

**Iowa Department of Inspections and Appeals**  
**Health Facilities Division**  
**Citation**

Citation Number: <b>6919</b>		Date: <b>February 15, 2019</b>		
Facility Name: <b>Good Samaritan Society-Red Oak</b>		Survey Dates: <b>January 28 to January 31, 2019</b>		
Facility Address/City/State/Zip: <b>201 Alix Avenue Red Oak, IA 51566</b>		MW/SS		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date
<b>58.24(4)d</b> <p><b>481—58.24(135C) Dietary.</b>  <b>58.24(4) Therapeutic diets and nutritional status.</b>  <i>d. The facility shall ensure that each resident maintains acceptable parameters of nutritional status, such as body weight, unless the resident's clinical condition demonstrates that this is not possible. (I, II, III)</i></p> <p><b>DESCRIPTION:</b></p> <p>Based on clinical record review, observation, and staff interview, the facility failed to initiate a dietitian recommendation for dietary supplement for two residents with a weight loss of greater than 9 % in one month (Residents #44 and #46) out of three residents reviewed for nutrition. The facility reported a census of 53 residents.</p> <p>Findings include:</p> <p>1. The admission Minimum Data Set (MDS) assessment dated 1/6/19 for Resident #44 identified a Brief Interview for Mental Status (BIMS) score of 3 without signs/symptoms of delirium. A score of 03 indicated severe cognitive impairment. The MDS revealed the resident independent with no setup help needed from staff for eating. The MDS documented diagnoses that included Crohn's disease (a chronic inflammatory bowel disease that affects the lining of the digestive tract), diabetes, other fracture, and non-Alzheimer's dementia. The MDS recorded a weight of 105.0 lbs (pounds). The assessment documented she entered the facility on 12/31/18.</p>	<b>I</b>	<b>\$ 2250.00</b>	<b>Upon Receipt</b>	

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	<p>The care plan focus area dated 12/31/18 identified an ADL (Activities of Daily Living) self care deficit related to dementia and cast to right arm. The care plan informed staff Resident #44 could hold a cup, feed herself, and eat finger foods independently. The care plan focus area revised 1/2/19 identified a potential nutritional problem related to a decline in cognitive ability. The care plan focus area revised 1/8/19 identified impaired cognitive function related to dementia evidenced by forgetfulness and need for cues or reminders.</p> <p>The Progress Notes dated 1/16/19 at 11:45 a.m. documented a care conference held that included discussion of the resident's eating habits and her current weight with the resident's family.</p> <p>The Progress Notes dated 1/17/19 at 11:11 a.m. documented a Nutritional Status Dietician Assessment. The assessment recorded the resident ate 50% of meals independently with no chewing or swallowing problems. The assessment documented the resident's current body weight measured 97.0 lbs, her ideal body weight would be 100 lbs, and an admission weight 105 lbs. The Dietician wrote Resident #44 was at risk for impaired nutritional status related to dementia. The assessment documented interventions to maintain her weight or gain, maintain skin integrity, improve the resident's oral intake to greater than 50% of all meals and continue diet as ordered. The Dietician recommended that staff start a house supplement 90</p>			

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	<p>ml (milliliters) TID (3 times a day), weigh as ordered, and report weight/appetite changes to RD (Registered Dietician).</p> <p>The Progress Notes dated 1/17/19 at 12:30 p.m. documented a weight warning of a 7.6% weight loss and to see the RD assessment dated 1/17/19.</p> <p>The Weights and Vitals Summary dated 1/30/19 recorded the following weight measurements for Resident #44:</p> <p>12/31/18 - 105.0 lbs;  1/1/19 - 97.0 lbs;  1/18/19 - 96.0 lbs;  1/25/19 - 95.5 lbs.</p> <p>Comparison of the starting weight of 105.0 lbs with the ending 95.5 lbs showed a weight loss of 9.05% in one month.</p> <p>The clinical record lacked documentation that staff provided the resident's house supplement 90 mls TID.</p> <p>Observation on 1/29/19 at 4:43 p.m. revealed the resident walked independently into the dining room following her husband to the table, greeting others and socializing. At the time of the observation, the Director of Nursing (DON) reported the resident as very social and on the go since she arrived to the facility.</p> <p>In an interview on 1/30/19 at 2:25 p.m., the DON acknowledged she expected the nursing staff to document the administration and consumption of</p>			

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<p>house supplements on the EMAR (Electronic Medication Administration Record). Review of the EMAR revealed no administration of supplements. At 4:15 p.m., the DON stated the dietician's recommendations from the 1/17/19 assessment were not passed on to anyone and therefore the recommendations got missed. The DON reported Resident #44 did not receive the house supplement 90 mls TID as recommended.</p> <p>2. The admission MDS assessment dated 1/9/19 for Resident #46 identified a BIMS score of 02 with continuous signs of disorganized thinking. A score of 02 indicated severe cognitive impairment. The MDS revealed the resident independent with no setup help needed from staff for eating. The MDS documented diagnoses that included thyroid disorder, Non-Alzheimer's dementia, and malnutrition. The MDS recorded a weight of 122.0 lbs.</p> <p>The care plan focus area revised 1/3/19 identified an ADL self care performance deficit related to dementia and right hip fracture/post-op right hip hemiarthroplasty (surgical hip joint replacement). The care plan informed staff the resident could hold a cup, feed himself, and eat finger foods independently. The care plan focus area dated 1/3/19 identified a nutritional problem or potential problem related to poor nutrition evidenced by weight loss. The care plan intervention dated 1/11/19 informed staff Resident #46 had an order for medical nutritional supplement and to see the EMAR. The care plan focus area dated 1/22/19</p>				

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	<p>identified impaired cognitive function related to dementia evidenced by pleasantly confused and forgetful with need for cues or reminders</p> <p>The Progress Notes dated 1/17/19 at 11:28 a.m. documented a Nutritional Status Dietician Assessment. The assessment recorded Resident #46 ate 50% of meals independently with no chewing or swallowing problems. The assessment documented his current body weight measured 105.0 lbs, a usual body weight of 117 lbs, and an admission weight of 122 lbs. The Dietician wrote the resident underweight status as evidenced by a BMI (Body Mass Index) of 16. The assessment documented interventions included to gain weight, improve his oral intake to greater than 75% of meals, improve skin integrity and continue diet and nutritional supplements. The Dietician recommended that staff administer Ensure pudding TID with meals, weigh as ordered, and report weight/appetite changes to RD.</p> <p>The Progress Notes dated 1/17/19 at 12:29 p.m. documented a weight warning of a 14% weight loss and to see the RD assessment dated 1/17/19.</p> <p>The Weights and Vitals Summary dated 1/31/19 recorded the following weight measurements for Resident #44:</p> <p>1/2/18 - 122.1 lbs; 1/11/19 - 105.0 lbs; 1/18/19 - 106.0 lbs; 1/25/19 - 110.0 lbs.</p>			

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	<p>Comparison of the starting weight of 122.1 lbs with the ending 110.0 lbs showed a weight loss of 9.91% in less than one month.</p> <p>The clinical record lacked documentation that staff provided the resident's Ensure pudding TID following the dietitian's assessment and recommendation on 1/7/19.</p> <p>Observation on 1/28/19 at 1:02 p.m. revealed Resident #46 appeared very thin with the outline of his rib cage visible as he laid in bed.</p> <p>Observation on 1/29/19 at 4:38 p.m. revealed Resident #46 self-propelled into the dining room for supper and conversed with his wife to tell her where they sat and to prepare for supper. At the time of the observation the DON stated she thought the resident's admission weight was an error as the resident looked no different that day than the day he came; very thin. The DON said the resident had been eating 50% or more of meals and doing pretty good. The DON thought Resident #46 had started on a supplement. The DON reported he just snacked throughout the day for meals at home and since being in the facility had been very active and social, on the move. The DON said the resident had snacks in his room as well.</p> <p>In an interview on 1/30/19 at 4:15 p.m., the DON confirmed the dietitian's recommendations from the 1/17/19 assessment did not get passed on to anyone and therefore the recommendations got missed. The</p>			

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	<p>DON reported the resident did not receive the ensure pudding TID with meals as recommended.</p> <p><b>FACILITY RESPONSE:</b></p>			

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