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	12/04/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, clinical record review, facility policy review, and staff interview, the facility failed to ensure a call light within the reach of 1 out of 21 dependent residents (Resident #95) in the sample. The facility reported a census of 101. Findings include: The Minimum Data Set (MDS) for Resident #95, dated 10/24/2025, list of diagnoses included atrial fibrillation or other dysrhythmias (irregular heart rhythm) diabetes mellitus, Non-Alzheimer's dementia, anxiety disorder, depression, and respiratory failure. The MDS identified Resident #95 dependent on staff for transfers and could not walk. The Care Plan for Resident #95, date initiated: 10/03/25, included a Focus area to address The resident has an ADL (activities of daily living) self-care performance deficit R/T (related to) copd (chronic obstructive pulmonary disease). Interventions included, in part: TRANSFER - Transfer Between Surfaces: assist x 2 with sit to stand with large harness if weak use the total lift high back large sling. Date Initiated: 11/7/25. During an observation on 12/02/2025 at 10:39 AM, Resident #95 sat in a recliner in her room. The resident called for help. The resident stated no one answered her and she needed help. The resident's call light observed tied to her bed with multiple knots, and outside the reach of the resident. The resident bed positioned across the room from the recliner. In an interview on 12/04/2025 at 11:20 AM, Staff A, Certified Nursing Assistant (CNA), stated call light buttons must be within reach of a resident at all times when they are in their rooms. She explained this is so they can call for help if they needed it. She stated it was unacceptable to have a call light in a resident's room and not within the residents reach when that resident is dependent on staff for mobility. During an interview on 12/04/2025 at 11:29 AM, Staff C, CNA, stated call lights are to be set up within reach of a resident when they are in their rooms. She stated it can be clipped to a number of surfaces, including their clothing, to ensure they have it within reach at all times. She then stated if they can't reach it they can't use it. During an interview on 12/04/2025 at 11:33 AM, Staff B, CNA, stated call lights staff are required to make sure a resident can reach their call light regardless of where they are in their room. He stated call lights should be handy, so that any time the resident needs help they can use it. During an interview on 12/04/2025 at 11:46 AM, the Director of Nursing (DON) acknowledged call lights should be within reach of a resident at all times. Review of a facility policy titled Call Light- R/S, LTC, Therapy & Rehab, dated 7/08/2025, included a Purpose section which included:a. To ensure a resident always has a method of calling for assistance.b. To promptly answer resident's call light. The Procedure section of the policy included, in part, the direction to #4. When leaving the room, place call light in easy reach of resident.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, clinical record review, facility policy review and staff interviews, the facility failed to respond to a weight loss in timely manner for 1 of 2 residents (Resident #104) reviewed for weight change. The facility failed to notify the physician of a weight loss in a timely manner which delayed the implementation of dietician recommended interventions. The facility reported a census of 101 residents. Findings include:Review of Resident 104's Minimum Data Set (MDS) assessment dated [DATE] revealed a diagnoses list which included hyperlipidemia, anxiety, depression, dementia, pain, and hypokalemia. A Brief Interview for Mental Status (BIMS) score of 2 out of 15 indicated severely impaired cognition. The MDS indicated Resident #104 required set up assistance with eating.Review of the Care Plan, initiated on 12/23/22, revealed a Focus area to address The resident has potential for nutrition issues r/t (related to) dementia, hx (history) surgical wound, anxiety d/o (disorder), muscle wasting increasing risk for malnutrition. Weight gain may occur given previous wt (weight) loss, and wound healed. Interventions, included, in part:a. Weight per orders. Date Initiated: 4/22/24b. Provide supplement as ordered. May eat meals on the wing if Res I'd over stimulate. Date Initiated: 3/15/24c. Monitor for poor intake at meals, meal refusals. Provide cueing at meals as needed. Resident noted for liking grilled cheese and cheerios. Meal Alternatives offered. Previously attempted assisting dining to encourage meal intakes, resident did not accept. Date Initiated: 4/10/24.d. Monitor for significant weight change, RD (Registered Dietitian) to f/u (follow up) prn (as needed). Date Initiated: 12/23/22. Review of the Weight Summary in the electronic health record (EHR) revealed a weight of 153.8 Lbs (pounds) recorded for Resident #104 on 10/6/25. On 11/10/25 a weight of 133.0 Lbs recorded. On 11/19/25 a weight of 132.8 Lbs recorded. During a phone interview on 12/3/25 at 1:09 PM, Staff L, Restorative Nurse Aide (RNA) stated the restorative nurse aides were responsible for weighing the residents monthly. Staff L stated she noted Resident #104 weight loss when she weighed her before breakfast on 11/10/25. Staff L stated she re-weighted the resident on 11/10/25 and confirmed the loss. Staff L stated she informed Staff G, Registered Nurse (RN) of the weight loss. Staff L stated on 11/19/25, the Director of Nursing (DON) asked her to re-weight Resident #104. Review of a document titled Dining RD Consultant Report for Diet Change PCP (primary care provider) FAX Report, dated 11/18/25, addressed to [name redacted, Medical Director of facility]. Resident: [name redacted, Resident #104]. Assessment: Weight Loss Progress Note. Summary: RD Weight Eval: CBW (current body weight) 133.0 # (pounds). BMI (body weight index). Resident's wt showing significant wt loss -13.52% x 30 d (times 30 days)/-13.52% x 90 d/-1250%x 180d observations. Intake of Regular diet. 7 Regular texture, 0 Thin consistency diet inconsistent avg (average) 50% with 5 meals refused x 30 d hx. No documented edema over 14d hx. Recommend adding house supplement 4 oz (ounce) BID (twice daily) at AM and HS (night time) snack time Dietary add fortification to breakfast foods as appropriate. RD to monitor intakes, weight status and reassess with monthly weight collection or PRN. Consultant Recommendation/Intervention: Fortified Foods: Fortified cereal/oatmeal. Nutritional Supplement: House supplement 4 oz BID at AM and PM snack time. The fax signed by Primary Care Physician on 12/2/25 with the Approve Recommendation box checked. Review of the EHR revealed a Communication with Resident/Family note, entered on 11/19/25 at 10:51 AM, Who did you talk to/notify: daughter [name redacted]. Summary of discussion/notification and any education provided: Called & informed of recent loss down approx (approximately) 20lbs & dietician to make recommendations. Very thankful for info. Was consent needed? No documentation added.On 12/2/25 at 12:50 PM, a Communication/Visit with Physician note entered Dr. [name redacted] here on rounds, reviewed communication fax from dietician, agree with house supplement 4 OZ BID. noted. Review of the December 2025 Medication Administration Record (MAR) revealed an order for House Supplement two times a day for Weight loss, poor appetite/Intake Amount to serve: 4 OZ. Start Date: 12/2/25. Scheduled for AM and PM. The MAR documented House Supplement started (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/2/25 during PM scheduled time. During an observation on 12/3/25 starting at 8:29 AM, Resident #104 assisted with wheelchair transport to the dining room. At 8:36 AM, Staff G, Registered Nurse prepared and offered a 4 oz nutritional supplement to the resident. Resident #104 consumed 100% of the supplement. At 8:39 AM, a Certified Nursing Assistant (CNA) encouraged Resident #104 to eat her breakfast. During an interview on 12/3/25 at 8:47 AM, Staff I, Manager of Nutrition and Food Services (MNFS), stated Resident #104's weight had fluctuated up and down in the past and was not too concerned right now with the resident's nutritional status.During an interview on 12/3/25 at 8:52 AM, the Consultant RD stated she would expect the recommendations she made for weight loss be implemented as soon as the resident's physician reviewed and approved the recommendations. The RD explained she visited the facility weekly to assist with the provider's nutrition and food services. She stated she communicated with the facility with the use of a document titled Nutrition Care Report. The RD stated the report gave a summary of her nutritional assessment for each resident reviewed during the weekly visit, and included recommendations. She stated if recommendations required physician approval she would send a document titled Consultant Request for Diet Change PCP FAX Report. The RD added Resident #104 was on her priority list due to the significant weight loss. During an interview on 12/3/25 at 10:39 AM, Staff G, RN Case Manager stated she is responsible for the residents on the 100, 200, and 300 wings which included the MDS assessments and coordination of Care Plans. Staff G stated that Resident #104's weight loss of 20 Lbs from 10/6/2025 to 11/10/25 was not addressed until nine days later, on 11/19/25. Staff G stated Resident #104 had been reweighted and the weight loss confirmed. Staff G stated the facility had a weekly At-Risk Committee meeting on Wednesdays. Staff G explained residents who were clinically at risk where discussed, which included significant weight changes. Staff G stated she could not recall if Resident #104's significant weight loss had been discussed at the 11/12/25 ARC meeting. She stated on 11/19/25, she had notified Resident #104's family of the significant weight loss. Staff G stated that nine days was a little lengthy to address a significant weight change and agreed that the facility had not promptly identified Resident #104's significant weight loss.Review of the facility's At-Risk Committee (ARC) meeting minutes revealed during the 11/12/25 no dietary staff had attended the meeting and Resident #104's significant weight loss had not been noted. On 11/19/25 Activities, Nursing, Social Services, Dietary staff and Consultant RD attended the ARC meeting and Resident #104's weight loss noted as having been discussed.During an interview on 12/4/25 at 8:15 AM, the Administrator stated the facility needed to develop a formalized protocol to address resident weight loss.During an interview on 12/4/25 at 10:14 AM, the DON stated on 11/10/25, when Resident #104's significant weight loss was identified, the nursing staff failed to notify the resident's physician and the RN Case Managers relied on the Consultant RD to complete her assessment and provide her recommendations to the resident's physician. The DON stated at the 11/12/25 ARC meeting she could not recall that Resident #104's weight loss had been discussed. The DON stated that at the 11/19/25 ARC meeting, Resident #104's significant weight loss of twenty-pounds had been discussed and she had asked RNA, Staff L, to re-weigh Resident #104 after that meeting ended. The DON stated she could not answer why Resident #104's significant weight loss had not been addressed immediately. Review of the facility policy titled Weight and Height, reviewed date of 9/30/25, included a Purpose section which included, in part: To report changes in a resident's clinical condition (significant weight change) to physician and family and/or resident. The Procedure section revealed in part:8. The licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days. 9. The licensed nurse should immediately notify the medical provider regarding any significant weight change as defined in step 8.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and staff interviews, the facility failed to use proper hand hygiene techniques during the administration of an insulin injection and eye drops for 1 of 3 residents (Resident #3) reviewed during medication administration observation. The facility reported a census of 101 residents. Findings include: A Minimum Data Set, dated [DATE], documented that Resident #3's diagnoses included type 2 diabetes Mellitus. A Brief Interview for Mental Status documented a score of 07 out of 15, which indicated severely impaired cognition. This MDS documented that Resident #3 received insulin injections 7 of the past 7 days of the review period. Review of the Medication Administration Record (MAR) for the month of December 2025, directed Humulin KwikPen Suspension Pen-injector (Insulin) 10 units be administered in the AM and PM. Staff A , Licensed Practical Nurse (LPN) signed the MAR on 12/3/25 to indicate the AM dose administered. Review of the MAR for the month of December 2025, directed Polyvinyl Ophthalmic Solution be administered 1 drop in both eyes four times a day for dry eyes, be instilled. Staff A, LPN signed the MAR on 12/3/25 to indicate the 8:00 AM dose administered. On 12/3/25 an observation of Staff A, LPN started a medication pass began at 7:39 AM. During this observation it was noted that both Resident #3's insulin and eye drops were given without Staff A donning gloves. On 12:3/25 at 8:20 AM, Staff A, LPN acknowledged that she should have put on gloves prior to administering Resident #3's eye drops and prior to administering Resident #3's insulin. On 12/3/25 at 9:27 AM, the Administrator acknowledged not wearing gloves during the administration of an insulin injection and eye drops is a concern.A review of the facility's medication administration policies revealed that the policies did not include wearing gloves specifically for insulin pen injection nor for eye drop administration. On 12/4/25 at 11:50 a.m., the Director of Nurse (DON) stated she was surprised to hear that donning of gloves for insulin pen injections and for eye drop administration was not mentioned in their policies. This DON stated that normally she would say they would follow the policies, but stated she would wear gloves while administering both the insulin and the eye drops. She stated gloves should be worn for infection control purposes and that it is a standard of practice.