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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165247	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - George	324 First Avenue North George, IA 51237

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy the facility failed to appropriately implement interventions to protect 1 out of 3 residents reviewed from physical abuse, (Resident #12). The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented diagnoses of stroke, hypertension and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Review of the facility provided Incident Report dated 6/27/24 at 5:00 p.m., completed by the Director of Nursing Services (DNS) revealed Certified Nursing Assistant (CNA) staff presented to my office to report that on 6/19/24 while providing bedtime cares one of the other CNA staff was frustrated with Resident #12 when he yelled out as his pericare was being provided and she swatted his upper arm as he yelled out. Review of Resident #12 ' s Progress Notes revealed on 6/27/24 at 10:20 p.m., staff notified DNS that an event had been witnessed on 6/19/24 during bedtime cares that another staff had swatted resident on his arm when he had called out during bedtime cares. Review of written statement by Staff B, CNA dated 6/27/24 revealed Staff C, CNA and Staff B were changing Resident #12. The resident was touchy and Staff C was getting angry. I asked the resident to hold my hand because she was getting very mad. Staff C began to hold up her hand in a hitting motion. I had Resident #12 roll toward me. Resident #12 began to yell because the wipes were cold and Staff C slapped Resident #12's arm. Resident #12 said ouch what was that good for. I said he's not even touching you. This was at approximately 8:00 p.m. when he was being changed. Review of written statement by Staff D, CNA dated 6/27/24 revealed last week a CNA confided in me that she witnessed Staff C smack Resident 12's arm after getting frustrated with him. She said they were getting Resident #12 read for bed at 10:00 p.m. and changing his brief. He was turned on his side, facing the wall and holding the other CNA's hand. Staff C got upset that he was holding the CNA's hand and smacked his arm. The CNA told her she had no reason to be upset since he wasn't touching her. (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	Interview on 8/28/24 at 11:19 a.m., with Staff B revealed she was assisting Staff C, CNA with changing Resident #12. Staff B rolled Resident #12 toward her as he had been touching Staff C and she was getting angry. Resident #12 starting touching Staff B and Staff C slapped him on his upper shoulder area. Resident #12 stated ouch you dumb broad. Staff C responded to Resident #12 by saying he needed to stop touching us. When Staff C left the room Staff B looked at Resident #12's upper shoulder area and did not see any red marks. Interview on 8/26/24 at 11:31 a.m. with Staff D revealed she was working with Staff B on an evening shift. Staff B told Staff D that Staff B witnessed Staff C hit Resident #12. Staff D revealed she told Staff B she needed to report that to the DNS. Review of facility provided policy titled Abuse and Neglect with a reviewed date of 7/22/24 revealed the resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Interview on 8/28/24 at 3:23 p.m., with the Administrator revealed the incident should have been reported right away to the charge nurse or management to be able to separate the staff member from the residents.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility record review, staff interviews and facility policy review the facility failed to report an allegation of abuse to the Iowa Department of Inspections & Appeals and Licensing (DIAL) within 2 hours of an allegation of abuse for 1 of 1 resident reviewed for abuse (Resident #12). The facility reported a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented diagnoses of stroke, hypertension and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Review of the facility provided Incident Report dated 6/27/24 at 5:00 p.m., completed by the Director of Nursing Services (DNS) revealed Certified Nursing Assistant (CNA) staff presented to my office to report that on 6/19/24 while providing bedtime cares one of the other CNA staff was frustrated with Resident #12 when he yelled out as his pericare was being provided and she swatted his upper arm as he yelled out. Review of Resident #12's Progress Notes revealed on 6/27/24 at 10:20 p.m., staff notified DNS that an event had been witnessed on 6/19/24 during bedtime cares that another staff had swatted resident on his arm when he had called out during bedtime cares. Review of written statement by Staff D, CNA dated 6/27/24 revealed last week a CNA confided in me that she witnessed Staff C smack Resident 12's arm after getting frustrated with him. She said they were getting Resident #12 read for bed at 10:00 p.m. and changing his brief. He was turned on his side, facing the wall and holding the other CNA's hand. Staff C got upset that he was holding the CNA's hand and smacked his arm. The CNA told her she had no reason to be upset since he wasn't touching her. Review of facility intake information showed the facility submitted a self report on 6/27/24 at 9:34 p.m Review of facility provided policy titled Abuse and Neglect with a reviewed date of 7/22/24 revealed if there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, then it will be reported immediately, but not later than two hours after the allegation is made. Interview on 8/27/24 at 1:22 p.m., with the Director of Nursing Services (DNS) revealed all allegations of abuse are to be reported to the state within 2 hours of the allegation of abuse. The DNS further revealed she knew as soon as it was revealed when it happened she knew it was going to be a concern.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review, facility investigation review, staff and resident interviews, and facility policy review the facility staff failed to report an allegation of abuse to a supervisor and the alleged prepetrator continued to work unattended behind closed doors with other residents. On June 27, 2024, the Director of Nursing Services (DNS) learned of a Certified Nurse Aide (CNA) slapping Resident #12 on his upper arm which occurred on June 19, 2024. This failure resulted in residents living at the facility to be exposed to the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of June 19, 2024 on August 27, 2024 at 2:01 p.m The facility staff removed the IJ on June 27, 2024 through the following actions: a. The local police, residents physician and family/responsible party were notified of the allegation on 6/27/24. An initial report was made to DIAL on 6/27/24 within the expected two hour time frame. b. Staff members who failed to report immediately on 6/19/24 received immediate education and re-did the Iowa required Dependent Adult Abuse course online on 6/27/24. Corrective action was completed as well with both staff members. c. The social services manager interviewed all residents to determine if there were any concerns by residents of care and treatment by staff members this began on 6/27/24. None were identified. d. Education on abuse and neglect began 6/27/24 to all staff regarding the treatment of residents and the importance of immediately notifying leadership and/or supervisor of any allegation so steps can be immediately taken to remove/separate suspected staff from residents. A quiz for comprehension was completed by staff. Education was completed with all staff prior to any staff working another shift. e. To ensure deficient practice will not recur, Administrator or designee will implement the following measures: i. Administrator or designee will audit through abuse and neglect questionnaires 5 team members randomly to include all shifts daily X10 days to ensure staff education on abuse and neglect investigation and reporting. ii. Audits will be taken to QAPI for further review and recommendations. f. Center leadership has continued to provide daily reminders to staff on the need to report immediately any suspected abuse and/or neglect. g. Center leadership to include the Director of Nursing, Administrator and Social Services have ensured that their phone numbers have been made available for all staff to place in their phones to ensure ability to call them at all times. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	h. A Skills Fair was completed on August 6 and 7 where continuing reminders and education was again provided. After ensuring the facility implemented education and their policy and procedures prior to surveyors entrance on August 26, 2024, the deficiency at F610 at a J level will be considered past non-compliance. The facility identified a census of 27 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 documented diagnoses of stroke, hypertension and depression. The MDS showed the Brief Interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. Review of the facility provided Incident report dated 6/27/24 at 5:00 p.m., completed by the Director of Nursing Services (DNS) revealed Certified Nursing Assistant (CNA) staff presented to my office to report that on 6/19/24 while providing bedtime cares one of the other CNA staff was frustrated with Resident #12 when he yelled out as his pericare was being provided and she swatted his upper arm as he yelled out. Review of Resident #12's Progress Notes revealed on 6/27/24 at 10:20 p.m., staff notified DNS that an event had been witnessed on 6/19/24 during bedtime cares that another staff had swatted resident on his arm when he had called out during bedtime cares. Review of written statement by Staff D, CNA dated 6/27/24 revealed last week a CNA confided in me that she witnessed Staff C smack Resident 12's arm after getting frustrated with him. She said they were getting Resident #12 read for bed at 10:00 p.m. and changing his brief. He was turned on his side, facing the wall and holding the other CNA's hand. Staff C got upset that he was holding the CNA's hand and smacked his arm. The CNA told her she had no reason to be upset since he wasn't touching her. Review of facility intake information the facility submitted a self report on 6/27/24 at 9:34 p.m Interview on 8/28/24 at 11:19 a.m., with Staff B revealed she was assisting Staff C, CNA with changing Resident #12. Staff B rolled Resident #12 toward her as he had been touching Staff C and she was getting angry. Resident #12 starting touching Staff B and Staff C slapped him on his upper shoulder area. Resident #12 stated ouch you dumb broad. Staff C responded to Resident #12 by saying he needed to stop touching us. When Staff C left the room Staff B looked at Resident #12's upper shoulder area and did not see any red marks. Staff B revealed she now knows that she should have reported the incident right away but did not trust the charge nurse that was working that night as they worked with Staff C on overnight shift. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/26/24 at 11:31 a.m. with Staff D revealed she was working with Staff B on an evening shift. Staff B told Staff D that Staff B witnessed Staff C hit Resident #12. Staff D revealed she told Staff B she needed to report that to the DNS. Staff D revealed she thought Staff B had told the DNS until she worked with Staff B again a couple days later and learned she had not reported it yet. Staff B had asked Staff D to go with her to report it. Staff D revealed she now knows she should have reported the incident as soon as she learned about it. Review of Staff C, CNA's time cards revealed the following information: a. 6/19/24 punch in at 5:49 p.m., and punched out on 6/20/24 at 6:09 a.m b. 6/20/24 punch in at 5:52 p.m., and punched out on 6/21/24 at 6:05 a.m c. 6/25/24 punch in at 5:57 p.m., and punched out on 6/26/24 at 6:05 a.m Review of facility provided policy titled Abuse and Neglect with a reviewed date of 7/22/24 revealed the following information: a. Alleged or suspected violations involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. b. If an employee receives an allegation of abuse, neglect, exploitation or misappropriation of resident property or witnesses suspected abuse, neglect or misappropriation of resident property, the employee will take measures to protect the resident, provided the safety of the employee is not jeopardized. The employee will then report the allegation to a supervisor. b. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation. If this is an injury of unknown origin, he or she also will attempt to determine the cause of the injury. The charge nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident. Interview on 8/28/24 at 3:23 p.m., with the Administrator revealed the incident should have been reported right away to the charge nurse or management to be able to separate the staff member from the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44420 Based on review of the menu, observation, and staff interviews the facility failed to serve the full portions of food and failed to consistently fill and empty scoop utensils when preparing meals for residents. The facility identified a census of 27 residents. Findings include: In an interview on 8/28/24 at 11:35 AM, the Dietary Manager (DM) reported the meals for 8/27/24 and today were partially switched due to meat not being completely thawed. The following replacement meal served to residents per the DM: a. 4 ounces (oz.) pork loin b. 2 oz. pork gravy c. 4 oz. mashed potatoes d. 4 oz. corn e. Bun with margarine Residents on a pureed diet received: a. 4 oz. minced pork loin b. 2 oz. pork gravy c. 4 oz. mashed potatoes d. 4 oz. minced buttered broccoli florets e. Bun with margarine pureed During meal service the DM failed to completely fill and empty the scoop when serving corn and minced pork. When asked if scoops should be completely filled and emptied when plating food, the DM reported yes, but thought the scoop used to serve corn looked too big. The DM reviewed the information and determined the scoop size used for corn as correct. Upon further review the DM determined the scoop size used to serve minced pork showed two residents received 1.5 ounces more while the last two residents failed to receive full scoops of pork. The DM also reported the incorrect scoop size used to serve broccoli shorted the resident 2. 5 ounces of broccoli. The facility failed to provide a policy specifically related to portion size and usage of food scoops when plating food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/29/24 at 8:57 AM, the Administrator reported he expected staff to serve the correct amount of food to residents as per the menu.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 44420 Based on the Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (January 1-March 31) review, facility staffing reports review, and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 27 residents. Findings include: The PBJ Staffing Data Report run date 8/21/24 triggered for excessively low weekend staffing- submitted weekend staffing data is excessively low and failed to have licensed nursing coverage 24 Hours/Day - four or more days within the Quarter with <24 Hours/Day Licensed Nursing Coverage. Review of staffing for nurses and Certified Nursing Assistants (CNAs) scheduled similarly for weekdays and weekends. No issues for nursing coverage found. In an interview on 8/26/24 at 8:57 AM, the Administrator and Director of Nursing reported incorrect payroll data resulted from the amount of hours the employees were not punched in for breaks and worked to correct the issue. The facility planned to check with CMS to see if the change impacted the most recent data submission.

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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. 44420 Based on observation, facility policy and staff interview, the facility failed to provide proper hand hygiene during urinary catheter care for 1 of 1 resident (Resident #16). The facility reported a total census of 27 residents. Findings include: Observation on 8/28/24 at 1:09 PM, Staff E, Certified Nursing Assistant (CNA) donned personal protective equipment (PPE) then retrieved the urine colander out of the closet. Staff D placed the colander in the bathroom, removed and discarded gloves, failed to complete hand hygiene then donned new gloves. Staff D lowered Resident #16's pants then assisted the resident to sit in the recliner. Staff D removed and discarded gloves, failed to complete hand hygiene then donned new gloves. Staff A cleansed the leg bag urine catheter drainage spout, drained the urine, cleansed the drainage spout then placed the spout back into the holder. Staff D emptied urine from the colander into the toilet, removed and discarded gloves, failed to complete hand hygiene then donned new gloves. Staff D then assisted the resident to pull up and fasten pants. Staff E, Nurse Educator present during observation. The Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation policy last revised on 7/30/24 instructed staff to perform hand hygiene after the removal of gloves. In an interview on 8/28/24 at 1:29 PM, when asked if they would do anything different during the observation, Staff E, Nurse Educator stated, I would have completed hand hygiene after changing gloves. The untitled document dated 8/28/24 at 11:25 AM, showed Staff E, Nurse Educator followed up with Staff D, CNA with written education related to hand hygiene. The documentation noted Staff D stated, I should have sanitized my hands in between changing my gloves, but I forgot to take my hand sanitizer out of my pocket, and I couldn't get to it because of the gown.