the wound and the ADON stated she didn't know why it was not addressed on the skin assessment unless Resident #2 had the wound prior to being at the facility.2. Review of Resident #15 MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, which indicated a severe cognitive impairment. The diagnoses listed included Alzheimer's dementia, renal insufficiency, and diabetes mellitus. Review of Resident #15 Care Plan dated 9/12/23 revealed a Focus area to address The resident has potential for pressure ulcer development r/t dementia. Interventions included, in part: Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc, noted during baths and daily care.During an observation on 6/2/26 at 10:00 AM, while Resident #15 sat in the common area Staff B, RN completed a dressing change on Resident #15 lower right arm. Review of the EHR Assessment page revealed the skin assessments, labeled V3 Skin Observation entered in 2026 on the following dates: 1/03/26, 1/10/26, 1/17/26, 1/25/26, 2/01/26, 2/08/26, and 2/15/26. Review of the EHR Physician Orders found no Physician Orders for wound care/dressing changes on Resident #15 right lower arm. During an interview on 6/2/26 at 2:21 PM, (continued on next page)

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	06/03/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B, RN queried about the dressing change for Resident #15 and Staff B stated she thought there was an order, and after Staff B reviewed Resident #15 chart, confirmed there was no order on the EHR. Staff B stated Resident #15 had a skin tear and she didn't know how it happened. Staff B stated the facility had a skin protocol, where they would put in the dressing change and the doctor would review and order it.During an interview on 6/2/26 at 4:00 PM, Staff D, Licensed Practical Nurse (LPN) queried on who did the skin assessments and Staff D stated they did them on the day shift. During an interview on 6/2/26 at 5:25 PM, the Director of Nursing queried on skin assessments, and the DON stated the skin assessments were done weekly. The DON stated the floor nurses were supposed to do the skin assessments. The DON stated residents had a skin protocol and staff followed the standing order and put the order in the chart. Review of the facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled Therapy and Rehab dated 3/30/26 revealed a Purpose section which declared: To systematically assess residents regarding risk of skin breakdown; To accurately document observations and assessments of residents; and To appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers.Review of the facility policy titled Physician/Practitioner Orders Policy dated 4/6/25, revealed, in part: Wounds: Orders must be obtained for wound care including product to be used, when to change and when to reassess. A licensed nurse must provide wound care.

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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 review, resident representative interview, and staff interviews, the facility failed to provide adequate supervision for 1 of 4 residents (Resident #2) reviewed for safety when staff left a resident with a history of falls unattended in the bathroom/shower room. The facility reported a census of 95 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #2 scored a 9 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderately impaired cognition. The MDS indicated Resident #2 utilized a manual wheelchair, required substantial/maximal assistance to roll right and left, lying to sitting on side on side of bed, and chair/bed-to-chair transfer. The diagnoses list included depression, heart failure, repeated falls, and polyarthritis (arthritis in multiple locations). The MDS indicated resident had 2 falls with no injury since the last assessment (01/01/26).A review SAFE Resident Event documents revealed in 2026 Resident #2 had falls on: 2/6/26, 2/8/26, 2/17/26, 2/26/26, 2/28/26, 3/13/26, 3/23/26, 3/28/26, 4/3/26, 4/7/26, 4/8/26, 4/27/26, 5/1/26, and 5/6/26. Review of Resident #2 Care Plan dated 5/11/26 revealed Focus areas to address:a. The resident is at risk for falls r/t (related to) poor safety awareness, noncompliant with asking for assist, falls are unavoidable, impaired balance. Res will put himself out on the floor. Res will use recliner remote to raise and fall floor on purpose. Interventions included, in part: Educate resident/family/IDT (interdisciplinary team) as to causes of fall. DO NOT LEAVE IN SHOWER HOUSE UNATTENDED. Date Initiated: 4/3/26.b. The resident has an ADL (activities of daily living) self-care performance deficit r/t impaired mobility. Interventions included, in part: BATHING: Resident requires reclining shower chair 1 x assist: cueing, etc. Date Initiated: 9/26/25. TOILET USE: Resident requires (1x staff assist, cueing, etc). Date Initiated: 9/26/25.During an interview on 5/28/26 at 2:03 PM, resident representative stated Resident #2 left in the shower room alone and he tried to stand up and fell and staff should have stayed in the shower room with him. Resident Representative stated Resident #2 thinks he can stand, but he can't. Review of document titled SAFE Resident Event revealed, in part: Resident Name: [Name redacted, Resident #2]. Date: 4/3/26. Location of Event: Public Bathroom. Description of Event: This nurse overheard yelling from 400 hall shower room. [Name redacted] medication aide opened the door resident observed to be laying on the floor in front of toilet on right side. Resident yelling Get me off of this god damn floor. Stand aid next to resident Residents pants appeared to be up and BM on sink next to toilet. Full ROM noted. No injuries noted. Resident assisted x3 from floor to WC. Resident brought into common area resident yelling I'm gonna throw myself on the god damn floor. Increased behaviors noted this AM. Resident yelling at staff. Describe the immediate intervention: Resident not to be left alone in shower room. Was there an injury of unknown origin: Not at this time. Type of Injury: No Injury Noted.During an interview on 6/1/26 at 4:59 PM, Staff A, CNA asked if she ever been with him when Resident #2 had a fall and Staff A stated on the 400 hall Resident #2 fell in the shower room. Staff A stated someone put the stand aide in front of him and locked it and went to get a brief, and Staff A didn't realize they left him alone. Staff A stated she knew not to leave Resident #2 alone and to keep Resident #2 where you can see him. Staff A stated she opened the door to the shower room and Resident #2 had pushed the stand aide out of the way and fell on the floor.During an interview on 6/2/26 at 2:21 PM, Staff B, Registered Nurse (RN)asked if ever here when Resident #2 fall in the shower room and Staff B stated no. Staff B stated she heard about it happening and heard it a couple of different ways, but if the stand aide was locked in front of the resident and they try to get up, that creates a safety barrier because they can get hung up on the stand.During an interview on 6/2/26 at 4:16 PM, Staff E, Licensed Practical Nurse (LPN) queried on leaving Resident #2 in the bathroom alone and Staff E stated no, Resident #2 shouldn't be left unattended at this point. Staff E asked if a resident with a BIMS of 9 should be left alone in the bathroom and Staff E stated no.During an (continued on next page)

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	06/03/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 6/2/26 at 5:25 PM, the Director of Nursing (DON) queried on Resident #2 fall on 4/3/26 and the DON stated she would have to review his chart because the DON didn't think Resident #2 was ever left alone in the shower room. The DON stated some days Resident #2 had good days and other days forgetful and it would depend on the day he was having. The DON stated with that being said, just knowing Resident #2, the DON would yell out for a brief and that was what staff usually did.Review of a facility policy titled Fall Prevention and Management Policy dated 6/2/26 included a Purpose section which declared, in part: To identify risk factors and implement interventions before a fall occurs. The Proactive Approach before a Fall Occurs section directed, in part: Care Plan the appropriate interventions, including personalizing all (SPECIFY)' areas.

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	165211	A. Building B. Wing	06/03/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review and staff interview, the facility failed to ensure residents received ordered medications for 2 of 5 residents reviewed for the provision of medications(Residents #1 and #8). The facility reported a census of 95 residents.Findings included: 1. The Minimum Data Set (MDS) assessment tool for Resident #1, dated 2/18/26, list diagnoses included pain, cancer, and constipation. The Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicated intact cognition. The MDS identified 2/12/26 as the admission date for Resident #1. Review of a hospital Active Outpatient Medications dated 2/10/26 list documented an active order for buprenorphine (a potent, long-acting narcotic pain medication) 7.5 micrograms (mcg)/hour (hr) 1 patch to the skin every 7 days. Review of an eAdmin Record noted entered in the electronic health record (EHR) on 2/16/26 at 7:58 PM revealed the buprenorphine patch did not arrive from the pharmacy. Review of a History and Physical dated 2/17/26 revealed, in part: Assessment: Cholangiocarcinoma, currently on hospice care. Cancer-related pain. Plan:.continue Butrans (buprenorphine) patch 7.5 mcg per hour, changed weekly. The February 2026 Medication Administration Record (MAR) listed a 2/13/26 order for buprenorphine patch 7.5 mcg/hr one time per day every 7 days for 7 days. The 2/13/26 entry contained the numeral 4 to indicate the medication was not available. The February 2026 MAR lacked documentation the resident received the medication during the month of February 2026. Review of the March 2026 MAR did not include an order for the buprenorphine patch and lacked documentation the resident received the medication during the month of March 2026. During an interview on 6/2/26 at 12:41 p.m., the Director of Nursing (DON) stated the resident's buprenorphine was put into the computer incorrectly for only 7 days instead of every 7 days. During an interview on 6/3/26 at 2:52 p.m., Staff Q Lead Administrative Assistant [company name redacted] Hospice Agency stated the only reason she knew that the resident did not receive his patch was because the hospital called and informed them (after he discharged). Staff Q stated she then spoke to a couple of facility nurses and found out he didn't get the patch he was supposed to. On 6/3/26 at 1:42 p.m., Staff N Registered Nurse (RN) Case Manager stated she erred when she input the resident's patch into the computer. She stated though that the nurses should confirm the orders once placed into the computer. 2. The MDS dated [DATE] revealed Resident #8 scored a 15 out of 15 on BIMS exam, which indicated cognition intact. The MDS revealed medical diagnosis for chronic obstructive pulmonary disease (often referred to as COPD, a chronic respiratory condition that makes breathing difficult) with acute exacerbation. The Care Plan revealed a focus area dated 2/3/26 for shortness of breath related to COPD. (continued on next page)

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	165211	A. Building B. Wing	06/03/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EHR revealed a Physician Order for Trelegy Ellipta Inhalation powder breath activated 100-62/5-25 mcg/act (micrograms per actuation) The Review of the April 2026 MAR revealed resident's Trelegy Ellipta Inhalation powder breath activated was not available for 4 days (April 4th-April 7th). Review of the EHR revealed the following eAdmin Record notes: a. Dated 4/4/26 at 9:07 AM, revealed Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT- 1 inhalation inhale orally in the morning. Ordered from pharmacy. b. Dated 4/5/26 at 8:28 AM, revealed Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT1 inhalation inhale orally in the morning.Ordered from pharmacy During an interview on 6/2/26 at 1:33 PM, Staff P, Pharmacy Technician asked when a refill made for Resident #8 Trelegy and Staff P stated the first fax the pharmacy received from the facility was on 4/7/26. Staff P stated the pharmacy received 2 faxes that day for the Trelegy one on 4/7/26 at 9:53 AM and the other one on 4/7/26 at 10:01 AM. During an interview on 6/2/26 at 4:16 PM, Staff E, Licensed Practical Nurse (LPN) queried on the process of reordering an inhaler and Staff E stated the inhalers usually had meters and showed when they got low and when the inhaler at 8,9, or 10. Staff E confirmed they faxed the pharmacy for refills and pharmacy was usually pretty good about refilling medications. During an interview on 6/2/26 at 5:25 PM, the DON asked about Resident #8 Trelegy inhaler being out for 4 days and the DON stated the pharmacy usually pretty good about refilling medication and Resident #8 inhaler might of been delayed because of the cost and would need to look into that. Per an email exchange 6/3/26 at 12:02 PM, the State Agency (SA) asked the DON about the process when a resident's medications runs low. At 12:23 PM, the DON responded It gets reordered. Review of the facility policy titled Local Pharmacy Medication Ordering Policy dated 8/29/25 revealed the following: a. If the medication is not available in the emergency/contingency kit and the pharmacy has not delivered the drug by the scheduled med pass time, call the pharmacy, and speak to a pharmacist to determine why the medication was not delivered. Document details in EMR. b. If the medication is not available, notify the ordering physician immediately to determine whether the order should be changed or starting the medication can wait until the medication is available from the pharmacy. Document in the PN – Communication with Pharmacy or PN – Communication/Visit with Physician/EMR as appropriate. c. Please follow the procedures in the local pharmacy's procedure manual, if available, from your local pharmacy for routine ordering and reordering. Note: Remember, if you wait to re-order a medication until you are out, you need to communicate to the pharmacy that you are out of the medication. Review of the facility policy titled Facility Physician/Practitioner Orders Policy dated 4/6/25 revealed, in part: Following Hospitalization: When a resident returns from the hospital, (continued on next page)

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	165211	A. Building B. Wing	06/03/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician/practitioner orders must be updated to reflect the resident's current needs. Drug regimen review is required following any return from hospital.

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	165211	A. Building B. Wing	06/03/2026

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, menu review, facility policy review, resident representative and staff interviews, the facility failed to follow the breakfast menu when fruit was not served for 2 of 2 breakfast meals. The facility reported a census of 95 residents. Findings include: Review of the breakfast menu for 5/28/26 revealed the meal to be served included french toast, sausage patty, mixed fruit cup, choice of hot or cold cereal, assorted juice, milk/beverageDuring an observation on 5/28/26 at 6:57 AM, Staff H, Dietary [NAME] conducted the pre temperatures for breakfast service. All the hot foods, milk, and juice temped for service. No fruit cup observed.During an interview on 5/28/26 at 9:10 AM, Staff H queried about the fruit cup and Staff H stated they put the fruit in dishes and she didn't know it wasn't done. Staff H stated the fruit usually came out of the can and put into dishes and she didn't know what happened. During an interview on 5/28/26 at 2:03 PM, Resident #2 resident representative stated the residents didn't always get fruit and vegetables with meals.During an observation 6/1/26 at 9:00 AM, residents ate in the dining room. No fruit cups observed in front of residents in the dining room.Review of the breakfast menu for 6/1/26 revealed the meal to be served included ancakes, bacon, mixed fruit cup, choice of hot/cold cereal, assorted juice, and milk/beverage.During an interview on 6/1/26 at 9:15 AM, Dietary Manager queried if fruit cups offered and the Dietary Manager asked Staff I, Dietary Aide if she gave fruit. Staff I stated she didn't know they had it and no one asked for it. The Dietary Manager stated they usually offered it, and it was stored in the back.During an interview on 6/2/26 at 1:00 PM, Staff I, Dietary Aide stated she told the residents in the dining room what they were having and if fruit on the menu it was dished up in the tulip dishes ready to go. Staff I stated she didn't see fruit on any of the room trays and the 100 hall didn't take fruit up.During an interview on 6/2/26 at 1:04 PM, the Dietary Manager informed of the 2 breakfast meals that did not serve fruit as indicated on the menu and the Dietary Manager stated she worked in the kitchen this week, so she knew what was being dished up. The Dietary Manager stated they usually had fruit on the cart every morning. The Dietary Manager stated she would start watching more.During an interview on 6/2/26 at 6:17 PM, the Administrator informed of the 2 breakfasts without fruit cups offered and the Administrator stated the facility should follow the menu or offer a substitution.Review of the facility policy titled, Menu Requirements- Food and Nutrition Services dated 11/18/25 revealed menus were prepared to meet the balanced nutritional needs of the residents in accordance with established national standards.

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	165211	A. Building B. Wing	06/03/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident representative interview, resident interview, staff interviews, and the facility policy, the facility failed to maintain appropriate food temperatures for a breakfast room tray. The facility reported a census of 95 residents. Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 scored a 15 out of 15 on the Brief Interview for Mental Status, which indicated cognition intact. During an interview on 5/26/26 at 4:01 PM, Resident #8 when asked about the food at the facility stated she didn't like the food. Resident #8 explained sometimes the food was hot and the meat can be cold on the outside and warm on the inside. Resident #8 stated the meat could partially cooked, or partially frozen. Review of the breakfast menu for 5/28/26 revealed the meal to be served included french toast, sausage patty, mixed fruit cup, choice of hot or cold cereal, assorted juice, milk/beverageDuring an observation on 5/28/26 at 6:57 AM, Staff H, Dietary [NAME] conducted the pre temperatures before breakfast service and received the following temperatures: a. French toast- 164.1 F (degrees in Fahrenheit)b. Sausage 196.1 Fc. Cream of wheat- 180.1 FDuring an observation on 5/28/26 at 8:46 AM, Staff H, Dietary [NAME] prepared the last room tray, which had a mechanical texture. At 8:50 AM, the cart prepared with one room tray and a test tray for the State Agency (SA) and waiting to be picked up by a staff. At 8:53 AM, the Dietary Manager took the cart with the room tray to the 400 Hall. At 8:55 AM, temperatures taken for the food items on the SA test tray. Temperatures completed by a staff member, with the following results: a. Cream of Wheat- 130.2 Fb. French toast - 113.1 Fc. Sausage link- 131.2 FAt 8:57 AM, the SA taste-tested the Cream of Wheat, sausage and French toast. The Cream of Wheat and sausage tasted warm, while the French toast tasted lukewarm.During an interview on 5/28/26 at 2:03 PM, Resident #2 resident representative stated the food was terrible and it was usually cold if the residents stayed in their room.During an interview on 6/2/26 at 1:04 PM, the Dietary Manager informed of the temperatures on the test tray and the Dietary Manager stated all the temperatures were low. The Dietary Manager stated she didn't know what she was going to do, the French toast sticks cool so fast and she even took the cart back to the unit. The Dietary Manager stated that was something she would have to figure out and the temperatures shouldn't be below 140 degreesDuring an interview on 6/2/26 at 6:17 PM, the Administrator informed of the test tray for breakfast temperature and the Administrator stated they temped to low, and stated we will have to look into it. Review of the facility policy titled Food Temperature Monitoring-Food and Nutrition Services revised on 3/23/26 revealed, in part:a. TCS (Temperature Control for Safety) hot foods should be served at 135 degrees Fahrenheit or higher. b. Test tray monitoring occurs as a part of quality assurance monitoring to ensure temperatures are acceptable when the location uses room trays or satellite dining rooms. Temperatures for test trays are based on proper serving temperature not tray line holding temperatures based on food safety.

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	06/03/2026

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, the resident council notes, and the facility policy, the facility failed to routinely offer fresh water to residents for extended amounts of time for 2 of 4 residents (Resident #15 and Resident #11) reviewed for hydration. The facility reported a census of 95 residents. Findings include: 1. The Resident Council Meeting Notes dated 4/21/26 revealed no fresh ice water, and fresh water at nights is an issue. The Resident Council Meeting Notes dated 5/19/26 revealed ice water was better than it was, not every day. During a continuous observation on 6/2/26 at 6:01 AM to 10:37 AM, no water pass completed on the 200 Hall. Multiple residents sat in the common area, in their wheelchairs with no tables within reaching distance. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 scored a 3 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated that cognition severely impaired. The MDS indicated the resident needed set up/clean up assistance with eating. The diagnoses list included Alzheimer's dementia, renal insufficiency, and diabetes mellitus. The MDS indicated resident took a diuretic, antidepressant, and antipsychotic. The Task Intake (for fluids outside of meals) for Resident #15 revealed no data found for type of fluid (do not include supplements) for the last 30 days. During a continuous observation on 6/2/26 from 6:01 AM to 10:35 AM, fluid not readily available to Resident #15 while he sat in the recliner in the common area. A table was not placed near the resident. Resident given fluids during medication administration and breakfast. During an interview on 6/1/26 at 4:59 PM, Staff A, Certified Nurse Aide (CNA), stated during the day shift, water pass was hard to get to, but the evening shift CNAs did it. Staff A stated some of the residents will ask for water and the staff used a pitcher on the medication cart. Staff A stated if the staff passed water to the rooms, the water would not be cold when they went back to their rooms anyway. Staff A stated Resident #11 and Resident #15 should have been given fresh water. During an interview on 6/2/26 at 2:21 PM, Staff B, Registered Nurse (RN) asked about water pass and Staff B stated the evening CNAs did it. Staff B stated a lot of the residents couldn't have it independently so she gave it from the medication cart. During an interview on 6/2/26 at 3:40 PM, Staff C, CNA, queried on water pass and Staff C stated they were supposed to do water pass, but quite a few days the staff didn't have time to do water pass. During an interview on 6/2/26 at 5:25 PM, the Director of Nursing (DON) queried on water pass and she stated once a shift water should be passed and with the residents in the 200 hall, a pitcher should be set beside them in the common area and the staff should try to push as much fluids as they can. (continued on next page)

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	06/03/2026

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

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated the elderly don't drink unless you give it to them. 3. The MDS assessment tool, dated 4/30/26, listed diagnoses for Resident #11 which included urinary incontinence, arthritis, and diabetes. The MDS stated the resident was occasionally incontinent of urine and required the assistance of 1 staff for toileting hygiene. The MDS listed the resident's BIMS score as 14 out of 15, indicating intact cognition. Observations on 6/1/26 revealed the following: At 8:32 AM, Resident #11 sat in her wheelchair in the dining room. The resident remained in the dining room while she ate breakfast and the DON wheeled her out to the common area at 9:09 AM. The resident remained in the common area until 9:42 AM when Staff O, Activities Assistant wheeled the resident to the chapel. The resident remained in the chapel until 11:03 AM. when Staff N, RN Case Manager wheeled her back to the common area. The resident remained in the common area until 11:18 AM when Staff K, CNA wheeled her to the dining room. During this observation staff did not offer the resident fluids from 9:09 AM. until 11:18 AM On 6/2/26 at 2:18 PM, Staff R, CNA stated staff usually passed water each shift. She stated on the day shift they tried to pass water after breakfast. She stated there were definitely days this was not completed due to staff being too busy. On 6/3/26 at 2:34 PM, the DON stated staff were assigned each shift to distribute fresh water and this was listed on the schedule. Review of the facility policy titled Nutrition and Hydration-Food and Nutrition Policy dated 4/27/26, Hydration section revealed, in part: 2. Offer sufficient fluid intake to maintain proper hydration and health. a. A goal of 1,500 mls (milliliters) of liquids per day is often recommended. Estimated fluid needs may vary depending on each individual resident. 3. Employees will monitor residents' intake of drinks and other fluids at meals through observation, offer alternative fluids and make changes as necessary. Fluids at meals may be recorded in [brand name redacted, electronic health record] per location process. 4. Fresh water will be available to the residents at bedside unless contraindicated.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, staff interviews, and the facility policy, the facility failed to maintain appropriate infection control practices during medication administration when staff handled pills with bare hands for 3 of 3 residents (Resident #2, Resident #10 and Resident #15), failed to perform hand hygiene after glove removal, and failed to ensure hairbrushes were used for a single resident, and failed to cover and label toothbrushing supplies stored in a common bathroom. The facility reported a census of 95 residents. Findings include:1. During an observation on 5/27/26 at 4:24 PM, a CNA (Certified Nurse Aide) used the same hairbrush in the common area in the 200 Hall on 3 different residents. Then at 4:26 PM, the CNA brushed another resident's hair with the same hairbrush. During an observation on 6/1/26 at 9:11 AM, two hairbrushes (one pink and one teal wet brush) sat on the ledge in the common area in the 200 Hall. During an interview on 6/1/26 at 4:59 PM, Staff A, CNA queried on using the same hairbrush for the residents and Staff A stated yes, the hairbrushes were for communal use. Staff A stated she knew they shouldn't use them for multiple residents.During an interview on 6/2/26 at 3:40 PM, Staff C, CNA queried on the hairbrushes used on multiple residents and she stated when they used single hairbrushes, staff couldn't find them in their room. Staff C stated if they had a designated area, the facility could have one brush for everyone. During an interview on 6/2/26 at 5:25 PM, the Director of Nursing (DON) queried on using the same hairbrush for multiple residents and she stated each resident should have their own hairbrush. 2. On 6/2/26 at 9:51 AM, in the common bathroom (the use of common bathroom is meant to describe a larger bathroom with a shower on the 200 hall that is available to all residents with a room on the hallway) observed multiple resident denture cups and multiple gray basins with toothbrushes/toothpaste tubes on a cart. The toothpaste and toothbrushes in the gray basins were not covered, or labeled to identify which basin belonged to which resident. During an interview on 6/2/26 at 3:13 PM, Staff G, CNA asked where the residents toothbrushes and toothpaste stored and she stated the dentures and toothpaste were in the common bathroom and the staff had a cart with the denture cups and toothpaste/toothbrush. Staff G stated she took the resident's supplies to their rooms in the morning to get them ready. During an interview on 6/2/26 at 3:40 PM, Staff C, CNA queried where the residents toothbrushes and toothpaste stored and she stated the staff left some of the residents' products in the common bathroom. Staff C stated they left the dentures in the common area so when they bring the residents down the hall, they can do their dentures. During an interview on 6/2/26 at 5:25 PM, the DON queried on storing the toothbrushes and toothpaste in the common bathroom and the DON stated the common bathroom was bigger and the DON not sure how the staff stored the items. The DON stated the items could be stored in the common bathroom if covered, labeled, secured from someone else, and where splashes couldn't get on their personal belongings. 3. During an observation on 6/2/26 at 6:34 AM, Staff B, Registered Nurse (RN) prepared Resident #10's medications. Staff B poured pills into the lid of the medication bottle and picked out the extra pills that fell in the lid with her ungloved finger and then put the extra pill back into the bottle. When Staff B popped the pills from the bubble packs, Staff B used her ungloved fingers to guide the pills into the medication cups. After Staff B finished preparing the pills, Staff B walked over to Resident #10 and administered the medications.4. Review of electronic health record revealed Resident #15 had Physician Orders for:a. Lantus Solostar (long acting insulin) subcutaneous solution pen-injector 100 unit/ml (milliliters)- Inject 60 unitsb. Accu check (measure blood sugar) twice a dayc. Vitamin D3 tablet 25 mcg (micrograms)During an observation on 6/2/26 at 8:15 AM, Staff B, RN prepared Resident #15 morning medications. Staff B cleaned off the bedside table, removed gloves and placed a barrier on the bedside table. Staff B placed new gloves, alcohol pads, and medication cups on the barrier. She then took keys out of her pocket and without completing hand hygiene started to prepare the medications. Staff B popped Resident #15 medications out of the bubble packs, and primed an insulin pen. Staff B then took a bottle of Vitamin D3 25 mcg from the medication cart, opened it and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dropped 2pills into the lid of the bottle. Staff B touched one pill with an ungloved finger and dropped it into the medication cup and put the second pill back into the bottle. During an observation on 6/2/26 at 8:23 AM, without completing hand hygiene or putting on gloves, Staff B, RN walked over to Resident #15 and re-positioned him in the electric recliner, prepared a cup of water, and then applied gloves (without first completing hand hygiene). Staff B used a lancet on the resident's right ring finger to measure blood glucose. Staff B unable to obtain an adequate blood droplet. Without a change of gloves or completing hand hygiene, she obtained a new lancet from the medication cart and again poked Resident 15's finger. Staff B wiped away the first drop of blood and then used the glucometer to get a blood sugar reading. Without a change of gloves or hand hygiene, Staff B picked up the medication cup and placed it to the resident's mouth. Staff B removed gloves, and without completing hand hygiene gave Resident #15 a Boost drink. Staff B then picked up the used supplies and threw them in the trash. Without completing hand hygiene, Staff B put on new gloves, opened the window blinds and proceeded to administer an injection of insulin in Resident #15 right arm. Staff B applied new glove and cleaned the accu-check machine before placing it back in the cart. 5. Review of electronic health record revealed Resident #2 had Physician Orders for, in part:a. Tylenol (acetaminophen) oral tablet 650 mg (milligrams) - give 650 mg (1 tab or 2 tabs of 325 mg) by mouth three times a day. b. Magnesium Oxide oral tablet 400 mg - give 400 mg by mouth in the morning.During an observation on 6/2/26 at 8:59 AM, Staff B, RN prepared Resident #2 medications. Staff B popped several medications from bubble packs into a medication cup. She then pulled a bottle of acetaminophen 325 mg tablets from a med cart drawer, opened the bottle and dropped 4 pills into the lid. Staff B held her ungloved finger on two pills, dropped the other 2 pills into med cup and put the other 2 pills back into the bottle. After Staff B popped several more medications from bubble packs into the med cup, she took a bottle of magnesium oxide 400 mg from the med cart, opened it and dropped 2 pills into the lid of the bottle. Staff B held one pill in her ungloved fingers, dropped the 2nd pill back into the bottle and placed the 1st pill in the med cup. Staff B popped the remaining medications out of bubble packs into the med cup, and then administered the medications to Resident #2. During an interview on 6/2/26 at 2:21 PM. Staff B, RN queried on touching the pills during medication administration and Staff B stated she would guide the pills with her fingers into the medication cup because Staff B wasn't very good at getting the pills from the bubble packs into the cups. Staff B stated she didn't directly touch the pills until 6 Tylenol tablets come out of the bottle. Staff B asked about glove use and Staff B stated use hand sanitizer after removing gloves. Staff queried on Resident #15 medication administration and Staff B stated if it was all the same resident she did not use hand sanitizer in between glove use. During an interview on 6/2/26 at 5:25 PM, the DON asked about touching the pills during medication administration and the DON stated the staff should not touch the pills. The DON confirmed staff should sanitize after removing gloves. Review of the facility policy titled Hand Hygiene Policy dated 11/13/25 directed staff to complete hand hygiene after glove removal.