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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165240 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/30/2025 |
| NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Waukon | | STREET ADDRESS, CITY, STATE, ZIP CODE 21 East Main Street Waukon, IA 52172 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37072</p> <p>Based on staff interview, record review, and policy review the facility failed to treat two out of three residents reviewed with dignity. The facility reported a census of 52 residents.</p> <p>Findings include:</p> <p>Review of Resident #1 face sheet reveals she was in room [ROOM NUMBER]-B.</p> <p>Review of Resident #2 face sheet reveals she was in room [ROOM NUMBER]-A.</p> <p>On 1/29/25 at 12:32 PM Staff A, Certified Nursing Assistant (CNA) stated on 1/23/25 in the evening an incident in room [ROOM NUMBER] occurred. I was in the room for a transfer with my coworker Staff C, CNA and there was a conversation about another staff member. The conversation was related to frustration because someone had left a dirty depend in the trash can and I was frustrated because the same staff member had taken a lift and had two people in a room for a transfer that only needed one person. I was not aware the daughter of Resident #1 was in the room.</p> <p>On 1/29/25 at 1:37 PM Staff B, Licensed Practical Nurse (LPN) stated she was not working but stopped in to talk to another nurse on the evening of 1/23/25. She said she stopped in the hall and started a conversation with Staff C, CNA who took Resident #2 into room [ROOM NUMBER] to provide cares. They then had a conversation in the room about other residents. I was not working and went in a residents room discussing other residents with Staff C and it was completely wrong. I did not realize the daughter was in the room. Staff C was in hallway and she was assisting Resident #2.</p> <p>During an interview with Staff C, CNA on 1/29/25 at 1:48 PM she stated she was working the evening of 1/23/25 and she did evening cares with Resident #2 in her room. She did upper body cares with an off duty nurse present in the room and she did have a conversation with her about non-work related things. She completed the residents cares and then went and got another CNA to assist with Resident #2 transfer into bed. They did converse about the situation and other staff and frustration with things not being done. I did not see the daughter sitting in the room and she was sitting behind the privacy curtain on Resident #1 side of the room and it was pulled from the wall over. We should not be talking about residents or other staff while providing cares and in residents rooms.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 1/29/25 at 3:34 PM with the Administrator she stated the conversation that took place in the residents room between staff members was not appropriate. They should not have talked about other staff members or residents. I was disappointed to hear they were speaking about other staff members. I would not expect them to be talking about other residents and family members.</p> <p>The facility provided a policy titled Resident Dignity - Rehab/Skilled dated 12/11/24 which directed the facility will 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. The policy directed staff to treat residents with respect (for example, addressing residents name of their choice; avoid using labels for residents, such as feeders;not excluding residents from conversations or discussing residents in community settings in which others can overhear private information).</p> | | |