Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165236 | A. Building<br>B. Wing | 11/26/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Manson | 1402 Main Street<br>Manson, IA 50563 |

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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26527<br><br>Based on record review and staff interview, the facility failed to ensure residents were free from significant medication errors for 2 of 4 residents reviewed (Resident #1 and #2). The facility reported a census of 36 residents.<br><br>Findings include:<br><br>1) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #1 scored 12 on the Brief Interview for Mental Status (BIMS) indicating some cognitive cognitive impairment. The resident had diagnoses including non-Alzheimer's dementia.<br><br>The Care Plan revised 5/23/24 identified the resident had impaired cognitive function/impaired thought processes related to dementia diagnosis, evidenced by confusion, forgetfulness, and misinterpreting information at times.<br><br>An Outpatient Psychiatric/Mental Health Progress Note on 10/14/24 documented the resident requested to have her memory pill increased.<br><br>The Progress Notes dated 10/14/24 at 2:19 p.m. documented the psychiatric Advanced Registered Nurse Practitioner (ARNP) completed rounds with Resident #1 via an audio and visual zoom appointment and gave new orders to increase Memantine (Namenda/to treat memory) to 14 mg for 7 days then 21 mg for 7 days then 28 mg one time a day.<br><br>The Progress Notes dated 10/14/24 at 5:39 p.m. documented left voicemail for Resident #1's family to call the facility regarding new orders.<br><br>The Progress Notes dated 10/16/24 at 3:08 p.m. documented Resident #1 continued on increased dose of Namenda with no adverse reactions. Resident stated she still got confused sometimes.<br><br>The Progress Notes dated 10/17/2024 at 6:33 p.m. documented no adverse reactions with increased dose of Namenda. Unable to assess it's effectiveness at this time.<br><br>The Progress Notes dated 10/18/24 at 2:29 a.m. documented no adverse reactions or noticeable changes with Namenda.<br><br>(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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Medication Administration Record (MAR) for October 2024 showed Resident #1's Namenda increased 10/15/25. Staff documented giving the increased dose of 14 mg daily 10/15-21/24.<br><br>A Medication Error report dated 10/22/24 documented the new order to increase Resident #1's Namenda on 10/14/24. The Pharmacy did not receive the order until 10/21/24. Resident #1 received the correct dose 10/21 and 10/22/24, indicating the medication administered for 6 days not the correct dose.<br><br>On 11/26/24 at 11 a.m. the DON stated when Resident #1's Namenda was increased the order did not get sent to the pharmacy, so they didn't send the increased dose. They found that 5 different staff charted administering the increased dose, but gave the dose she was previously on.<br><br>The facility policy, Medication: Administration Including Scheduling and Medication Aides revised 5/21/24 documented the procedure (for med pass) included performing 3 checks: (1) Reading the label on the medication container and comparing with the MAR when removing the container from the supply drawer, (2) when placing the medication in a med cup, (3) and just before administering the medication.<br><br>2) According to the Minimum Data Set (MDS) assessment dated [DATE] Resident #2 scored 7 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident received hospice services. The resident had diagnoses including rheumatoid arthritis.<br><br>The Care Plan initiated 11/24/21 identified the resident had chronic pain/discomfort related to a right below the knee amputation evidenced by phantom pain. The interventions included notifying the health care provider if interventions are unsuccessful or if current complaint was a significant change from residents past experience of pain.<br><br>A hospice Physician's Orders sheet for Resident #1 directed:<br><br>Discontinue Lorazepam intensol as needed (prn).<br><br>Start Lorazepam intensol 2 mg/ml 0.5 ml every 2 hours for restlessness (routine administration).<br><br>Discontinue Morphine concentrate 20 mg/ml 0.5 ml prn.<br><br>Start Morphine concentrate 20 mg/ml 0.5 ml every 2 hours for pain.<br><br>The Medication Administration Record (MAR) for September 2024 included Lorazepam Intensol Oral Concentrate 2 mg/ml, 0.5 ml by mouth every 2 hours for restlessness with a start date of 8/31/24.<br><br>The MAR indicated by a number instead of a check the resident did not receive the medication 9/1/24 at 9 p.m. or 11 p.m. and 9/2/24 at 1 a.m. 3 a.m. or 5 a.m.<br><br>The MAR included Morphine Sulfate Oral Solution 20 mg/5 ml give 0.5 ml by mouth every 2 hours for for pain with a start date of 8/31/24.<br><br>The MAR indicated by a number instead of a check the resident did not receive the medication 9/1/24 at 8 p.m. and 9/2/24 at 12, 2, 4 and 6 a.m.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Progress Notes dated 9/1/24 at 10:39 p.m. documented the resident's blood pressure (B/P) 131/72 Temperature (T) 99.4 Pulse (P) 83 regular, Respirations (R) 20 non labored. Pulse oximetry 89% with oxygen (02) at 2 Liters (L) via nasal cannula (NC). Skin was warm and dry, no mottling, color normal. No signs/symptoms (s/s) pain or restlessness, no dyspnea or apnea. Has not had any oral intake for several days due to unresponsiveness. Family has been at bedside nearly round the clock. Husband had questions and this nurse explained that at this time there are no obvious S/S of imminent death. Hospice has ordered morphine and lorazepam to be given at scheduled times for pain and restlessness. At this time she is showing no signs of pain or restlessness and the nurse would hold the medications unless she showed the symptoms. Also explained that dehydration may also cause fever and pain. The resident's spouse was appreciative of information and would go home to get some sleep and proper food since he cannot eat gluten. The nurse assured the spouse that she would contact him if there were any changes in the resident's condition and that she would sit with her periodically through the night. The resident had been repositioned and turned every two hours, oral care and hygiene performed.<br><br>The Progress Notes dated 9/2/24 documented when the aids went in to turn Resident #2 at 7 a.m. she was moaning and arms and eyelids were twitching. The resident's breathing was labored with short periods of apnea. B/P-90/88, P-90, and R-12. They notified hospice of Resident #2's condition, and continued with scheduled 0.5 ml of morphine and lorazepam every 2 hours.<br><br>The Progress Notes dated 9/2/24 at 1:20 p.m. documented Resident #2's vital signs had improved and the resident no longer moaned when being turned, and the twitching had stopped. They would continue to monitor.<br><br>The Progress Notes dated 9/2/24 at 1:23 p.m. documented Resident #2's spouse notified of the med error of the resident not receiving any scheduled morphine or lorazepam during the night. The resident's spouse stated a concern of not being able to trust the nurse from last night, but was happy that the resident was showing signs of comfort again.<br><br>A Medication Error Report Form completed 9/2-9/3/24 documented Staff A Registered Nurse (RN) held Resident #2's Lorazepam intensol and Morphine doses 9/1 to 9/2/24. The resident did not have any issues on Staff A's shift, but did have some labored breathing and signs and symptoms of pain the a.m. of 9/2/24.<br><br>A typed document signed by the DON 9/2/24 included education given to Staff A regarding need to contact hospice if concerned with potential for overmedication rather than holding medications.<br><br>On 11/25/24 at 11 a.m. the DON stated when the day shift came in on 9/2/24 they made her aware Resident #2 had not received the Morphine and Lorazepam, and the resident showed some s/s of discomfort. She talked to the nurse who held the meds and she had been off for awhile and thought the resident was snowed. She did education with the nurse to call the provider, hospice or the DON if she had concerns. |