DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. BUILDING _____ B. WING _____	C 04/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - RED OAK	201 ALIX AVENUE RED OAK, IA 51566

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date 5-24-17 Complaint #67467-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation, that the center is now in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 328 SS=G	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.	F 328	1. Staff A was re-educated by the Director of Nurses on 4/25/17 regarding the omission of entering resident #3 ostomy treatment on the treatment record upon admission. All nurses who performed ostomy care on resident #3 were re—educated on 4/25/17 by the Director of Nurses regarding the missing ostomy care order and not documenting the treatment. 4/26/17 2. All residents with an ileostomy or any skin treatment could be affected. All residents' treatment records were reviewed for accuracy of orders vs. current ostomy/skin issues by the Director of Nurses on 4/25/17. 4/26/17 3. All nurses were re-educated on 4/25/17 by the Director of Nurses reviewing the Good Samaritan Society's policies and procedures "Colostomy/Ileostomy Stoma Care," "Care plan," "Assessment (nursing)," "INTERACT – Change in Condition Evaluation (CICE)," and "Physician/Practitioner Orders." 4/26/17 4. Audits monitoring all residents treatment records for accuracy/completeness of ostomy/skin treatments will be done by the Director of Nurses/designee weekly x4, bi-weekly x2, monthly x3 then brought to the Quality Assurance Performance Improvement Committee for further review. 5. Completion date: 4/26/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Misty Eitzen
TITLE: DNS
(X6) DATE: 05/10/2017

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.

POC accepted 5/12/17 MKinnamon

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F 328	Continued From page 1 (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with staff, physician and hospital wound nurse and review of policy and procedures, the facility failed to provide ileostomy care services in order to meet the needs of the resident (Resident #3). Resident #3 had a new ileostomy and admitted to the facility for education and care for the ostomy. The facility failed to perform adequate and appropriate care to the stoma and intestinal drainage caused the skin to deteriorate and painful. The resident required hospitalization for care of the ostomy. The sample consisted of 4 residents and the	F 328		

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F 328	Continued From page 2 facility reported a census of 50 residents. Findings include: 1. Resident #3 had an admission MDS (Minimum Data Set) assessment with a reference date of 4/12/17. The resident came to the facility from the hospital. The MDS identified the resident had no cognitive problems or behaviors. The MDS indicated the resident required supervision with bed mobility, ambulation, dressing and personal hygiene. The resident required limited assistance with toileting. The Care Plan dated 4/7/17 indicated the resident had a new ileostomy (a stoma (surgical opening) constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin and to the surgical procedure which creates this opening. Intestinal waste passes out of the ileostomy and is collected in an artificial external pouching system which is adhered to the skin. The interventions directed the staff to provide education to the resident/family about managing the ileostomy, provide stoma care per the physician's order and monitor for signs and symptoms of complications regarding the ileostomy. The complications included fever, abdominal pain, guarding, tenderness, altered mental status, drainage or odor from the stoma site, etc. The interventions indicated the nursing staff are to perform the following cares: empty bag, report to nurse if dressing/skin barrier becomes soiled, keep skin clean and dry around site. Review of the hospital transfer/discharge orders dated 4/7/17, indicated the resident discharged from the hospital and transferred to a	F 328		

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F 328	Continued From page 3 rehabilitation facility with a diagnosis of observation for ostomy care. A hospital wound assessment, completed 4/7/17, at 11:10 a.m. indicated the ileostomy wafers had been holding for longer periods. Previous wafer held for 40 plus hours. The hospital wound care nurse spoke to the facility nurse about the resident's wounds and current treatments. A follow-up appointment with the general surgeon and the hospital wound care nurse planned for 4/12/17 in the outpatient clinic. A review of the hospital discharge orders did not include treatment parameters for ileostomy care. A form titled, Nursing Admit Re-Admit Data Collection, dated 4/7/17 at 11:45 a.m. identified the resident had an ileostomy. The assessment had no other information related to the ileostomy. Note: The assessment incorrectly identified the ostomy as a colostomy and bowel sounds diminished. The ileum is a portion of the small intestine and not the large intestine-colon so is an ileostomy. The form titled Skin Observation, dated 4/7/17 indicated the abdomen as beefy red, raw skin around stoma and unable to have the ileostomy appliance (wafer to skin with bag to collect intestinal waste) adhere to the skin. A skin assessment completed 4/10/17 documented denuded (loss of the epidermis (layer of skin), caused by exposure to urine, feces, body fluids, wound exudate or friction). The denuded area measured 6 centimeters (cm) by 9 cm in size. The area appeared beefy red and the wafer around the stoma, wound not adhere. The treatment consisted of a stoma	F 328		

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F 328	Continued From page 4 paste and stoma powder mixed together before wafer attached. The Progress Notes dated 4/7/17 at 11:45 a.m. documented the resident admitted to the facility post strangulated hernia repair with colostomy, Foley catheter and wound care on coccyx. Colostomy (ileostomy) bag intact and the skin excoriated around the wound. Notes dated 4/7/17 at 7:09 p.m. documented the ileostomy in the right upper quadrant (RUQ) leaking periodically with the bag replaced three (3) times. The skin around the stoma very excoriated. Notes dated 4/8/17 at 10:23 a.m. indicated the ileostomy bag leaking and the bag and bed sheets changed. The Progress Notes dated 4/8/17 at 12:45 p.m. documented the ileostomy bag changed twice and the skin around the stoma slightly irritated. Notes dated 4/9/17 at 2:09 a.m. documented the ileostomy bag changed and the skin under the bag and around the stoma as very red, irritated and slightly tender to touch. The Progress Notes dated 4/9/17 at 2:56 a.m. documented the ileostomy bag leaking. Staff changed the bag again and used powder and paste mixed together to help hold bag in place over stoma and didn't use the ostomy ring per resident suggestion. Notes dated 4/9/17 at 9:53 a.m. identified the ileostomy bag slightly leaking and noted not enough paste available. Staff notified the wound nurse who reported she had to get supplies and would come to the resident's room. Staff placed a pad over the area to absorb the leaking contents. The Progress Notes dated 4/9/17 at 10:41 p.m.	F 328		

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F 328	Continued From page 5 noted the ileostomy stoma site red and irritated. Staff noted they would inform the physician of the resident's status. Notes dated 4/10/17 at 1:49 a.m. documented Hydrocodone 5 mg/Acetaminophen (analgesic) 325 mg given as the resident complained of abdominal skin pain. Notes dated 4/19/17 at 3:50 a.m. documented the Hydrocodone/Acetaminophen 5 mg/325 mg given earlier had been effective in reducing the resident's pain. Notes dated 4/10/17 at 8:08 a.m. documented Hydrocodone/Acetaminophen 5 mg/325 mg given as the resident cried in pain from the ileostomy site. Notes dated 4/10/17 at 10:22 a.m. revealed the pain medication effective in reducing the resident's pain. The Progress Notes dated 4/10/17 at 2:01 p.m. documented the resident upset and crying about the ileostomy appliance not sticking. The wound nurse attempted everything to get the dressing to stay. Hydrocodone/Acetaminophen given for pain with relief. Notes dated 4/11/17 at 8:28 a.m. revealed Hydrocodone/Acetaminophen 5 mg/325 mg given as the resident complained of ileostomy pain. Notes dated 4/11/17 at 11:33 a.m. revealed pain medication effective. Notes dated 4/11/17 at 7:10 p.m. documented Hydrocodone/Acetaminophen 5 mg/325 mg given as the resident complained of ileostomy pain. The Progress Notes dated 4/11/17 at 10:13 a.m. documented the ileostomy bag has leaked and caused a red raised area on the abdomen causing discomfort. Notes dated 4/12/17 at 10:00 a .m. documented Hydrocodone/Acetaminophen 5 mg/325 mg given as the resident complained of ileostomy "trouble". The Progress Notes dated 4/12/17 at 10:15 a.m.	F 328		

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F 328	Continued From page 6 documented the resident left the facility for a scheduled appointment with the general surgeon. The facility received a phone call from the local hospital reporting the physician admitted the resident for ileostomy care. The Progress Notes dated 4/12/17 at 12:37 p.m. documented the hospital wound nurse called and reported the resident admitted to the hospital due to the condition of the stoma site. The area around the stoma was so reddened and the feces leaking out around the wafer of the ileostomy. Staff A, a licensed practical nurse (LPN) and wound nurse told the hospital wound nurse the resident had been admitted to the facility with raw skin around the stoma and the ileostomy appliance would not adhere to the skin. The hospital wound nurse asked why she hadn't received a call from the facility so she could "tell you what we were doing here." Staff A reported she did exactly what she (the hospital wound nurse) did while hospitalized by mixing the powder and paste together so the wafer would adhere to the skin. Facility staff had worked with the stoma site multiple times to get the wafer to adhere the skin. A review of Treatment Administration Records (TARs) for 4/7/17-4/12/17 revealed no documentation of an entry for ileostomy care. During a phone interview dated 4/24/17 at 3:55 p.m., the hospital wound nurse reported she would complete a written statement of the events that took place during the resident's hospitalization and collaboration with the facility's wound nurse. The written statement dated 4/24/17 reads as follows: The resident had been hospitalized due to	F 328		

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F 328	Continued From page 7	F 328		

difficulty with her ileostomy appliances not adhering. Hospital staff tried several different styles of appliances, skin preps and adherence techniques. Prior to discharge, an appliance was on for 2 days then the last one on for approximately 12 hours. The hospital wound nurse stated she had talked with Staff A, the facility wound nurse on 4/5/17, explaining the difficulties with the ostomy appliance adhering and what we had discovered worked best at the time. She gave Staff A her cell phone number and encouraged her to call if any problems, even over the weekend. The hospital wound nurse stated she returned a call to Staff B on 4/5/17 in the late afternoon regarding what type of appliance wafers/bags we had used as well as how many so that she could order supplies for the patient. The resident returned to the hospital on 4/12/17 at 10:15 a.m. for a follow up appointment with Wound Care and the physician. On arrival, an ostomy appliance was over the stoma, but not adhered. Patient's skin distal to stoma was red, excoriated and weeping in an area of 30.0 by 20.0 cm. Excoriation also extended anterior to the stoma, but not measured. Area identified as extremely painful even without touching. The resident readmitted to the hospital. The appliance was removed, skin flushed and gently cleansed. A thick layer of Calazime ointment was applied to entire area to protect skin. A roll of fluffed Kerlix gauze was placed over stoma to absorb stool. Staff repeated this procedure approximately every 30 to 60 minutes as needed to absorb stool, protect skin to allow healing. She did not write specific orders regarding the ileostomy care on discharge due to the extended conversations she had with Staff A. Since ensuring that the nursing home had my cell number, I was expecting them to call me if

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F 328	Continued From page 8 problems occurred. No calls were received. During the resident's admission to the hospital (4/12/17), the resident reported nursing home staff had not cut the ostomy wafers to fit the stoma, but had applied the round factory cut over the oval stoma, repeatedly. The resident reported he/she could feel it pop right off. The resident reported the nursing home had run out of supplies and had placed incontinence briefs over area to absorb stool, but no skin barrier was utilized. During an interview dated 4/24/17 at 3:55 p.m. Staff A reported she completed an admission assessment which included a skin assessment which noted the resident had an ileostomy. She reported she had received a phone call from the hospital wound nurse the day before the resident had been admitted (4/7/17) and discussed the problems hospital staff had with the resident's care of the ileostomy. The hospital wound nurse reported the stoma wafer would not adhere to the skin. The hospital wound nurse described the procedure for the placement of the wafer and the stoma care the facility was to follow. She reported she had written down the procedure but she had misplaced the notes and couldn't find them. She reported she hadn't placed the ileostomy care on the TARs and the treatment for the ileostomy had not been documented in the resident's file. Staff A reported she had been aware of the problems facility staff had in caring for the resident's ileostomy care. She voiced her concerns and felt uncomfortable with the situation. She reported she didn't call the resident's physician or the hospital wound nurse with the resident's change in status and the worsening excoriation of surrounding skin and	F 328		

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F 328	Continued From page 9 difficulty with placement of the wafer and appliance. Staff A reported the facility wasn't prepared to care for the resident. During an interview dated 4/25/17 at 9:00 a.m. Staff B, health information management (HIM) officer reported she had spoken to the hospital wound nurse on 4/5/17 regarding what ostomy supplies to order prior to the resident's admission. The hospital wound nurse reported hospital staff had difficulty getting the ostomy pouch/wafer to adhere to the resident's abdomen. Staff B reported she discussed with the hospital wound nurse supplies used previously on another resident specifically for Ileostomy. Both agreed and Staff B ordered the supplies and they arrived the morning of 4/7/17 prior to the admission of the resident. During an interview dated 4/25/17 at 2:50 p.m. Staff C, a registered nurse (RN) reported she had completed ileostomy care for the resident at the request of another nurse who had difficulty successfully placing the wafer and appliance to the ileostomy. She reported the skin around the ileostomy had denuded and she had difficulty with placement of the wafer and appliance. She reported she had not documented the treatment on the TAR, as it hadn't occurred to her to do so. During an interview dated 4/25/17 at 3:10 p.m., Staff D, LPN, reported he remembered two episodes of the resident's ileostomy leaking. He had completed ileostomy care on 4 separate occasions and followed the suggestions made by the resident in the process of cleansing the skin around the area of the stoma, the application of the barrier wipes in order to for a sticky surface for placement of the wafer around the stoma. He reported he didn't document the treatments	F 328		

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because the software program on the computer didn't prompt him to do so. He reported he had documented the resident's status on the facility's "24-hour report sheet" but those reports were not available as the facility destroys them.

During an interview dated 4/24/17 at 3:12 p.m., the resident's general surgeon (also referenced as the resident's physician) reported the hospital wound nurse gave specific instructions for ileostomy care. The surgeon stated he expected facility staff to contact him of any change in the resident's ileostomy status.

The Policy and Procedure titled Colostomy/Ileostomy Stoma Care, with a revised date of 5/16 directed staff to observe condition of the ostomy and prevent complications such as skin irritation or infection, to prevent odor or leakage of intestinal material and monitor throughout the shift and report to the nurse if little or no contents noted in the bag. Staff are to document routine stoma care on the TAR (Treatment Administrative Record) and note color, consistency and amount of stool in ostomy appliance.

During an interview dated 4/25/17 at 7:50 a.m. the Director of Nursing (DON) stated prior to admission, Staff A received a phone call from the hospital wound nurse on 4/6/17. The hospital wound nurse provided instructions for the ileostomy care the resident had received when hospitalized. The DON stated she didn't know exactly what had been discussed. The DON acknowledged the hospital discharge orders didn't include orders for treatment of the resident's ileostomy. She expected facility staff, including the wound nurse to contact the

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F 328	Continued From page 11 resident's physician of any changes in the resident's status and ask for any new orders. Treatments performed by staff needed to be documented in the TARs along with a description of what treatment and the date and time performed.	F 328		