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	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Ottumwa	2035 West 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** 46513 Based on observation, staff interviews, and policy review, the facility failed to ensure dignity to residents in the main dining room. Resident with soiled shirt of spilt drink and processed food propelled self near other residents eating thorough the dining area (Resident #71). The facility reported a census of 111 residents. Findings include: The Minimum Data Assessment (MDS) assessment dated [DATE] revealed Resident #71 scored 00 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition was severely impaired. Diagnoses included non-traumatic brain dysfunction, Alzheimer's disease, dysphagia (indicates difficulty swallowing) and pain. The MDS revealed resident required supervision or touching assistance with eating and required a mechanically altered diet. The Care Plan revealed a focus area initiated 5/31/24 for ADL (Activities of Daily Living) self care performance deficit related to Alzheimer's disease. The intervention dated 5/31/24 revealed resident required assistance of one. The intervention dated 9/15/24 revealed Resident #71 wore a food protector at meals to protect clothing per family request. During an observation on 10/9/24 at 5:20 PM in the main dining room, the dining room filled with residents enjoying dinner meal. Resident #71 eating independently, spilled liquid down his shirt and had pureed food going down his shirt with food in residents beard as well, began to exit self in his wheelchair through the dining room. In an interview on 10/9/24 at 5:22 PM with Certified Nursing Assistant, (CNA) Staff C stated the resident usually does wear a clothing protector, they are no longer available in the dining room. Stock is normally in another hall and there are not many. A staff must remember to bring it with the resident. Relayed resident wants to try to feed himself. In an interview on 10/9/24 at 5:24 PM with the Director of Nurses, (DON) relayed we have done away with using clothing protectors, only use if family wants them and the family would have to provide them. Relayed would reach out to the family. (continued on next page)

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	Policy provided titled Resident Dignity-Rehab, Skilled revised 11/16/23 documented would promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality.

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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 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** 46513 Based on staff interviews, electronic record review, Iowa Physician Orders for Scope of Treatment (IPOST) form, and facility polic review the facility failed to ensure consistent documentation of code status for 1 of 32 resident reviewed for advanced directives (Resident #67). The facility reported a census of 111 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #67 medical diagnoses for Parkinson's disease, respiratory disease and scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The Care Plan revealed a focus initiated [DATE] for the resident, relayed had a terminal prognosis related to cancer and directed staff to review resident's advance care planning choices and assist other to respect choices. A document titled Iowa Physician Orders for Scope of Treatment IPOST dated [DATE] for Resident #67 was located at the nurse's station to review in the event of an emergency and indicated to complete Cardiopulmonary Resuscitation (CPR) in the event the resident has no pulse and is not breathing. The form was signed by the resident only. Electronic Clinical Resident Profile Record, dated [DATE] for Resident #67 directed, Do Not Resuscitate (DNR). In an interview on [DATE] at 5:00 PM the Director of Nurses, (DON) acknowledged the discrepancy between two forms and relayed there should not be conflicted information to ensure appropriate resident end of life choice. In an interview on [DATE] at 5:07 PM Registered Nurse (RN) Staff D relayed she had completed the IPOST form incorrectly and per resident #67 choice should have marked DNR before asking the resident to sign. Staff D relayed she would ensure a correct form completed immediately for the physician to sign. Policy titled, Advance Care Planning revised [DATE] documented Residents, and their decision makers have the right to make decisions concerning medical care, included right to accept or refuse.

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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 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** 46513 Based on observations, clinical record review, staff interviews and policy review the facility failed to provide eating assist to maintain good nutrition to 1 of 3 residents reviewed (Resident #67). The facility reported a census of 111 residents. Findings include: The MDS assessment dated [DATE] revealed Resident #67 medical diagnoses included Parkinson's disease and respiratory disease. A BIMS score of 13 out of 15 indicated cognition intact. The Care Plan revealed a focus initiated at admit 8/27/24 for resident #67 titled, Eating. Interventions noted, resident required hand over hand guidance, reminding, prompting and cueing. Electronic record revealed admit weight on 9/4/24 weighed 198.8 pounds and on 10/2/24 weighed 182.8 pounds, an 8.75% weight loss. Progress notes revealed Registered Dietician (RD) note dated 8/30/24, observed him eating and cannot hold silverware, needs assistance, discussed with resident #67 and he would like that. Telephone interview on 10/11/24 at 10:02 AM with the RD, confirmed resident needed assistance with meals. Relayed monthly follow up planned this week on weights and new interventions would be addressed. Continuous observation on 10/9/24, 8:05 AM to 9:02 AM, breakfast, Resident # 67 sat in his wheelchair at a table in the main dining room. 8:19 AM plate of scrambled eggs and a donut delivered to resident table 8:24 AM Staff fed 4 bites to resident on a fork and moved away to another resident. 8:27 AM Resident food fell off the fork several times as attempted to get into mouth, observed slow movements and hand tremors as attempted to eat. 8:30 AM Staff returned, fed two bites and offered drink then moved away to other residents 8:33 AM Resident continued to eat independently, dropped food on his lap before getting to the mouth, spilled juice on shirt when attempted to drink. 9:02 AM staff approached voiced to Resident #67, needed a new shirt that one is dirty, was assisted via wheelchair from the dining room, observed few bites of donut still on the plate. Continuous observation on 10/9/24, 11:50 AM to 12:40 PM, lunch, Resident # 67 sat in his wheelchair at a table in the main dining room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:30 PM Resident picking up cup, slow and unsteady hand with tremor. Following resident attempted repeatedly to get food into his mouth with the fork, dropped food at times onto his lap. No feeding assistance was offered to Resident #67 during the entire lunch meal. Continuous observation on 10/9/24, 4:20 PM to 5:20 PM, dinner, Resident # 67 sat in his wheelchair at a table in the main dining room. 4:20 PM resident sat at table awaiting drinks and food 4:30 PM observed with difficulty bringing cup to mouth, slow and unsteady with hand tremor 5:07 PM resident attempted independently to bring food to mouth, sat in wheel chair approximately a foot from the table, spilled food off the fork as brought to the mouth 5:17 PM attempted to get food off pants with a fork. No feeding assistance was offered to Resident #67 during the entire supper meal Policy titled, Nutrition and Hydration, Food and Nutrition, revised 4/1/24 documented, to routinely assess resident's nutritional status and monitor nutritional risk. Identify a resident at nutritional risk and address risk factors for impaired nutritional status to the extent possible including, but not limited to diet order, also included, disease processes, functional ability. To provide nutritional care and services to each resident, consistent with the resident's comprehensive assessments and periodic reassessments. Policy included to identify, implement, monitor and modify interventions, as appropriate, consistent with the resident's assessed needs, choices, preferences, goals and current professional standards of practice to maintain acceptable parameters of nutritional status.

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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** 46513 Based on observations, clinical record review, staff interviews, and policy review, the facility failed to assist with scheduled repositioning, and toileting for a resident with impaired skin and a pressure ulcer risk for 1 of 3 residents observed for skin concerns (Resident #81). The facility reported a census of 111 residents. Findings include: The Minimum Data Assessment (MDS) assessment dated [DATE] revealed Resident #81 diagnoses included Alzheimer's disease, dementia, urinary tract infection (UTI), pain, and cellulitis of buttocks. Resident required substantial, maximal assistance with transfers and sit to stand, had moisture associated skin damage. Resident #81 required pressure reducing devices for the wheelchair and the bed, a turning/repositioning program to manage skin problems. The Brief Interview for Mental Status (BIMS) exam scored 6 out of 15, which indicated cognition severely impaired. The Care Plan revealed a focus area revised 9/13/24 included potential of pressure ulcer development related to immobility and abscess. The interventions included to turn, reposition at least every two hours. The care plan relayed resident had bladder incontinence related to confusion. During a continuous observation on 10/8/24 at 8:50 AM to 11:05 AM (2 hours and 15 minutes), Resident #81 sat on in a recliner, lying on back side, was not assisted with repositioning or toileted. During a continuous observation on 10/9/24 at 9:15 AM to 11:40 AM (2 hours and 25 minutes) Resident #81 sat in a recliner, lying on back side, staff did not approach, did not assist her with repositioning or toileting. During an observation on 10/09/24 at 12:53 PM, Staff B, CNA (Certified Nurse Aide) assisted resident for toileting per the surveyor's request. The resident's briefs taken off, observed entire buttocks reddened, excoriated, peeling skin on the buttocks and upper inner thighs with scant amount of reddish drainage in various places of buttocks and on the removed brief. Staff B acknowledged the resident had not been toileted for hours. During an interview and toileting observation on 10/9/24 at 12:58 PM, Staff B commented, Resident #81 buttocks was so bad. During an interview on 10/09/24 at 10:15 AM, the Director of Nursing (DON), reported it was her expectation that the interventions implemented be followed for those at risk for pressure ulcers, included repositioning, toileting, protective equipment and skin care. Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24 documented: 6. Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches.

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F 0689 Level of Harm - 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** 35434 Based on observation, clinical record review, policy review, and staff and resident interviews, the facility failed to provide adequate supervision or provide timely care in order to prevent a fall with major injury. The facility also failed to implement new interventions to reduce falls from the wheelchair for 1 of 3 residents reviewed (Resident #2) for falls. The facility failed to ensure safe wheelchair transport and proper use of foot pedals during a general observation of Resident #67. The facility reported a census of 111. Findings: 1. The Minimum Data Set (MDS) assessment tool, dated 8/5/24, listed diagnoses for Resident #2 which included intellectual disabilities, seizure disorder, and pain. The MDS stated the resident was dependent on staff for chair to bed transfers, shower transfers, and toilet transfers. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 8 out of 15, indicating moderately impaired cognition. The Slipped or fell report dated 8/11/24 at 11:00 am documented staff getting residents up for lunch when a resident yelled out that someone was on the floor. Resident #2 found on the floor face flat on the floor. Resident stated the wheelchair hurts her back and when asked how she fell she stated from the side of the wheelchair. The Care Plan initiated 5/10/2016 documented the resident is at risk for falls related to debility, impaired mobility, seizures and intellectual disability. The Care Plan documented a goal that the resident will not sustain serious injury through the review date. On 8/11/24 the Care Plan was updated with an entry directing staff to ensure the resident was in a proper sitting position in her wheelchair with her hips and back secured in the back of the chair and in good alignment with foot pedals on her chair. An 8/18/24 Mood/Behavior note stated the resident leaned forward in her wheelchair. The resident was very close to falling forward out of her chair and (staff) assisted her to sit back in her chair multiple times. Staff then used a Hoyer (a type of mechanical lift) to transfer her to a recliner to assist with safety. A 9/6/24 Other Progress note stated the resident colored at the counter slumped over and sliding out of her wheelchair. Staff manually lifted her back to a properly seated position. The Slipped or fell report dated 9/23/24 at 7:39 pm documented the resident was yelling bed. Resident then leaned forward, screamed, and fell forward out of the wheelchair onto the floor. The nurse did not see if she hit her head due to partial wall in the way. The wheelchair was in the reclined position. The resident sustained a bruise to the front of the right shoulder. A 9/24/24 Communication/Visit with Physician stated the resident complained of pain in the right leg, did not want to move the leg, and yelled when touched. Tylenol did not help with the pain. The facility submitted a request for an x-ray of the right leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An undated handwritten note by Staff A Licensed Practical Nurse (LPN) stated she heard the resident yell bed and heard Staff K Certified Nursing Assistant (CNA) tell the resident she would finish another resident and help Resident #2 next. Staff A then walked down the hall to assist another resident. Staff A observed the resident lean forward as she normally did to color. The resident screamed and fell forward out of her wheelchair, which was in a reclined position. A 9/24/24 Care Plan entry directed staff to remind the resident not to lean forward in the wheelchair and offer an earlier time to go to bed. The Care Plan lacked documentation to address the resident's wheelchair positioning concerns on 8/18/24 and 9/6/24 and lacked a related intervention prior to 9/24/24. A 9/25/24 Communication/Visit with Physician stated the resident was in pain. The facility received an order for Tramadol (a narcotic pain medication every 4 hours as needed). A 9/25/24 Final Radiology Report stated the resident had right fibular (referring to the long, lower leg bone) and tibial (referring to the shin bone) fractures. A 10/1/24 Health Status note stated the resident reported pain to the right lower extremity. On 10/9/24 at 9:51 a.m. Staff L and Staff M (CNAs) transferred Resident #2 from the wheelchair to the bed using a mechanical lift. When the resident rolled over to the right side she stated ow. On 10/10/24 at 8:24 a.m. via phone Staff A stated she was present when Resident #2 fell . She stated the resident yelled bed three times earlier that night from the time she returned from the dining room around 6:00 p.m. She stated a CNA trained another CNA and told the resident she would be right with her. She stated she heard a crash and a scream and the resident laid on her left side. She stated she did not see the fall due to the presence of a partial wall. She said the fall occurred between 7:00 p.m. and 8:00 p.m. and the resident initially did not appear to have an injury. On 10/10/24 at 8:49 a.m. Staff F CNA stated there was an occurrence when the resident tried to bend over and slide out of her wheelchair. She stated the resident liked to toss herself out of her wheelchair and if she yelled bed, she would prioritize assisting her. On 10/10/24 at 8:55 a.m., Staff G Certified Medication Assistant (CMA) stated the resident had been close to falling when she sat way up in her wheelchair. On 10/10/24 at 9:13 a.m. Staff H Registered Nurse (RN) stated the resident was impulsive and when pushed in her wheelchair, she immediately moved forward. On 10/10/24 at 9:24 a.m., Staff I CMA stated the resident threw herself around in her chair and it terrified her. On 10/10/24 at 11:20 a.m., Staff J RN Case Manager stated the resident did not try to get out of her chair any other times. She stated staff did not report to her that the resident almost fell out of her wheelchair prior to the 9/23/24 fall. She stated if the resident voiced that she wanted to go to bed, staff should have assisted her sooner. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/10/24 at 12:06 p.m., the Director of Nursing (DON) stated if a resident yelled bed, staff should ask her what was wrong and meet her needs. On 10/10/24 at 1:10 p.m., via phone, Staff K CNA stated on the night of the fall, she did not get on the floor until 6:30 p.m. She stated Resident #2 said bed but she had another resident that she needed to take care of who she could not leave. She went down and took care of the other resident for 10-15 minutes and then heard that the nurse needed her because Resident #2 was on the floor. Staff K stated there should have been another CNA on the floor and she did the best she could. She did not want the other resident to fall. The facility policy Fall Prevention and Management reviewed 7/29/24, stated the facility would have a fall prevention and management program and stated the facility would identify the causes of a problem so solutions could be identified and put into place. The policy directed staff to include appropriate interventions on the Care Plan. 46513 2. The MDS assessment dated [DATE] for Resident # 67 included medical diagnoses for Parkinson's disease and respiratory disease. The MDS revealed the resident required partial/moderate assist with chair/bed transfers, sit to stand, lying to sitting and scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The Care Plan revealed a focus area initiated on 8/27/24 for Resident #67, documented limited physical mobility related to weakness. Interventions included use of a wheelchair for locomotion and foot rest use. During an observation on 10/7/24 at 12:28 PM, Staff E, CNA (Certified Nurse Aide) pushed Resident #67 down the hall after lunch and the left foot was off the foot pedal and dragged on the floor. During an interview on 10/7/24 at 5:00 PM, the DON (Director of Nursing) acknowledged awareness of possibilities of falls and injuries if feet are not on the wheel chair when pushed. Facility memo provided, DON relayed was made available to staff and directed, do not push any resident that is in a wheel chair without pedals. Serious injury can result, please make sure pedals are in place before you push a resident.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observations, clinical record review, family interviews, staff interviews and the facility policy the facility failed to ensure adequate hydration for 1 of 3 residents reviewed. (Resident #81). The facility reported a census of 111 residents. Findings include: The Minimum Data Set assessment (MDS) dated [DATE] revealed Resident #81 diagnoses of Alzheimer's disease, dementia, Urinary Tract Infection (UTI), pain, and cellulitis of buttocks, required substantial/maximal assistance with chair/bed to chair transfers and sitting to standing. the Brief Interview for Mental Status (BIMS) exam scored a 6 out of 15 indicated cognition severely impaired. The MDS revealed treatments that included a turning/repositioning program; and nutrition/ hydration interventions to manage skin problems. The Care Plan initiated date 4/8/24 for Resident #81 revealed a focus area for bladder incontinence related to confusion. The interventions included encourage resident to drink more fluids during morning and afternoon and limit fluids in the evening/night. During an interview on 10/7/24 at 3:49 PM, a family member of Resident #81 relayed a concern with the resident not getting enough water. Relayed frequently visited and had viewed the same empty cup left in the same spot with no fluids obtainable to the resident. During a continuous observation on 10/8/24 at 8:50 AM to 11:05 AM (2 hours and 15 minutes) Resident #81 sat in a recliner, was not offered fluids, and did not have fluids on the table next to the residents recliner. During a continuous observation on 10/9/24 at 9:15 AM to 11:40 AM (2 hours and 25 minutes), Resident #81 sat in a recliner and was not offered fluids, no fluids on the bedside table within resident reach. During an observation on 10/9/24 at 2:16 PM, Resident #81 sat in a recliner, and no fluids were available within reach. In an interview 10/9/24 at 10:15 AM the Director of Nursing (DON) relayed awareness of reported concerns regarding water being passed and had been working on the concerns. In an interview and observation with the Administrator on 10/10/24 at 12:20 PM included escort to recliner Resident #81 sits much of the day, was revealed no accessibility to any fluids near the recliner. The Administrator viewed the area and acknowledged the concern. Policy titled, Nutrition and Hydration, Food and Nutrition, revised 4/1/24 documented, Hydration: 2. Offer sufficient fluid intake to maintain proper hydration and health. 4. Fresh water will be available to the residents at bedside unless contraindicated.

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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. 47336 Based on observation, staff interview, and the facility policy, the failed failed to use appropriate hand hygiene between resident's medication administration and failed to use proper technique for preparation of medication administration and touched resident's pills with their bare fingers for 2 of 5 oral medication administrations observed (Resident #13 and Resident #269). The facility reported a census of 111 residents. Findings include: 1. During an observation on 10/8/24 at 7:23 AM, Staff A, LPN (Licensed Practical Nurse) finished giving another resident his pills and did not use hand hygiene prior to prepping Resident #13 medications. Staff A opened a bottle of acetaminophen and tapped the bottle and then used her finger to push out 2 pills into a medication cup. Staff A then prepped oral medications for Resident #13. Staff A popped out the furosemide pill from the card and as she popped it out, her fingers touched the pill prior to the tablet going into the cup. Staff A popped out the resident's gabapentin and as she popped the pill from the card her fingers touched the capsule prior to going into the cup. After administering the medications she touched the water pitcher, pushed the resident in her wheelchair, then unlocked the medication cart and did not wash her hands prior to starting a new medication pass with another resident. The Physician Orders dated last order review 8/27/24 for Resident #13 revealed the following information: a. acetaminophen 325 mg (milligrams)- give two tablets by mouth twice a day b. furosemide 40 mg give one by mouth one time a day c. gabapentin 100 mg give one by mouth three times a day 2. During an observation on 10/8/24 at 7:29 AM, Staff A prepared medications for medication pass for Resident #269. Staff A opened a bottle of Senna 8.6 tablets and tipped the bottle and then used her finger to push the pill out of the bottle into the medication cup. The Physician Orders dated last order review 8/27/24 for Resident #269 revealed the following information: a. Senna S oral tablet 8.6/50 mg give one tablet my mouth every morning During an interview on 10/8/24 at 8:49 AM, Staff A queried when she needed to wash her hands during medication administration and she stated after every med pass. Staff A asked if she could touch the pills during medication administration and she stated no. Staff A informed of the observations seen, and she acknowledged it and stated she would pay closer attention to what she was doing. (continued on next page)

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Good Samaritan Society - Ottumwa	2035 West 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 10:48 AM, the DON (Director of Nursing) stated staff needed to use hand hygiene before medication pass and between residents. The DON queried if staff can touch the pills with bare hands and she stated whatever the policy says. During an interview on 10/10/24 at 10:51 AM, the Administrator queried she didn't think they could touch the pills if they didn't use hand hygiene, but she would go with what the policy stated. The Facility Medication Administration Including Scheduling and Medication Aides Policy dated 3/29/23 revealed the following: a. medication administration procedure 1. wash your hands prior to beginning med pass and following the administration of medication for each resident. If hands were visibly soiled wash hands with soap and water, if hands not visibly soiled or contaminated with body fluids use of an alcohol-based hand rub was acceptable.