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 _____	10/12/2017

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

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F 000	INITIAL COMMENTS Correction date: 11/9/17 X FW14 Doc 11/2/17 The following deficiencies were identified during the facility's annual survey. Investigation of facility-reported incidents # 69234-I, # 69622-I and #71510-I did not result in deficiency. Complaint #79637-C was not substantiated. See Code of Federal Regulations(45 CFR) Part 483, Subpart B-C.	F 000		
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		

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

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.

Summary - POC accepted 11/8/17

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F 156	Continued From page 1 personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42	F 156		

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F 156	Continued From page 2 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:	F 156		

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F 156	Continued From page 3 (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and	F 156		

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F 156	Continued From page 4 regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 156		

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on facility record review and staff interview, the facility failed to adequately inform two of three residents reviewed of their appeal rights following discharge from skilled services (Residents #2 and #9). The facility reported a	F 156		

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F 156	Continued From page 6 census of 51 residents. Findings include: 1. A facility list titled Residents that Stayed in LTC (long term care), dated 4/9 to 10/9/17, documented Resident #2 received Medicare Skilled (SNF) Services 7/8/17 to 7/28/17. The Notice of Medicare Non-Coverage form CMS 10123 had a signature dated 8/9/17 and the SNF determination on Continued Stay form lacked a box checked, signature and date. The form indicated staff contacted family members on 7/26/17 and left a message. 2. A facility list titled Residents that Stayed in LTC, dated 4/9 to 10/9/17, documented Resident #9 received Medicare Skilled Services 9/25/17 to 10/11/17. The Notice of Medicare Non-Coverage form CMS 10123 had a signature dated 10/10/17. The SNF Determination on Continued Stay form had a signature dated 10/10/17. In an interview on 10/11/17 at 2:20 p.m., the MDS (Minimum Data Set) Coordinator verified resident #2's forms were incomplete and lacked a signature. The MDS coordinator also stated tat Resident #9 did not receive the appropriate 48 hour notices.	F 156		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care	F 279		

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F 279	Continued From page 7 plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and	F 279		

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F 279	Continued From page 8 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility failed to update cares for 2 of 12 residents reviewed (Residents #8 and #11) after displaying behaviors towards other residents and staff members and also failed to update directions on how to transfer a resident when they are being uncooperative (Resident #5). The facility reported a census of 51 residents. Findings include 1. According to the Minimum Data Set (MDS) assessment dated 8/16/17, Resident #8 had a Brief Interview of Mental Status (BIMS) score 15 which indicated no cognitive impairment. The MDS listed the following diagnoses for Resident #8: hypertension, seizure disorder, anxiety, depression, and manic depression. The MDS recorded she displayed no behavioral symptoms or mood problems at the time of the assessment. Resident #8 required the assistance of one staff with transfers, walking, eating and toilet use. Review of Resident #8's care plan, revised on	F 279		

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6/20/17, revealed Resident #8 had impaired cognitive function related to dementia. The resident saw a geriatric psychologist every 8 weeks in the facility. The care plan advised staff to attempt non-pharmacological interventions when Resident #8 experienced impaired thoughts and had signs and symptoms of anxiety and depression.

Review of the Visual/Bedside Kardex (a shortened care plan) for Resident #8 revealed staff should use non-pharmacological interventions when Resident #8 experienced impaired thoughts and she had signs and symptoms of anxiety and depression.

Record review of Progress Notes and Health Status Notes for Resident #8 revealed the following information:
a. 9/22/16 at 4:09 p.m. - Resident #8 went into another resident's room. When staff attempted to remove resident from a room, she stood up and started to hit the nurse.
b. 9/24/16 at 6:58 p.m. - Resident #8 was upset before dinner and received as needed (PRN) pain medication. The resident threw the medications onto the table and refused cares. After dinner, Resident #8 was in the hallway, quiet with back of wheelchair against the wall facing another resident. Resident #8 hit at other resident when resident went by. Resident #8 hit staff several times and another resident one time with an open hand. Resident #8 refused PRN (as needed) medication to decrease anxiety.
c. 12/2/16 at 4:13 p.m. - Resident #8 sat on the edge of her wheelchair. Staff tried to redirect the resident to scoot back and she became very angry and started yelling, cursing and hitting at staff. Staff left Resident #8 alone and she

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scooted herself back in the wheelchair.
d. 12/8/16 at 1:40 p.m. - Resident #8 displayed combative behaviors with all cares today, hitting and yelling at staff.
e. 8/14/17 at 8:41 a.m. - The resident was witnessed yelling and cussing at aides this shift.

The care plan lacked any documentation of Resident #8's behaviors towards staff and peers or how to intervene during these behaviors.

During interview on 10/12/17 at 11:52 a.m. the Social Worker stated care plans are updated quarterly. When a care plans needs to be updated following a behavior the Social Worker stated she updates them with the MDS Coordinator. She stated she knew Resident #8's care plan was just updated after a recent incident on 10/8/17. She stated that she and the MDS Coordinator go through risk management and incidents daily then communicate who will update the care plan.

During interview on 10/12/17 at 12:30 p.m. the MDS Coordinator stated she reviews all of the care plans and is responsible for updating some.

Review of Resident #8's previous care plans with the MDS Coordinator revealed no care plans that addressed her specific behaviors.

During interview on 10/12/17 at 12:30 p.m. the MDS Coordinator stated she would expect a more definitive explanation of behaviors specific for each individual resident to be on the care plans.

2. According to the MDS assessment dated 9/27/17, Resident #11 had a BIMS score of 3

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F 279	Continued From page 11 indicating severe cognitive impairment. The MDS indicated Resident #11 had physical behavioral symptoms directed toward others during 1 to 3 days of the 7-day assessment period; these behavioral symptoms put others at significant risk for physical injury. The MDS listed the following diagnoses for Resident #11: atrial fibrillation, pneumonia, Alzheimer's disease and dementia. Review of Resident #11's care plan, revised on 7/3/17, documented a focus of behavior symptoms and directed staff to minimize potential for resident's disruptive behaviors by offering tasks which divert attention. The care plan also documented a focus of depression with directed staff to attempt non-pharmacological interventions when Resident #11 resisted care and/or displayed depression symptoms. Review of Resident #11's Visual/Bedside Kardex report directed staff to attempt non-pharmacological interventions when she resisted cares and/or displayed depression symptoms. Review of progress notes for Resident #11 revealed the following: a. 8/10/17 at 3:52 p.m. - Resident # 11 attempted to kick her roommate and made no contact. The roommate then attempted to swing at Resident #11, making no contact. b. 9/3/17 at 5:41 p.m. - Resident #11 hit her roommate. The charge nurse stated Resident #11 hit the roommate but there were no injuries. The facility moved the roommate to another hall. The care plan lacked documentation of previous behaviors with peers.	F 279		

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F 279	Continued From page 12 During interview on 10/12/17 at 12:30 p.m. the MDS Coordinator stated she reviews all of the care plans and is responsible for updating some. Review of Resident #11's care plans with the MDS Coordinator revealed no care plans that addressed the resident's specific behaviors. 3. According to the MDS assessment dated 9/20/17, Resident #5 possessed modified independence with cognitive skills for daily decision-making; she had some difficulty in new situations only. The MDS indicated Resident #5 had diagnoses that included heart failure, hypertension, diabetes mellitus and constipation. The resident required the assistance of two staff with transfers and the assistance of one staff for bed mobility. The MDS indicated Resident #5 had unsteady balance and she could stabilize only with staff assistance when moving from seated to standing position and surface-to-surface transfer (a transfer between the bed to the chair or wheelchair). Review of Resident #5's care plan, revised on 9/12/17, revealed a focus of activities of daily living self care deficits related to weakness. The care plan directed to transfer him with the extensive assistance of one and gait belt from the wheelchair to bed, bed to wheelchair, wheelchair to toilet and toilet to wheelchair. Review of Resident #5's Visual/Bedside Kardex also directed staff to transfer the resident with the extensive assistance of one and gait belt from the wheelchair to bed, bed to wheelchair, wheelchair to toilet and toilet to wheelchair. Review of Physical Therapy (PT) Plan of Care,	F 279		

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dated 7/25 to 9/12/17, revealed prior to therapy Resident #5 required minimal assistance for transfers to bed/chair and sit to stand, currently required total assistance with a goal of needing minimal to moderate assistance.

The PT Progress and Discharge summary dated 9/12/17 documented the resident currently required contact guard assistance and had the anticipated goal of needing minimal assistance.

Review of the Occupational Therapy (OT) Plan of Care, dated 7/25 to 9/14/17, revealed prior to therapy Resident #5 showed modified independence (assistive device or extra time needed) for functional transfers and he currently required maximum assistance (76 - 99% assistance) with a goal of modified independence.

Review of the OT Therapist Progress and Discharge Summary with a date of 9/14/17 revealed he currently required minimal assistance (1-25%) with a goal of modified independence (assistive device or extra time needed).

During an observation on 10/11/17 at 6:39 a.m. Staff A Certified Nursing Assistant (CNA) assisted Resident #5 with morning cares. Staff A assisted Resident #5 to the edge of the bed. Resident #5 did not hold himself up in a sitting position and kept leaning back. Staff A obtained a gait belt and placed it on Resident #5 and attempted to transfer Resident #5 to the wheelchair. Resident #5 would not stand up. Staff A then obtained an EZ-stand (mechanical) lift and transferred Resident #5 to the wheelchair.

During interview on 10/11/7 at 6:45 a.m. Staff A

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F 279	Continued From page 14 stated when Resident #5 does not want to cooperate with standing by using a gait belt and staff, staff will use an EZ-stand lift to transfer. Staff A stated it is documented that they are to use the EZ-stand. During interview on 10/12/17 at 11:34 a.m. the Director of Nursing (DON) stated Resident #5 is a 1 to 2 person transfer. The DON stated that it is standard practice to do more than what staff are supposed to do. The DON stated the Social Worker updates care plans after looking at incident reports.	F 279		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, the facility failed to following care plan instructions for 4 of 12 residents reviewed (Residents #1, #2, #3 and #5). The facility reported a census of 51 residents. Findings include 1. According to the MDS (Minimum Data Set) assessment dated 9/20/17, Resident #5 possessed modified independence with cognitive skills for daily decision-making; he had some	F 282		

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difficulty in new situations only. The MDS indicated Resident #5 had diagnoses that included heart failure, hypertension, diabetes mellitus and constipation. The resident required the assistance of two staff with transfers and the assistance of one staff for bed mobility. The MDS indicated Resident #5 as at risk for developing pressure ulcers and listed the following skin and ulcer treatments: pressure reducing device for chair and bed.

Review of Resident #5's care plan, revised 8/21/17, revealed a focus of Activities of Daily Living (ADLs) deficit related to weakness. The care plan directed staff to place heel protector boots while the resident lay in bed only and to float the resident's heels.

The resident's Visual/Bedside Kardex Report (a shortened care plan) also instructed staff to place heel protector boots while the resident lay in bed only and to float the resident's heels.

Review of Resident #5's Treatment Record for October 2017 documented heel protectors to both heels while in bed every shift with a start date of 9/15/17 and to off load heels while in bed every shift for a blister beginning 7/26/17.

During observation on 10/11/17 at 6:39 a.m., Staff A Certified Nursing Assistant (CNA) assisted Resident #5 with morning cares. Resident #5 lay in bed with no heel protectors on and his heels were not floated. Resident #5's feet sat flat against the footboard of the bed. The observation revealed no heel protectors on Resident #5's bed side table, night stand, in the closet or on the dresser.

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F 282	Continued From page 16 During interview on 10/11/17 at 4:15 p.m., Staff B CNA stated Resident #5 wore heel protectors at night because the resident is up all day and he preferred to wear boots during the day. Staff B also stated they are to float Resident #5's heels while in bed. During observation on 10/12/17 at 7:45 a.m., Resident #5 sat up in his wheelchair without shoes on and the heel protectors sat on the bed side table. 2. The MDS assessment dated 8/16/17 documented Resident #1 had diagnoses that included, heart failure, paraplegia, anxiety, osteoarthritis of the knee and a pressure ulcer. The resident scored three out of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Resident #1 required the assistance of 2 staff for bed mobility, transfers, toilet use and personal hygiene activities. The MDS indicated the resident as at risk for pressure ulcer development and that he had one unhealed pressure ulcer. The care plan dated 5/15/17 documented a focus of the potential for pressure ulcer development or re-development related to lower extremity immobility. The care plan instructed staff to provide "heels up" pressure relieving/reducing device when supine (laying flat on his back). Observation on 10/10/17 at 10:37 a.m., revealed the resident laying in bed on his back without his heels elevated. An extra pillow and navy blue bunny boots lay on the dresser. At 11:15 a.m., the resident remained in bed facing the right side with no pillow under the resident's knees and without heel elevation. At 12:00 p.m., the resident	F 282		

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F 282	Continued From page 17 remained in bed with a pillow tucked under his right hip and his feet/heels not elevated. 3. The MDS assessment dated 7/15/17 documented Resident #2 had diagnoses that included Parkinson's disease, anxiety, depression and Non-Alzheimer's Dementia. The MDS indicated the resident scored 12 out of 15 on the BIMS test, indicating moderate cognitive impairment. The resident required the assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS indicated the resident had a fall history prior to admission. The resident's care plan dated 9/27/16 had a focus the risk for falls in part, related to a tendency to want to self-transfer. An intervention instructed to tuck away the lift chair control after positioning the resident for comfort. Observation on 10/10/17 at 10:34 a.m. revealed Resident #2 sitting in her recliner with the call light and lift chair control to the recliner within reach. At 12:51 p.m., the resident sat in her recliner with the lift control within reach on the arm rest. Observation on 10/11/17 at 7:10 a.m. revealed the resident sat up in her recliner with the lift chair control within reach. 4. The MDS assessment dated 7/26/17 indicated indicated Resident #3 had diagnoses that included heart failure, Non-Alzheimer's dementia and dysphagia. The MDS indicated the resident scored four out of 15 on the BIMS test, indicating severe cognitive impairment. The MDS recorded he required the of one staff with bed mobility,	F 282		

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dressing, personal hygiene and eating. The MDS indicated the resident received nutritional intake through a feeding tube.

The resident's care plan, revised on 8/25/17, included a focus of the risk for falls related to dementia and instructed staff to keep the resident's recliner remote control out of reach. Another focus area recorded the resident required a feeding tube and instruction to not keep a water pitcher at the bedside due to his NPO (nothing by mouth) status.

The Visual/Bedside Kardex with a print dated of 10/11/17 under Safety instructed the recliner's remote control is to be out of reach and to ensure no water pitcher at the bedside due to his NPO status.

Observation on 10/10/17 at 10:45 a.m., revealed the resident sitting up in his electric recliner with the recliner remote control within reach and a water pitcher on the bedside table. At 12:42 p.m., the water pitcher remained on the bedside table.

Observation on 10/10/17 at 1:05 p.m., revealed Staff A gave Resident #3 the recliner remote control and he then reclined himself back.

An interview on 10/10/17 at 1:20 p.m., Staff A stated any changes made with the resident's care plans are communicated during report or located on the huddle board. Staff A stated there is a Kardex in the computer that directs staff how to care for individual residents. Staff A verified that Resident #3's Kardex indicated to keep the resident recliner remote control out of reach and he is not to have a water pitcher at bedside due being NPO.

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F 282	Continued From page 19 An interview on 10/12/17 at 11:34 a.m., the Director of Nursing (DON) stated that CNAs have access to a Kardex on the computer and staff are expected to follow residents' individual care plans.	F 282		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, review of records and the facility policy and procedures, the facility failed to prevent an avoidable suspected deep tissue injury wound on the heel (Resident #4). The sample consisted of 2 residents and the facility reported a census of 51 residents. Findings include: 1. Resident #4 had a quarterly Minimum Data Set	F 314		

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(MDS) assessment with a reference date of 5/3/17. The MDS identified the resident had diagnosis including hip fracture, non-Alzheimer's dementia, anxiety, and depression. The MDS indicated the resident scored a 1 out of 15 on the Brief Interview for Mental Status (BIMS). A score of 1 identified the resident had a severe cognitive impairment. The MDS indicated the resident required extensive assistance of 2 staff members for bed mobility, and depended upon 2 staff members for transfers and toilet use. The MDS identified the resident at risk for pressure ulcers and had no pressure ulcers. The MDS indicated the resident used a pressure reducing device on the chair and bed. The MDS indicated the resident weighed 97 pounds.

The Care Plan identified a focus area with activities of daily living (ADL) self-care performance deficit related to a hip fracture manifested by the resident required total care dated 7/31/14.

The Care Plan indicated the resident's ADL preferences dated 6/30/17 included to be put back in bed after meals and [for staff] to turn [the resident] every 2 hours. The intervention on 8/10/17 identified the resident as totally dependent on staff to provide repositioning and turn in bed. The resident is totally dependent on staff for toilet use and is incontinent of bowel. The resident had a bladder indwelling catheter. The Care Plan intervention revision date of 5/26/15 indicated the resident required weight bearing support of 2 staff members with a full body lift.

The Care Plan identified a focus area with the potential for pressure ulcer development related to immobility dated 8/28/14. The Care plan

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F 314	Continued From page 21 directed the staff to turn/reposition the resident at least every 2 hours while in bed, use pillows to ensure proper body alignment, and reposition with 2 people and lifter, and initiated on 6/30/17. Another intervention initiated on 4/13/15 and revised on 8/9/17 directed a pressure relieving/reducing device air mattress on bed and cushion in wheelchair and recliner. The intervention for heel protectors were initiated on 8/9/17. The intervention initiated on 4/13/15 and revised on 6/30/17 and 8/9/17 directed staff to return the resident to bed after meals and turn every 2 hours. The Braden Scale for Predicting Pressure Sore Risk dated 4/26/17 revealed a score of seventeen indicating the resident at risk for skin break down. The Braden Scale for Predicting Pressure Sore Risk dated 7/26/17 revealed a score of seventeen indicating the resident at risk for skin break down. A Progress Note dated 7/20/17 revealed staff noted a 1.5 centimeter (cm) x 1 cm purple area on the left lateral heel. No open areas noted on heels. No erythema noted on periwound (around the wound) skin. Heel protectors applied to bilateral heels to off load heels off bed. Air mattress on bed. A document titled fax communication to physician dated 7/20/17, noted a 1.5 centimeter (cm) x 1 cm purple area on the left medial heel. No open area noted on heel or erythema. Air mattress on bed, heel protects bilateral heels to off load heels, may we apply skin prep to area twice a day (BID) and Arginaid 1 package by mouth BID. The physician responded yes to the above order request on 7/20/17.	F 314		

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F 314	Continued From page 22 A document titled Wound Data Collection identified the following measurements: On 7/20/17, revealed a suspected deep tissue injury (SDTI) to the left lateral heel that measured 1.5 cm x 1 cm. On 7/25/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm and 1 cm redness around purple area. On 7/27/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm, unable to determine depth. 1 cm x 1 cm purple area with 1 cm x 1 cm light redness around purple. On 7/28/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm, soft purple area in center with 1 cm x 1 cm redness around wound. On 8/3/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm. 1 cm x 1 cm purple area with 1 cm x 1 cm purple/red area around center. 8/8/17 revealed a SDTI to the left heel that measured 1 cm x 1 cm. 1 cm x 1 cm dark purple area on left heel with 1 cm x 1 cm purple/red around the center. On 8/13/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm. On 8/15/17, revealed a SDTI to the left heel, area now calloused and measured 2 cm x 2 cm and area dark brown in color and 100 % eschar (dark and leathery, consisting of dead cells). On 8/18/17, a SDTI to the left heel measured 2	F 314		

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F 314	Continued From page 23 cm x 2 cm and area now a soft, partially calloused area. On 8/21/17, revealed a SDTI to the left heel and the area now calloused and measured 2 cm x 2 cm with 100% eschar. On 8/25/17, revealed a SDTI to the left heel that measured 2 cm x 2 cm with 100% eschar. On 8/29/17, revealed a SDTI to the left heel that measured 2 cm x 2 cm with 100% eschar. On 9/2/17, revealed a left heel intact with eschar and no measurements documented. On 9/5/17, revealed a SDTI to the left heel, area now calloused and measured 1.3 cm x 1.3 cm with a 100% eschar. On 9/8/17, revealed a SDTI to the left heel that measured 1.2 cm x 1.2 cm with 100% eschar. On 9/13/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm calloused area. On 9/15/17, identified a SDTI to the left heel that measured 1 cm x 1 cm calloused and stable with 100% eschar. On 9/17/17, the left heel has half black eschar and half red healing. On 9/18/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm calloused area with 100% eschar. On 9/23/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm calloused area with 100% eschar.	F 314		

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F 314	Continued From page 24 On 9/28/17, revealed a SDTI to the left heel that measured 1 cm x 1 cm stable callous. On 10/4/17, revealed a SDTI to the left heel, area light brown , stable callous that measured 0.5 cm x 0.5 cm. On 10/9/17, revealed a SDTI to the left heel which measured 0.5 cm x 0.5 cm calloused area. On 10/10/17 at 6:45 a.m., observation identified the resident had an approximate 1 cm (centimeters) x [by]1 cm callous on the left heel. The treatment record dated 7/1/17-7/31/17 directed staff to apply skin prep to the left medial heel BID with a start date of 7/21/17. The treatment record dated 8/1/17-8/31/17 directed staff to apply heel protects to bilateral heels, off load heels while in bed every shift with a start date on 8/8/17. On 10/12/17 at 8:13 a.m., the Director of Nursing (DON) was interviewed and stated Resident #4 was a full body lift prior to the suspect deep tissue heel injury. The resident was dependent on staff for transfers and repositioning. The DON doesn't recall any injury that caused the suspected deep tissue injury and feels it was developed by not suspending the heels and due to pressure. An interview on 10/12/17 at 9:30 a.m., Staff C licensed practical nurse (LPN), stated the resident has been a full body lift and dependent on staff prior to the injury and feels the suspected deep tissue injury was caused due to pressure. On 10/12/17 at 10:00 a.m., Staff D LPN/Wound	F 314		

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F 314	Continued From page 25 Care Nurse, was interviewed and stated the resident had navy blue heel protectors on and had worn those for a long time. The navy blue heel protectors are a preventative and placed per nursing judgement. An order was obtained for a different heel boot that suspended the heels after the SDTI developed. Staff D stated the resident was a full body lift and depended on staff for bed mobility. The policy and procedures titled Pressure Ulcers, revised January 17, directed the staff that based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable.	F 314		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		

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F 441	Continued From page 26 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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(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 441	Continued From page 27 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, staff interview and facility policy review, the facility failed to perform proper hand hygiene for 2 of 7 residents observed during incontinent cares (Residents #5 and #7). The facility reported a census of 51 residents. Findings include: 1. According to the MDS (Minimum Data Set) assessment dated 9/20/17, Resident #5 possessed modified independence with cognitive skills for daily decision-making; he had some difficulty in new situations only. The MDS indicated Resident #5 had diagnoses that included heart failure, hypertension, diabetes mellitus and constipation. The resident required the assistance of two staff with transfers and the assistance of one staff for bed mobility. The MDS indicated Resident #5 is frequently incontinent of urine and bowel. Review of Resident #5's care plan, revised on 9/12/17, directed to transfer Resident #5 with the extensive assistance of one and gait belt for wheelchair to bed, bed to wheelchair, wheelchair to toilet and toilet to wheelchair transfers. During an observation on 10/11/17 at 6:39 a.m.	F 441		

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 _____	10/12/2017

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GOOD SAMARITAN SOCIETY - RED OAK	201 ALIX AVENUE RED OAK, IA 51566

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F 441	Continued From page 28 Staff A Certified Nursing Assistant (CNA) washed her hands, donned gloves and placed wet wipes on the head of the resident's bed. Staff A then put on the resident's edema wear, socks and checked his incontinent pad, put on resident's pants, shoes and assisted Resident #5 to the edge of the bed and finally assisted him to put a shirt. Staff A then moved the wheelchair next to the bed and attempted to stand Resident #5 but he would not stand up. Staff A then stepped out of the room and obtained an EZ-stand lift. Staff A then removed her gloves, donned a new pair without performing hand hygiene and assisted Resident #5 to stand with the EZ-stand lift. Staff A removed the incontinence pad, performed peri-care with the wet wipes placed on the bed and using the same gloved hands, she manipulated the EZ-stand lift and removed the incontinent pad. Staff A then removed her left glove and pulled up Resident #5's brief and pants with both hands. Staff A then took off the glove on her right hand and used the EZ-stand to transfer the resident to the wheelchair. Staff then washed her hands before taking Resident #5 to breakfast. Staff A failed to perform hand hygiene after providing perineal care and before completing other tasks and touching other surfaces. 2. According to the MDS assessment dated 7/19/17, Resident #7 had a Brief Interview of Mental Status Interview score of 2, indicating severe cognitive impairment. The MDS listed she had diagnoses that included mental disorders due to a physiological condition and constipation. The MDS indicated Resident #7 required the assistance of one staff with bed mobility and personal hygiene and as frequently incontinent of urine and bowel.	F 441		

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 _____	10/12/2017

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F 441	Continued From page 29 Review of Resident #7's care plan, with a revision date of 1/20/17, revealed she required staff participation for toilet use. The resident was incontinent of bowel and bladder and wore incontinence products. During observation on 10/1017 at 6:54 a.m., Staff A assisted Resident #7 to the toilet with an EZ-stand lift. Staff A wore gloves, provided perineal care, took her gloves off and put a new incontinent pad on Resident #7's cloth brief and the pulled up Resident #7's pants without performing hand hygiene between tasks. Staff A then assisted Resident #7 to the wheelchair with the EZ-stand lift. Staff A donned gloves, obtained Resident #7's toothbrush and toothpaste so the resident could brush her teeth. Staff A then brushed Resident #7's hair and put Resident #7's hearing aids in place. Staff A then removed her gloves and transferred Resident #7 to the television room. Staff A then went back in to Resident #7's room and washed her hands. During interview on 10/12/17 at 11:34 a.m., the Director of Nursing (DON) stated she expects staff to wash their hands between clean and dirty tasks. A review of the facility's Hand Hygiene and Handwashing Procedure with a revision date of 3/16 revealed if hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning hands: before having direct contact with residents, patients and children; after having direct contact with another person's skin; after touching equipment or furniture near the resident/patient; and after removing gloves.	F 441		

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 _____	10/12/2017

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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 not 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.

F156

Correction to the affected individuals: It's too late to correct for resident #2 & #9 .Going forward the facility's policies and procedures will be followed to insure that the proper notices are given at the correct times.

Measures taken to ensure problem does not occur: Residents receiving Medicare skilled services or part B service have the potential to be affected. Going forward the facility's policies and procedures will be followed to insure that the proper notices are given at the correct times.

Measures taken to ensure problem does not occur: The Medicare Team was educated on the notice of Medicare Non coverage and the SNF determination on continued stay on 10/31/17 by GSS National campus Medicare Specialist, Nathan Ovenden. A tracking system for notification will be initiated and monitored for timely notification by the MDS Coordinator.

Monitor performance: Notice of Medicare non coverage and SNF determination on continue stays will be audited for accuracy and timely notification weekly x 4 twice a month x w months. Results of the audit will be reported to QAPI committee for review and further recommendation.

Completion date: Nov. 9, 2017.

F279

Correction to the affected individuals: Resident # 8 care plan will be update to reflect current/ historic behaviors. Resident # 11 care plan will be update to reflect current / historic behaviors. Resident # 5 care plan will be updated to reflect resident's intermittent need for sit to stand or other assistive device for transfers.

Action to protect residents in similar situations: Residents that have exhibited behaviors within the past 3 months will be reviewed to make sure care plan reflects behaviors and appropriate interventions are in place. IDT team will review residents care plans, who need assistance with transfers, to ensure appropriate interventions are documented.

Measures taken to ensure problem does not reoccur: Licensed nurses will be educated by the staff development coordinator or designee on 11/6/17 and 11/7/17 to document mood and behaviors under the progress heading of mood/behavior and updating care plans. Resident's behavioral care plan will be reviewed by the Interdisciplinary team at the weekly At Risk Committee and will be updated as needed.

Monitor Performance: Progress notes will be audited for mood/behavior to assure any new behavior/behavior is captured in the residents care plan. Audit will be completed weekly x 4 and twice per month x 2 months. Results of the audit will be reported to QAPI committee for review and further recommendation.

Completion date: Nov. 9, 2017.

F282

Correction to the affected individuals: Resident #1, 2, 3, & 5 care plans were reviewed by the IDT. Resident #5 will have heel protectors, heels floated when in bed, and have shoes or non-slip slippers on when up in chair. Resident #1 heel s will be floated when in bed. Resident # 2 chair control will not be within reach as indicated on the care plan. Resident #3 will not have chair control within reach, water pitcher was removed from room.

Action to protect residents in similar situations: All residents who are considered at pressure ulcer risk development care plan were reviewed to make sure appropriate interventions are in place and being followed. All residents who are in electric recliner chairs were evaluated for safeness of utilizing these chairs and the controls associated with them.

Measures taken to ensure problem does not reoccur: All nursing staff will be educated on pressure ulcer risk, interventions associate with and the importance of caring out the interventions on 11/6/17 and 11/7/17 by the Staff Development Coordinator or designee. Nursing staff will be educated on residents who cannot have a water pitcher due to NPO status and residents with electric recliners on 11/6/17 and 11/7/17 by the Staff Development Coordinator or designee. The facility contacted the QIO on 11/2/17 to request further information and training on pressure ulcer care and prevention.

Monitor performance: Audits will be completed daily, various shifts, on pressure ulcer risk intervention implementation, electric recliner controls and water pitchers for NPO residents daily, various shifts, x 3 weeks, then 3x/week for 3 weeks, then weekly x 3 weeks. Results of audits will be reported to QAPI committee for review and further recommendation.

Completion date: Nov 9, 2017

F314

Correction to the affected individuals: Per the care plan, Resident #1 has heels floated or other pressure relieving device for heels while in bed, has air mattress in place, and pressure relieving device in wheelchair. Interventions for resident #1 were reviewed and updated for accuracy on 10/31/17.

Action to protect residents in similar situations: All residents with pressure ulcer risk were reviewed by the DNS to make sure appropriate interventions are in place and being used on 11/3/17.

Measures taken to ensure problem does not recur: All staff will be educated on pressure ulcer risk, interventions associate with and the importance of caring out the interventions on 11/6/17 and 11/7/17 by the Staff Development Director or designee. The facility contacted the QIO on 11/2/17 to request further information and training on pressure ulcer care and prevention.

Monitor Performance: Audits will be completed daily, various shifts, on pressure ulcer risk intervention implementation on various shifts, x 3 weeks, then 3x/week for 3 weeks, then weekly x 3 weeks. Results of audits will be reported to QAPI committee for review and further recommendation.

Completion date: Nov. 2, 2017

F441

Correction to the affected individuals : Staff will perform proper hand hygiene for Resident # 5 when perform cares. Staff will perform proper hand hygiene when perform cares for resident #7. Staff A will be re-educated on proper hand hygiene while performing cares during staff education on 11/6/17 and 11/7/17.

Action to protect residents in similar situations: All residents that require cares have the potential to be affected. Staff A will be re-educated on proper hand hygiene while performing cares during staff education on 11/6/17 and 11/7/17.

Measures taken to ensure problem does not recur: All nursing staff will be reeducation on proper hand hygiene procedure, knowledge and skills will be validated by the Staff Development Coordinator or designee on 11/6/17 and 11/7/17.

Monitor Performance: Random observation audits on hand hygiene during cares will be conducted 3 x a week x 6 weeks, twice a week x 2 weeks then weekly x 4.

Completion date: Nov 9, 2017