STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 2/22/19 The annual health survey resulted in the following deficiencies. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		

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.

POC accepted 3/1/19 VV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff and family member interviews, the facility failed to promptly notify a resident's representative regarding a physical change in condition for one of three residents reviewed for hospitalization (Resident # 17). The facility reported a census of 46 residents. Findings included: According to a Minimum Data Set (MDS) assessment dated 9/24/18, Resident #17's diagnoses included Alzheimer's disease and diabetes mellitus. The MDS identified the resident's Brief Interview Mental Status (BIMS) as 7, indicative of severely impaired cognition. The MDS revealed the resident as independent with	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 580	Continued From page 2 bed mobility, transfers, dressing and had a steady balance and required the use of a urinary catheter. Resident #17's care plan included a focus, with an initiation date of 7/31/18, for an indwelling catheter related to an enlarged prostate and history of urinary retention. The care plan included an intervention for staff to monitor, record and report to a health care provider any signs and symptoms of pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature (temp), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. Review of Resident #17's nursing Progress Notes revealed the following information: On 10/15/18 at 2:03 P.M., Resident #17 had a Foley (urinary) catheter draining straw colored urine (straw colored urine is considered normal color). On 10/15/18 at 5:42 P.M. - The resident displayed increased confusion, a low grade fever of 99.8 degrees Fahrenheit (F), abdominal tenderness at times, purulent green discharge in his catheter bag. Other vitals: Pulse (p)- 96 beats per minute (bpm), Respirations (r) -18 per minute, blood pressure (BP) 140/84. Staff requested a UA (urinalysis). On 10/15/18 at 8:40 P.M. - Staff described Resident #17 as confused and he refused supper. The urine in his catheter had increased odor, purulent drainage and at times he stated he	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 580	Continued From page 3 had abdominal pain. Staff documented a low grade temp of 99.8 degrees F and sent a fax (facsimile) to the physician to inquire about a UA. On 10/15/18 at 8:01 P.M. - Staff documented a 'Change in condition, symptom or signs called about' note regarding Resident #17's altered mental status and fever. Staff documented the resident's vital signs as t- 99.8, p-96 r-18. Review of a Change in Condition Evaluation form dated 10/15/18 at 8:01 P.M., revealed staff documented Resident #17 had altered mental status, fever and the following vital signs: BP-140/84, t-99.8, p- 96, r-18. Staff described the resident with increased confusion, an abrupt significant change in cognitive function, symptoms or signs of pain, abdominal distension or tenderness, occasional labored breathing and documented the resident's symptoms as worse since the initial change in condition occurred. On 10/16/18 at 12:05 A.M. staff documented the resident complained of being cold and shivering and administered Tylenol 650 milligrams (mg). On 10/16/18 at 10:24 A.M. - Staff documented the resident as very weak and lying naked across his bed this morning. He sat up with the assistance of two staff and a nurse needed to help him get dressed. The resident walked to a recliner with his walker with a slow unsteady gait. The resident complained he had not felt well and wanted to return to bed after breakfast. Staff described the resident's urine in his drainage bag as thick milky white in color. Staff documented the resident's daughter had been in the facility and aware of the resident being ill.	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 580	Continued From page 4 In an Emergency Department Provider note dated 10/16/18 at 2:18 P.M., the physician documented Resident #17 presented to the ER with fever and confusion. The physician documented a septic workup had been initiated and described the resident's urine as a thick purulent liquid and because of the urine and the indwelling catheter, the resident's sepsis was probably due to the catheter. The physician diagnosed the resident with a bladder infection and sepsis. A History and Physical note dated 10/17/18 at 5:49 P.M. documented the resident with acute renal failure. During telephone interview on 1/30/19 at 3:44 P.M., the resident's daughter stated the facility did not let her know of her father's change in condition until she received a phone call on 10/16/18, when they informed her that her father was very ill and he needed to be transferred to an emergency room. She stated she absolutely would have wanted to be notified immediately the moment her father started to become ill.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 609	Continued From page 5 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility policy review, facility staff failed to report a resident to resident altercation to the state survey and certification agency involving two of two residents reviewed (Residents #5 and #147). The facility reported a census of 46 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 10/19/18, Resident #5 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included dementia. The nursing Progress Notes dated 11/18/18 at 3:40 p.m. documented Resident #5 sat in the common area next to a male resident. When she	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 609	Continued From page 6	F 609		

got up the male resident grabbed her right arm and pulled her back down into the chair stating sit your ass back down. No injuries/bruising noted to her right arm at the time. Would continue to monitor.

2. According to the MDS assessment dated 11/9/18, Resident #147 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included Alzheimer's disease.

The nursing Progress Notes dated 11/18/18 at 3:45 p.m. documented the resident sat in a recliner in the common area when a female resident came and sat next to him. When she went to get up, Resident #147 grabbed her right arm and pulled her back down into the chair stating sit your ass back down. The residents were separated and no injuries were noted.

During an interview on 1/29/19 at 11:53 a.m. the Administrator stated they did not report the altercation between Resident #5 and Resident #147 (to the state survey and certification agency).

During an interview on 1/29/19 at 1:38 p.m. Staff A Certified Nursing Assistant (CNA) stated she recalled the incident in November with Resident #5 and Resident #147. She said she was at the computer and saw Resident #5 walk over where Resident #147 sat. She heard Resident #147 say don't look at me. Resident #5 did not say anything, she just sat down. Resident #5 then stood up and Resident #147 grabbed her arm and yanked her down into the chair and told her to sit her ass back down. Staff A stated as soon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 609	Continued From page 7 as Resident #5 sat down Resident #147 let go of her arm. Staff A said you could tell by Resident #5's body language it was not a gentle grab. She said Resident #5 had redness to her arm that dissipated pretty quickly but she didn't want anyone touching her arm. Staff A thought Resident #147 grabbed the elbow or a little above. She said Resident #147 definitely yanked her down. During an interview on 1/29/19 at 1:53 p.m. Staff B CNA stated when the incident occurred he sat with another resident and her husband. Resident #147 sat in a recliner and Resident #5 wandered around per her usual. Resident #5 sat in the chair next to Resident #147. It didn't appear threatening. When Resident #5 stood up Resident #147 grabbed her arm and pulled her back down. Resident #5 made a little noise and they responded immediately. Resident #147 let go of her arm. Resident #5 had a red mark but it didn't last. During an interview on 1/30/19 2:20 p.m. Staff C Licensed Practical Nurse (LPN) stated she documented the incident 11/18/18. The day of the incident she was facing the other way when she heard Resident #5 holler out. She turned to see Resident #147 had a hold of her arm and pulled her down to the chair. It was not gentle, he pulled her down and said sit your ass down. She said they responded immediately and he let go. The facility Abuse and Neglect Policy and Procedure revised 10/18 documented the purpose included assurance that all identified incidents of alleged or suspected abuse/neglect were promptly investigated and reported. The policy included alleged or suspected violations	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 609	Continued From page 8 involving any mistreatment, neglect, exploitation or abuse including injuries of unknown origin would be reported immediately to the administrator and to other officials in accordance with state law, including the state survey and certification survey.	F 609		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 625	Continued From page 9 by: Based on clinical record review, staff interview and facility policy review, facility staff failed to provide written information to the resident or the resident representative of the facility bed hold policy for three of three residents reviewed (Residents #18, #28, and #17). The facility reported a census of 46 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 9/7/18, Resident #18 scored 3 on Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The resident's diagnoses included Alzheimer's disease. The nursing Progress Notes dated 10/20/18 at 4 p.m. documented the primary care provider gave the order to transfer the resident by ambulance. The hospital nurse called with an update and they would keep the resident for at least a couple days for chronic obstructive pulmonary disease (COPD) exacerbation, urinary tract infection (UTI) and new onset atrial fibrillation (an irregular heart rhythm). The clinical record lacked documentation that staff provide written information of the bed hold policy. During an interview on 1/29/19 at 1:12 p.m. the Director of Nursing (DON) stated they did not have record of bed hold information for the resident's admission to the hospital. 2. According to the MDS assessment, dated 7/16/18, Resident #28 demonstrated long and	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 625	Continued From page 10 short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included anxiety and depression. The nursing Progress Notes dated 7/30/18 at 8:59 a.m. documented the resident's discharge/therapeutic leave instructions. The nursing Progress Notes 8/16/18 at 1:27 p.m. documented a readmission note. The note included the resident received services at a hospital. The clinical record lacked documentation that staff provided written information of the bed hold policy. During an interview on 1/29/19 at 12:45 p.m. the DON stated the documentation did not specifically state they (resident/resident representative) were notified of the bed hold. 3. The MDS assessment, dated 9/24/18, recorded Resident #17's diagnosis included Alzheimer's disease. The MDS identified the resident's BIMS score of 7, indicative of severe cognitive impairment. On 10/16/18 at 1:20 P.M., staff documented the resident required transfer to an emergency room due to a change in his physical status. On 10/23/18 at 4:18 P.M., staff documented the resident returned to the facility after a hospital admission. The clinical record lacked documentation of the resident or the resident's family receiving any information on the facility's bed hold policy.	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 625	Continued From page 11 During interview on 1/29/19 at 3:31 P.M., the DON stated the facility had no bed hold documentation in regards to the resident's hospital stay 10/16 - 10/23/18. During interview 1/30/19 at 9:00 A.M., the Administrator stated the facility had not charged residents for bed holds, but confirmed there needed to be documentation the bed hold policy had been reviewed with a resident or the resident's representative. A facility Policy re: Bed-Hold Notice, with a revision date of 11/2016, included a policy for staff to provide information to a resident or the resident's representative at the time of an admission, transfer or therapeutic leave that specified the duration of the bed hold policy and how a resident is permitted to return and resume the same residence.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 655	Continued From page 12 (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to review baseline care plan with the resident or resident representative within 48 hours after admission to the facility for one of four residents reviewed (Resident #3). The facility reported a census of 46 residents. Findings include:	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 655	Continued From page 13 Resident #3's Minimum Data Set (MDS) assessment dated 1/11/19 showed a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition. The resident's Admission Record dated 1/17/18 documented the resident's niece acted as her primary contact person. Review of the resident's Care Plan showed a created date of 1/17/18 and no documentation or signature to show that staff reviewed the care plan with the resident or her representative within 48 hours of admission to facility. Review of her clinical chart and progress notes revealed no documentation of review of the care plan with Resident #3 or her representative within 48 hours of admission to the facility. On 1/30/19 at 12:51 PM, the Director of Nursing stated she could not show documentation staff reviewed the resident's Baseline Care Plan with either the resident or her representative within 48 hours of admission.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 657	Continued From page 14 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and resident and staff interviews, the facility failed to revise the comprehensive care plan to reflect accurate transfer needs, pain interventions and behavioral symptom interventions for two of 13 total residents reviewed (Residents #30 and #45). The facility reported a census of 46 residents. Findings include: 1. Resident #30's Minimum Data Set (MDS) assessment dated 12/7/18 documented he had a Brief Interview for Mental Status (BIMS) of 15 indicating intact memory and cognition. The assessment documented he had independence with bed mobility, transfer, walking in and out of room, locomotion on and off unit, and toilet use. This resident required set up help with personal hygiene and the assistance of one with dressing. The resident's diagnoses included atrial	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 657	Continued From page 15 fibrillation, heart failure, orthostatic hypotension, renal insufficiency, diabetes, a history of transient ischemic attack and cerebral infarction, shortness of breath and long term current use of insulin. An observation on 1/29/19 at 3:08 PM showed Staff D and Staff E (certified nursing assistants) transferred Resident #30 with an electric stand from the wheelchair to the resident's recliner. In review of Care Plan interventions for Activities of Daily Living (ADL) self-care performance deficit with a revision date of 1/22/19 showed Resident#30 is unable to walk at this time. In review of impaired mobility focus showed resident as able to walk independently through the facility without staff assistance, with an initiation date of 9/18/18, and used four wheeled walker for ambulation with an initiation date of 5/16/16. In review of After Visit Summary from the Emergency Room dated 1/19/19 showed resident with closed nondisplaced fracture of greater trochanter of right femur. The resident presented by ambulance stating he walked out of his room at 4 PM today, went to turn and fell onto his right hop. Resident #30 used the walker at the time. He was assisted to a chair, but could not bear full weight to his right leg without significant pain. Discharge medications included Tylenol 650 mg (milligrams) scheduled three times daily for three days and Hydrocodone-Acetaminophen (narcotic pain reliever) 5/325 mg 1 tablet every 4-6 hours as needed for three days. In review of Family Health Care clinic note dated 1/25/19 showed resident with present joint pain.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 657	Continued From page 16 In review of January Medication Administration Record (MAR) showed Resident #30 with current physician orders for Tylenol 325 mg by mouth every 6 hours as needed for pain (no doses given in January 2019), Tylenol 650 mg by mouth every 6 hours as needed for pain (one dose given each day on January 23rd, 27th and 30th, 2019), Hydrocodone-Acetaminophen 5/325 mg one tablet by mouth every 4 hours as needed for pain (two doses given on January 23rd and one dose given on January 24th, 2019) and Hydrocodone-Acetaminophen 5/325 mg one tablet every 4 hours as needed for severe pain for three days (one dose given January 21st and two doses given January 22nd, 2019). Resident #30 had scheduled Tylenol 325 mg give two tablets by mouth three times a day for three days January 20th through January 22nd, 2019. In an interview on 1/28/19 at 11:49 AM with resident stated he has pain in right hip when moving around in his chair or bed and rated the pain at a 5 on a 1 to 10 pain scale. The resident's Care Plan showed no focus, goal or interventions for pain related to the right hip fracture on 1/19/19. In an interview on 1/29/19 at 4:00 PM, the Director of Nursing confirmed the resident's care plan was not updated to reflect that he can no longer walk independently. In an interview on 1/30/19 at 9:35 AM with Staff F RN (Registered Nurse) confirmed the resident's care plan did not address his hip pain, but this would be expected. At 1:45 PM with Staff F, stated the resident is currently in the process of a significant change MDS assessment related to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 657	Continued From page 17 his fall with fracture. 2. Resident #45's MDS assessment of 1/4/19 showed documented he had a BIMS of 9 indicating moderately impaired cognition. The assessment documented he experienced delusions. The resident's diagnoses included Non-Alzheimer's dementia, anxiety disorder, depression, psychotic disorder, unspecified dementia without behavioral disturbance, restless/agitation and personality disorder. Review of the resident's progress note dated 1/21/19 at 8:38 PM showed the resident with a single episode of suicidal ideation and staff planned to continue to monitor him. The progress notes showed no further entries from 1/21/19 at 8:38 PM until 1/22/19 at 12:37 PM. In review of resident progress notes dated 1/22/19 at 12:37 PM showed resident denied suicidal thoughts, did not remember the conversation with staff, appointment set up with Psychiatric ARNP (Advanced Registered Nurse Practitioner) and staff would continue to monitor his mood/behaviors every shift. The note dated 1/23/19 at 10:57 AM showed receipt of an order from the resident's psychiatric appointment to increase Zoloft (anti-depressant) to 200 mg daily. In review of Psychiatric ARNP note dated 1/23/19 at 9:50 AM showed resident was seen by provider and Zoloft increased to 200 mg every morning. In review of resident Care Plan showed focus for resident at risk for suicide and intervention of 15 minute checks initiated 1/23/19. In review of documentation no additional	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 657	Continued From page 18 information found to show increased monitoring of resident related to suicidal ideation implemented prior to 1/23/19. In an interview on 1/29/19 at 3:45 PM with Director of Nursing confirmed 15 minute checks were not initiated on the resident's care plan until 1/23/19 after resident psychiatric appointment. On 1/30/19 at 11:10 AM, Staff F stated the facility used a daily log to document concerns with residents and Resident #45 showed no information related to increased suicidal ideation monitoring from 1/21/19 until 1/23/19. Staff F was not aware of any additional documentation or monitoring put in place for him during this time frame other than regular shift checks and medication pass times. Staff F confirmed 15 minute checks were put in place for the resident on 1/23/19. In an interview on 1/30/19 at 3:38 PM with Director of Nursing stated her expectation when a resident has suicidal ideation is to have increased monitoring care planned for and put in place for staff to document on the resident.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on clinical record review, physician and staff interviews and facility policy review, the facility failed to immediately notify the physician in order to obtain prompt treatment for a physical change in condition that resulted in a blood infection (urosepsis) for one of three residents reviewed for hospitalization (Resident # 17). The facility reported a census of 46 residents. Findings included: According to a Minimum Data Set (MDS) assessment dated 9/24/18, Resident #17's diagnoses included Alzheimer's disease and diabetes mellitus. The MDS identified the resident's Brief Interview Mental Status (BIMS) as 7, indicative of severely impaired cognition. The MDS revealed the resident as independent with bed mobility, transfers, dressing and had a steady balance and required the use of a urinary catheter. Resident #17's care plan included a focus, initiated on 7/31/18, for an indwelling catheter related to an enlarged prostate and history of urinary retention. The care plan included an intervention for staff to monitor, record and report to a health care provider any signs and symptoms of pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature (temp), urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. Review of Resident #17's nursing Progress Notes revealed the following information:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 20 On 10/15/18 at 2:03 P.M., Resident #17 had a Foley (urinary) catheter draining straw colored urine (straw colored urine is considered normal color). On 10/15/18 at 5:42 P.M. - (Note- Staff documented this note as a Communication/Visit with Physician) - The resident displayed increased confusion, a low grade fever of 99.8 degrees Fahrenheit (F), abdominal tenderness at times, purulent green discharge in his catheter bag. Other vitals: Pulse (p)- 96 beats per minute (bpm), Respirations (r) -18 per minute, blood pressure (BP) 140/84. Staff requested a UA (urinalysis). On 10/15/18 at 8:40 P.M. - Staff described Resident #17 as confused and he refused supper. The urine in his catheter had increased odor, purulent drainage and at times he stated he had abdominal pain. Staff documented a low grade temp of 99.8 degrees F and sent a fax (facsimile) to the physician to inquire about a UA (even though a previous fax had been sent after office hours). On 10/15/18 at 8:01 P.M. - Staff documented a 'Change in condition, symptom or signs called about' note regarding Resident #17's altered mental status and fever. Staff documented the resident's vital signs as: t- 99.8, p-96 r-18. (Note- even though the progress note states "called about", no phone call had been made to a physician, other than a fax to a physician's office after hours). Review of a Change in Condition Evaluation form dated 10/15/18 at 8:01 P.M., revealed staff	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 21 documented Resident #17 had an altered mental status, fever and the following vital signs: BP-140/84, t-99.8, p- 96, r-18. Staff described the resident with increased confusion, an abrupt significant change in cognitive function, symptoms or signs of pain, abdominal distension or tenderness, occasional labored breathing and documented the resident's symptoms as worse since the initial change in condition occurred. The evaluation form included a notification section with guidance to notify a medical doctor, nurse practitioner or physician assistant immediately in regards to the resident's general weakness, abdominal pain, increased confusion and memory loss (the record review revealed staff failed to notify a Medical Practitioner in regards to the resident's ongoing symptoms). On 10/16/18 at 12:05 A.M. staff documented Resident #17 complained of being cold and shivering and administered Tylenol 650 milligrams (mg). On 10/16/18 at 10:24 A.M. - Staff documented the resident as very weak and lying naked across his bed this morning. He sat up with the assistance of two staff and a nurse needed to help him get dressed. The resident walked to a recliner with his walker with a slow unsteady gait. The resident complained he had not felt well and wanted to return to bed after breakfast. Staff described the resident's urine in his drainage bag as thick milky white in color. Staff documented the resident's daughter had been in the facility and aware of the resident being ill. On 10/16/18 at 1:20 P.M. staff documented calling a physician to report an elevated temperature of 103.6 degrees F, p-112 and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 22 described the resident's urine as dark in color and milky. Staff documented the physician ordered the resident to be sent to a hospital emergency room (ER). Review of a pain level summary report form revealed the resident had no complaints of pain between 10/1 - 10/14/18. On 10/15/18 at 5:41 P.M. the resident rated his pain at 5 (on a scale of 0 -10, 10 being the worse pain). On 10/16/18 at 8:53 A.M., the resident rated his pain at 4. In an Emergency Department Provider note dated 10/16/18 at 2:18 P.M., the physician documented Resident #17 presented to the ER with fever and confusion. The physician documented a septic workup had been initiated and described the resident's urine as a thick purulent liquid and because of the urine and the indwelling catheter, the resident's sepsis was probably due to the catheter. The physician diagnosed the resident with a bladder infection and sepsis. A History and Physical note dated 10/17/18 at 5:49 P.M. documented the resident with acute renal failure. Review of a Procedures -Encounter Notes, dated 10/22/18 at 8:01 P.M., revealed the resident required the insertion of a PICC (peripheral inserted central catheter) line. Review of a Discharge Summary form, with an admission date of 10/16/18 and discharge date of 10/23/18, revealed a discharge diagnosis that included Klebsiella urosepsis and the resident's discharge orders included Levaquin (antibiotic), 500 milligrams, intravenously for 7 days, put in PICC line. The physician's brief history	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 23 description of the resident's course of illness documented Resident #17 became lethargic and subsequently transferred to the hospital. At that time of arrival to the ER the resident's temperature measured 102.2, BP -88/51 and a blood sugar of 500. The physician described the resident as quite sick. According to a nurse Progress Note dated 10/23/18 at 11:50 A.M., the resident returned to the facility following his hospitalization. According to a nurse Progress Noted dated 10/23/18 at 6:30 P.M., staff documented the resident required the assistance from 2 staff and the use of a platform walker from transfers. A facility Policy for Notification of Change, dated 11/16, included the following: A facility must immediately inform the resident's physician and the resident's representative of a significant change in a resident's physical, mental or psychosocial status. During interview on 1/29/19 at 1:20 P.M., the Director of Nursing (DON) stated there was no copy of the fax sent to the resident's physician on 10/15/18 at 5:40 P.M. She stated if the doctor does not respond, they don't keep the fax. The DON stated she expected a nurse to notify the doctor directly if a resident had thick purulent drainage in their catheter bag, abdominal tenderness, increased confusion and a low grade temp. The DON expected the nurses to follow the assessment tool the facility uses. The DON stated the nurse did a change in condition assessment on 10/15/19, but then did nothing with it regarding physician contact. The nurse should have notified a doctor with the beginning	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 684	Continued From page 24 of significant changes on 10/15/18. During telephone interview on 1/29/19 at 3:11 P.M., the resident's physician confirmed staff needed to contact a physician at the time Resident #17 began to have symptoms of purulent green drainage in his catheter bag, abdominal pain, confusion, etc. The physician confirmed in the event there are concerns after office hours, there is always a physician available at a local ER.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to assist one resident to walk as planned (Resident #32) and failed to initiate a restorative nursing program for one	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 688	Continued From page 25 resident (Resident #28). The sample consisted of three residents reviewed for range of motion, The facility reported a census of 46 residents. Findings included: 1. According to a Diagnosis Report form dated 1/29/19, Resident #32's diagnosis included dementia, pain and left artificial hip joint . A Minimum Data Set (MDS) assessment dated 12/14/18 revealed the Resident required extensive assistance from staff with transfer and ambulation. Resident #32's care plan included a focus area, with an initiation date of 10/12/15, for restorative intervention due to a self care performance related to dementia. The care plan included intervention for staff to walk the resident daily with the assistance of one staff member and to follow with a wheelchair. According to a Therapy Screen Form dated 12/7/18, a Physical Therapist Assistant evaluated Resident #32 and wrote a plan for the resident to continue on a walking program with assistance from two staff. Review of the walking (ambulation) documentation forms between November 2018 and January 2019 revealed the following information: a. November 2018 - Staff documented Resident #32 walked six times during the entire month. b. December 2018 - Staff documented the resident walked 11 times during the entire month. c. January 2019 - Staff documented Resident #32 walked nine times between 1/1 - 1/28/19.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 688	Continued From page 26 During interview on 1/30/19 at 9:00 A.M., the facility Quality Assurance nurse stated at times the resident could be difficult to walk, but confirmed staff needed to make attempts throughout the day to get the resident to ambulate. She confirmed staff needed to document a reason the ambulation did not occur. 2. According to the MDS assessment, dated 12/7/18, Resident #28 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility, transfer, ambulation, dressing, toilet use, and personal hygiene. The resident's diagnoses included anxiety and depression. An Occupational Therapy (OT) Therapist Progress and Discharge Summary dated 11/8/18 documented the analysis of functional outcome/clinical impression: education on restorative nursing program (RNP) and safety with wheelchair management in the unit. Discharge plan and instructions to discontinue OT to remain in the unit to RNP. The resident's clinical record lacked documentation of an restorative program. During an interview on 1/29/19 11:59 a.m. the Therapy Manager (TM) stated she did not have the resident on a restorative program because they did not recommend one. She did not realize they had discharged the resident to an RNP. During an interview on 1/31/19 at 7:55 a.m. the Occupational Therapist (that wrote to discontinue	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 688	Continued From page 27 to the RNP) stated she worked on Thursdays and talked with the the other therapist on Wednesdays and Fridays. She said she did want the resident on an RNP. She was told they had a daily exercise group in the unit, so she wanted the resident to attend the group daily to get some range of motion (ROM). She said if they did not have the group exercise in the unit she wanted him on another RNP. During an interview on 1/31/19 at 8:04 a.m. Staff G Licensed Practical Nurse LPN stated they did not have daily group exercise in the unit. During an interview on 1/31/19 at 8:11 a.m. the TM stated they usually did exercise group three days a week in the unit: Monday, Thursday, and Saturday. At 8:36 a.m. the TM printed off a form regarding physical activity which she said would be the exercise group. She said the resident did not attend the exercise group.	F 688		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 700	Continued From page 28 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation, and staff interview, the facility failed to adequately assess each resident for the use of bed/side rails (including grab or assist bars), review the risks and benefits with the resident or their representative, or obtain informed consent for use of side rails for two of two residents reviewed (Residents #5 and #28). The facility reported a census of 46 residents. Findings include: 1. According to the Minimum Data Set (MDS) assessment dated 10/19/18, Resident #5 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident's diagnoses included dementia. A Mobilization Support Data Collection Tool dated 4/25/18 documented the resident showed independence with bed mobility without a device (grab bar). The progress Notes dated 5/16/18 at 3:15 a.m. documented during cares the resident had a 1 cm triangle shaped skin tear to the top of her right hand, base of 3rd knuckle. A follow up note at 3:26 p.m. documented per nursing, sheepskin	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 700	Continued From page 29 was added to the resident's bed assist bar. A Sit-Stand-Walk Data Collection Tool dated 1/17/19 did not identify the resident needed a grab bar. The current Care Plan with a goal target date of 2/6/19 indicated the resident independent to 1 staff assist with bed mobility and did not identify the use of a grab bar. During an observation on 1/29/19 at 1:34 p.m. the resident lay in bed with a grab bar on the wall side of the bed. The clinical record lacked documentation of an assessment showing the need for a grab bar, a review of the risks and benefits with the resident or the resident representative, or informed consent for use of bed rails. During an interview on 1/30/19 at 11:15 a.m. the Unit Manager stated the Sit-Stand-Walk Data Collection tool indicated the resident did not need the grab bar. 2. According to the MDS assessment dated 12/7/18, Resident #28 demonstrated long and short term memory problems and severely impaired skills for daily decision making. The resident required extensive assistance with activities of daily living (ADL's) including bed mobility. The resident's diagnoses included arthritis. The Care Plan identified the resident with an ADL self care performance deficit related to dementia and needing extensive assistance, revised on 1/30/19. The interventions included to position	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165207	A. BUILDING _____ B. WING _____	01/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOLSTEIN	505 WEST SECOND STREET HOLSTEIN, IA 51025

(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 700	Continued From page 30 him up in bed with assist of one and an assist bar, lying to sitting with one assist with use of the assist bar and sitting to lying with one assist with use of assist bar, guided. A Sit-Stand-Walk Data Collection tool dated 12/4/18 documented the resident could move up in bed with an assist device or employee assistance. The tool indicated Resident #28 had an assist bar. During an observation on 1/29/19 at 7:08 a.m. the resident had a grab bar to the outside of the bed. The clinical record lacked documentation of a review of the risks and benefits with the resident or the resident representative, or informed consent for the use of bed rails. During an interview on 1/30/19 at 9:35 a.m. the Administrator stated they did an assessment for the use of grab bars, but unsure about consent. At 3:48 p.m. the Administrator stated they did give the resident/family a brochure regarding side rails on admission to the facility.	F 700		

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 580

1. Resident #17 representative was notified of change in condition on 10/16/18.
2. All residents could have been affected.
3. The charge nurses were educated on 10/30/19 regarding Interact Change in Condition. The DNS will educate the nursing staff on family nonfictions of a change in a resident's condition on 2/12/19 and again on 2/19/19.
4. The DNS or designee will review progress notes daily and audit any changes in resident condition to ensure representative was notified. Audits will be conducted weekly X 4 weeks, monthly x 4 and then the results will be brought to QAPI for review.
5. Compliance date: 2/22/19

F 609

1. The Administrator and Director of Nursing Services reviewed the regulation on reporting guidelines on 2/1/2019.
2. All residents could have been affected.
3. The facility will ensure that all incidents requiring reporting will be reported according to state regulations.
4. The Administrator or designee will audit progress notes daily and all incident reports to ensure proper reporting according to current procedure for an ongoing base. Will audit 5x week for 4 weeks and weekly x 4 weeks, all will be reviewed at QA.
5. Compliance date: 2/1/2019

F 625

1. Resident's #18, 28 and 17 returned to the facility.
2. All residents could be affected.
3. The Administrator educated staff on 2/13/2019 on the facility bed hold policy and procedure.
4. The Administrator or designee will audit all transfers/discharges to ensure bed hold's completed weekly x 4 weeks then to QAPI for review.
5. Compliance date: 2/22/2019

F 655

1. Resident #3's care plan was reviewed with Resident #3 resident representative on 1/30/19.
2. All new residents could have been affected.

3. The Administrator provided education to the care plan team regarding the 48 care plan and requirements on 2/13/2019.
4. The DNS or designee will audit new residents baseline care plan weekly X4 weeks then to QAPI for review.
5. Compliance date: 2/22/2019

F 657

1. Resident's #30 and #45 care plans were reviewed and updated on 2/1/2019.
2. All residents could have been affected.
3. The Administrator provided education to the interdisciplinary team on 2/13/2019 on resident care plan revisions and ensuring they are reviewed and appropriate show the residents current health needs on 2/13/2019.
4. The DNS or designee will audit resident care plans to ensure they are addressing the resident's current health needs weekly x 4 weeks and then to QAPI for review.
5. Compliance date: 2/22/2019

F 684

1. Unable to correct to Resident #17.
2. All residents could have been affected.
3. The DNS re-educated charge nurses and nurse managers on proper resident assessments and physician notification on and 2/12/19.
4. The DNS or designee will audit residents' conditions to ensure assessments are completed timely weekly for 4 weeks then results will be reviewed at QAPI.
5. Completion date: 2/12/19

F 688

1. Resident #32's restorative plan was updated on 2/7/19 by the Therapy Director. Resident #28 restorative therapy program was re-evaluated on 2/7/19 by the Therapy Director.
2. All residents receiving restorative therapy could have been affected.
3. The Administrator provided education to the therapy director on 2/13/2019 regarding restorative therapy plans and ensures they are checking discharge recommendation from therapy for a restorative plan.
4. Therapy Director or designee will audit the restorative plans weekly x 4 weeks then to QAPI for review.
5. Completed date: 2/13/2019

F 700

1. Resident #5 grab bar was removed on 1/30/2019. Resident #28 was completed assessment and notification of family that the use of the grab was care planed on 1/30/2019.
2. All resident could have been affective.
3. All residents care plans and assessments were completed 1/30/2019. The Administrator provided education on 2/13/2019 on the facility policy on bed rails and grab/assist bars.

4. The DNS or designee will audit resident grab bars for proper assessment and family notification weekly x 4 weeks then to QAPI for review.
5. Completed date: 2/22/2019