STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165213	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Forest City	606 South Seventh Street Forest City, IA 50436

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident was free from abuse for 1 resident reviewed (Resident #2). The facility reported a census of 34 residents.The citation is considered past non-compliance.Findings include:According to the Minimum Data Set (MDS) assessment dated [DATE], Resident #2 scored 13 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The resident depended on staff for toileting hygiene, shower/bathing, lower body dressing, and transfers. The resident's diagnoses included aphasia (a language disorder that affects a person's ability to communicate), stroke, and hemiplegia (paralysis) or hemiparesis (weakness on 1 side of the body). The Care Plan revised 6/11/25 identified the resident:a. Had impaired cognitive function and impaired thought processes related to cerebral infarction (stroke) evidenced by inattention, disorganized thinking, and behaviors.b. The resident had a communication problem due to expressive aphasia related to a history of strokes.Revised 3/11/25:c. The resident was adjusting to admission related to a recent stroke and needing 24 hour care.Revised 7/14/25:d. The resident had the potential to experience trauma related to abuse allegations and ongoing investigation.A facility Investigation documented on 7/11/25 at 9:30 a.m. the Social Worker (SW) was asked to assist Resident #2 to help him with his new phone that he received the day prior. He told her he was not sure he was receiving messages and asked her to help. He gave her the phone and his password. When the SW unlocked the phone in front of the resident, she saw that there was a text message thread with someone with the same 1st name as Staff A Certified Nursing Assistant (CNA)/Certified Medication Aide (CMA), and because it was a unique name, she questioned if it was Staff A from work, and Resident #2 said no. The resident asked her to click on a text message thread to see if she could get a message to send. The SW scrolled up on the feed to see if any messages were sent. She saw a picture of Staff A and other messages. The SW was concerned by photos she had seen. The resident said it was a friend from another town. The resident then asked her to hold on to his phone for him so that she could work on it which he has done prior when his phone didn't work properly. She went into his messages to see the last time he received a message. When she clicked on the Staff A contact and saw that it said, Good Morning Love, I miss you, she had some concerns that it may be the employee that worked at the facility and scrolled back to see a picture of Staff A, and then saw a picture of male genitalia. At that point she put the phone down and called the Administrator. The investigation ensued and included obtaining an interview with Staff A and a report to police.In a statement written by Staff A, she documented she met Resident #2 when he first came to the facility. They hit it off immediately. They had always had a very good working relationship. A couple of months ago feelings between the two of them became more than just friends. They exchanged phone numbers and had conversations outside of work. The relationship was physical one time with a kiss. It was never her intention for this to happen. It sprung up on her. There had never been any ill intentions. It was consensual on both sides. There had never been any sexual contact. At work their relationship had been professional with the exception of the one kiss. She admitted she knew it was wrong, but her feelings got the best of her.The Police Incident Report dated 7/11/25 at 10:54 a.m. documented the incident occurred 5/9/25 through 7/11/25, and the offense dependent adult abuse. The Police Arrest History dated 7/14/25 documented Staff A arrested for dependent adult abuse.A review of images from Staff A's phone showed it contained inappropriate messages and pictures sent to Resident #2's phone.During an interview on 8/6/25 at 2 p.m. Staff A stated she was empathetic to the resident. She said she got to know Resident #2 when he came in the facility. She said he was hospitalized and several wondered where he went and how he was doing. When he came back to the facility he asked for her phone number, so if he went back to the hospital, he could let her know how he was doing. She gave it to him, but she did not get his. He initiated things by giving her very nice compliments. She said he started texting her, and she texted back, mostly memes. There were a few phone calls, but communication over the phone was very difficult. She did start to have feelings for him. Some of the memes had I Love You in them. She confirmed the resident sent texts with a male's genitals in them. She did not know where he obtained them. She also admitted the pictures of a woman in a bra and panties, and exposing a breast were of her sent to the resident. She said it was not physical except for 1 kiss. It was a consensual relationship, and she did not hurt anyone. She knew it was wrong because she was employed at the facility, but it was consensual, and no one was hurt. A review of Staff A's personnel file showed she completed the Iowa Department of Health and

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, Centers for Disease Control and Prevention (CDC) recommendations and policy review the facility failed to provide appropriate catheter care for 1 of 1 resident reviewed (Resident #17). The facility reported a census of 34 residents.Findings include:Resident #17's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS identified Resident #17 was dependent on staff assistance for toileting hygiene. Residents #17 MDS included a diagnosis of benign prostatic hyperplasia (enlarged prostate gland). The MDS revealed Resident #17 had an indwelling catheter (tube inserted into bladder to drain urine).The Care Plan revised dated 07/03/25 identified Resident #17 had an indwelling catheter due to urinary retention (inability to completely empty the bladder). The care plan lack direction on where to place the catheter urine bag and tubing to prevent the bag/tubing from touching the floor.Review of the form titled Catheter Data Collection dated 07/23/25 documented resident education to keep the urine bag lower than the bladder and off the floor.On 08/04/2025 at 1:53 PM, observed Resident #17 lying in bed and his catheter urine bag was laying on floor next to the bed. The urine bag did not have a dignity bag in place.On 08/05/2025 at 10:18 AM, observed Resident #17 catheter urine bag attached to the bed rail with the bag touching floor. The urine bag did not have a dignity bag in place. On 08/06/2025 at 7:29 AM, observed Resident #17 catheter urine bag attached to the bed rail with the bag touching floor. The urine bag did not have a dignity bag in place.On 08/06/2025 at 9:02 AM, the Director of Nursing (DON) stated her expectation of the catheter urine bag placement was that the bag should not be touching the floor while attached to the bed.Review of the CDC Guidelines for Prevention of Catheter-Associated Urinary Tract Infections dated 2009 directed the catheter urine bag not to be rested on the floor.The facility policy titled Catheter: Care, Insertion/Removal, Drainage Bags, Irrigation, and Specimen revised 04/06/25 directed staff to keep the resident's catheter bag covered and catheter tubing should never be allowed to touch the floor.