STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165236	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Manson	1402 Main Street 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview and record review the facility failed to accurately complete the Resident Assessment Information (RAI) for 1 of 12 residents reviewed (Resident #29). The facility reported a census of 35 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #29 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). The resident was independent with eating and required supervision with transfers and dressing. Her diagnoses included chronic kidney disease, atrial fibrillation and Alzheimer's disease. The Care Plan revised on 6/17/24, showed Resident #29 had self-care performance deficit related to Alzheimer's Disease. She was able to ambulate with staff assistance and a walker. The resident had regular meals with small portions, per her request, she was at risk for malnutrition. Staff were directed to monitor for weight loss, and to offer high protein high calorie fortified foods. Resident #29 had a terminal prognosis related to severe protein calorie malnutrition and was admitted to Hospice services on 6/1/24. On 6/24/24 at 1:15 PM Resident #29 was sleeping in a recliner and found to be very thin. The Vitals Tab in the electronic chart showed the following: a. On 5/15/24 at 10:21 AM, Resident #29 weighed 84 lbs. and on 4/16/24 at 11:22 AM she weighed 88.5 lbs. , (5.08% loss.) b. On 12/25/2023, 11:33 AM, Resident #29 weighed 88 lbs. On 06/25/2024 at 10:39 AM, the resident weighed 77.5 pounds which is a -11.93 % loss. According to the MDS dated [DATE] for Resident #29, Section K; Nutritional Status presented the question: Did the resident have a loss of 5% or more in last month or loss of 10% or more in last 6 months? The answer was no, or unknown On 6/26/24 at 1:10 PM Staff B, RN, MDS Coordinator said that the RD completed Section K of the MDS and she thought the look back period was 7 days. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 11:23 AM, the Registered Dietician (RD) said that she tried to get to the facility at least once a month but she'd been gone a lot and that she would get behind in her documentation. She acknowledged that Resident #29 had experienced steady weight loss.

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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 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** 41785 Based on observation, interview and record review the facility failed to intervene when a resident experienced significant weight loss for 1 of 3 reviewed (Resident #29). The facility reported a census of 35 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #29 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). The resident was independent with eating and required supervision with transfers and dressing. Her weight was 84 pounds (lbs.) and her diagnoses included chronic kidney disease, atrial fibrillation and Alzheimer's disease. The Care Plan revised on 6/17/24, showed Resident #29 had self-care performance deficit related to Alzheimer's Disease. She was able to ambulate with staff assistance and a walker. The resident received regular meals with small portions, per her request, and she was at risk for malnutrition. Staff were directed to monitor for weight loss, and to offer high protein high calorie fortified foods. Resident #29 had a terminal prognosis related to severe protein calorie malnutrition and was admitted to Hospice services on 6/1/24. On 6/24/24 at 1:15 PM Resident #29 was sleeping in a recliner and found to be very thin. The Vitals Tab in the electronic chart showed the following: a. On 5/15/24 at 10:21 AM, Resident #29 weighed 84 lbs. and on 4/16/24 at 11:22 AM she weighed 88.5 lbs. , (5.08% loss.) b. On 12/25/2023, 11:33 AM, Resident #29 weighed 88 lbs. On 06/25/2024 at 10:39 AM, the resident weighed 77.5 pounds which is a -11.93 % loss. An Admission Dietitian assessment dated [DATE] at 1:28 PM, indicated that Resident #29 was malnourished, the Registered Dietician (RD) recommended to add 4 ounces of Food First shakes once a day to aid nutrient intake. A review of the RD updates and assessments revealed that no other nutritional supplement interventions had been attempted after down trending weights. The electronic record Clinical Census tab showed that upon admission, Resident #29 was on Hospice services and was discharged from Hospice on 2/1/24. A Nursing Note communication to the doctor, dated 5/31/24 at 6:30 PM, showed that the resident had lost 10 pounds since discharge from Hospice and the doctor wrote an order to readmit to Hospice. A review of the Nursing Notes revealed that the doctor had not been contacted about the on-going decline in weight from 2/1/24 - 5/31/24. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:04 AM Staff A, Certified Nurse Aide (CNA) said that she would get weights on Resident #29 a couple of times a week. She said that she told at least 3 different nurses about the residents' steady decline in weight. The response she got was that they were aware and the resident was in decline. They did move the resident to a table where she could get more assistance with meals. On 6/26/24 at 11:40 AM, a clinic Registered Nurse (RN) for the Nurse Practitioner (NP) who was providing services to Resident #29, stated that the NP was first notified on 5/31/24 of the resident's weight loss. On 6/25/24 at 11:43 AM, the Dietary Manager (DM) said the Food First shakes that they used were given out at meal time. She said that they did not have documentation of the amount that Resident #29 had consumed daily. On 6/25/24 at 11:23 AM, the RD said that she tried to get to the facility at least once a month but she'd been gone a lot. She acknowledged that Resident #29 had experienced steady weight loss and that she hadn't made any changes to the recommendation for the Food First shakes. She did not have a formal report of how much of the shakes the resident had been consuming. On 6/26/24 at 1:10 PM, Staff B, RN said that the staff had been aware of the steady weight loss and acknowledged that they should have tried some other interventions. On 6/26/24 at 12:30 PM, the Director of Nursing (DON) said that the Dietician communicated with the Dietary Manager but they did not have regular meetings with the Dietician to review weight concerns. On 6/27/24 at 10:15 AM The DON said Resident #29 had started to improve so they took her off Hospice. She then declined more and didn't have much of an appetite. She said that the Food First had a lot of nutrients in it, but they did not have documentation of how much she had been getting. She acknowledged that the care plan should have been updated since December with other interventions. According to the Weight and Height Policy last reviewed on 9/8/23, the facility would ensure that staff reported changes in a resident clinical condition (significant weight change) immediately to the physician and family and or resident.

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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** 41785 Based on observation, interviews and record review the facility failed to ensure that residents had timely and accurate nutrition assessments by a dietician for 3 of 5 residents reviewed, (Residents #29, #31 and #24). Resident #29 had a steady weight loss and the dietician failed to provide quarterly assessments and failed to intervene in a timely manner. The dietician failed to provide a nutrition admission assessment within 14 days for Residents #31 and #24. The facility reported a census of 35 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #29 had a Brief Interview for Mental Status (BIMS) score of 11 (moderate cognitive deficit). The resident was independent with eating and required supervision for dressing and transfers. Resident #29 weighed 84 pounds and had diagnoses that included; chronic kidney disease, atrial fibrillation and Alzheimer's disease. The resident was admitted to the facility on [DATE]. The Care Plan revised on 6/17/24, showed Resident #29 had self-care performance deficits related to Alzheimer's Disease. She was able to ambulate with the assistance of a gait belt and a walker. The resident was at risk for malnutrition related to weight loss, staff were to monitor for weight loss and to offer her high protein, high calorie fortified foods. Resident #29 had a terminal prognosis related to severe protein calorie malnutrition and was admitted to Hospice services on 6/1/24. On 6/24/24 at 1:15 PM Resident #29 was sleeping in a recliner and found to be very thin. According to a Dietician assessment dated [DATE], her weight was stable, but she had inadequate caloric intake and was malnourished. The Registered Dietician (RD) recommended to add 4 ounces (oz) of a supplemental, Food First shake once a day. The following was found in Nutritional Status updates and Dietician Assessments for Resident #29: a. On 10/22/23 at 9:47 PM, weight decrease at 92.5, RD to follow up. b. On 12/4/23 at 5:59 AM, weight decrease at 84 pounds. c. On 1/16/24, a slight increase at 87.5. d. The next Dietician Assessment was dated 2/19/24 at 7:46 AM, and indicated a trending weight loss with inadequate caloric intake. The resident was getting Food First shakes three times a day and her weight was down 7# in 6 months. Staff were to continue to encourage intake and shakes, RD to follow up on weight. From 2/19/24 until 4/5/24 the chart lacked assessment or nutritional status updates. e. On 4/5/24 at 12:29 PM weight was 87.5. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 5/21/24 at 10:00 PM, weight down 4# in month. RD to follow on weight. f. Dietitian assessment dated [DATE] at 6:40 AM, weight not stable, down 8# in 1 month. Weight dropped significantly, will notify nursing, and will follow up on weights. g. On 6/26/24 at 6:14 AM, weights has been declining greatly, will notify nursing 77.5 pounds. On 6/26/24 at 11:04 AM Staff A, Certified Nurse Aide (CNA) said that she would get weights on Resident #29 a couple of times a week. She said that she told at least 3 different nurses about the residents' steady decline in weight. The response she got was that they were aware and the resident was in decline. On 6/25/24 11:23 AM, the RD said that she tried to get to the facility at least once a month but she'd been gone a lot. She said that she mostly communicated with the facility through email and the expectation for residents Dietician Assessments was upon admission, quarterly and when there was a significant change. She acknowledged that there should have been an assessment in September of 2023 and in December of 2023 for Resident #29. She said that she recommended the Food First shakes that were monitored by the Dietary Manager (DM) and she would touch base with her once in a while. She did not have a formal report of how much of the shakes the resident had been consuming. On 6/26/24 at 12:30 PM, the DON said that the Dietician communicated with the Dietary Manager. They did not have regular meetings with the Dietician to review weight concerns. 2) According to the MDS dated [DATE], Resident #31 had a BIMS score of 10 (moderate cognitive ability). She was independent with eating and dependent on staff for toileting, hygiene and dressing. Her diagnoses included anemia, arthritis, chronic pain and intellectual disabilities. The Care Plan initiated on 1/29/24 impaired cognitive function related to intellectual disabilities, confusion. ADL self-care deficits with the exception of eating. According to the Census tab in the electronic chart, Resident #31 was admitted to the facility on [DATE]. The Dietitian Assessment was completed on 3/25/24 and indicated that the resident had a trending weight gain with a 6-pound gain in 1 month, and a 13.5-pound gain in 2 months. The RD indicated that she would notify nursing. 3) According to the MDS dated [DATE], Resident #24 was admitted on [DATE] with a BIMS score of 3 (sever cognitive deficit). She required supervision for eating, dressing and hygiene needs. The resident was on a mechanically altered diet. The Care Plan dated 7/28/24, showed Resident #24 had impaired cognitive function and impaired thought processes and vascular dementia. The resident had the potential for nutritional problems due to low weight. The resident required staff assist of one with eating and she was on pain medication therapy due to chronic back pain. Her diagnoses included; intervertebral disc degeneration, chronic pain syndrome and osteoporosis. An Admission Dietician assessment dated [DATE] at 7:21 AM indicated that the resident's weight was stable with adequate caloric intake, but she was at risk for malnutrition. Regular diet easy to chew level 7, underweight, eats with supervision. Added Food First shakes twice a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 10:15 AM the DON said that the Dietician resigned on 6/26/24 because she had many other responsibilities and was not able to get to the facility or complete assessments in a timely manner. The DON said that they spent a lot of time reeducating her on getting paperwork and assessment completed. Initially when the RD was hired, she would stay in touch with them on a weekly basis but it soon became monthly and she was doing most of the work remotely and wasn't getting good input from staff or residents. According to the facility policy titled Responsibilities of the Dietitian, dated 5/7/24; The dietitian would be accountable and responsible for her practice and sere to the location and would provide communication to the administrator or designee. The dietitian would be involved in the nutritional risk committee and the interdisciplinary care plan team. The assessment of nutritional status would be conducted onsite.