STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. BUILDING _____ B. WING _____	C 01/30/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 2/22/18 AM POC Correction date 2/22/2018 Complaint 72940-C was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.)	F 000	Correction to affected individuals: No correction available for affected Resident #4. Action to protect residents in similar situations: IDT team reviewed all resident care plans on 12/14/17 and identified all residents with aspiration or swallowing concerns requiring staff observation while eating. A list of residents requiring supervision was developed and placed in the nursing communication binders on 12/14/17. The list of residents will be reviewed, updated and signed by the charge nurse of the station daily. Measures taken to ensure problem does not occur: All staff has been educated between 12/14/17 and 12/18/17 by the staff development coordinator or designee. Employees were not allowed to return to work until education was complete. The DNS will maintain a list of residents requiring supervision while eating which will be posted at each nursing station. All staff re-educated on the Heimlich maneuver and process for alerting other staff members in the event of a choking incident between 1/4/18 and 1/12/18. Monitor performance: Observation audits of supervision in dining room 5 days/wk x 12wks. Observation audits of supervision in room 5 days/wk x 12 weeks. Stand up note audit 5 days/wk x 12 wks. Results will be reported to the QAPI committee for further review and recommendations. Correction Date: 2/13/18	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with staff, physician and therapist, the facility failed to provide Resident #4 with adequate supervision while eating in his room alone. Resident #4 had difficulties swallowing, at risk for choking and placed in an immediate jeopardy situation which resulted in choking and death. Although staff found the resident unresponsive and blue in color, they attempted techniques (suctioning, back blows and Heimlich maneuver), the resident did not respond. The sample consisted of 2 additional residents with swallowing difficulties (Resident #2, Resident #3). The facility reported a census of 53 residents. Findings include: 1. Resident #4 had a Minimum Data Set (MDS)	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christy Sundeegaard | TITLE: RN-Administrator | (X6) DATE: 2/22/2018 | 02/13/2018

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 2/28/18 VSummers

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F 689	Continued From page 1 assessment with a reference date of 11/8/17. The MDS identified the resident had diagnoses that included non-Alzheimer's dementia and nasopharyngeal phase dysphagia (difficulty swallowing). The MDS indicated the resident had a BIMS (Brief Interview of Mental Status) score of 5. A score of 5 identified severe cognitive impairment. The MDS indicated Resident required supervision and 1 person assistance when eating [a mechanically altered and therapeutic diet]. The Care Plan, initiated on 11/20/16, identified a potential nutritional problem related to the diagnosis of oropharyngeal dysphagia/swallowing problem that may be accompanied by nasopharyngeal regurgitation, aspiration, and/or a sensation of residual food remaining in the pharynx. The interventions included and directed staff to provide supervision/observation at meals. Another Care Plan intervention, initiated 7/31/15 identified the resident able to eat independently but spills foods and liquids at times so needed partial assistance when spilling, utilized a Flo-Trol cup for all liquids and served a reduced sodium Level 3-advanced diet with nectar thick liquids. An addendum to this intervention dated 9/20/16, directed the staff to monitor the resident's chewing and swallowing ability during mealtime and the resident would be moved to a table closer to the nurse's work area. The ST (speech therapy) Therapist Progress & Discharge Summary dated 10/26/16 documented the resident received speech therapy treatment 9/19-10/26/16 for the diagnosis of oropharyngeal phase dysphagia. The report documented the resident exhibited increased tendency to overfill	F 689		

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F 689	Continued From page 2 his mouth with mild residual remaining in the left buccal cavity and the tongue after swallowing. The resident displayed a delayed reflexive cough on a regular textures/liquids and large quantities and identified the resident at high risk of aspiration due to reduced awareness, tendency to be compulsive and history of dysphagia. The resident discharged from speech therapy on 10/26/16 after the therapist printed and distributed compensatory feeding strategies and Safe Swallow Precautions for the resident to the resident as well as the nursing staff. A document titled Safe Swallow Precautions for the resident dated 10/26/16 directed the following: 1. Always eat and drink while sitting up as close to 90 degrees as possible. 2. Remain sitting up for at least 30 minutes after eating, drinking or taking meds. 3. Swallow everything before taking another bite or drink. 4. Small bites and 1 drink at a time. 5. Alternate a bite then a drink. Review of the resident's Care Plan identified these directives not incorporated on the resident's current Care Plan. On 1/28/18 at 3:26 PM the speech therapist was interviewed and stated she treated Resident #4 from 9/19/-10/26/16 and staff needed to follow the recommendations she provided. The speech therapist stated she had educated the staff to the fact the resident required supervision with eating as the resident being at high risk for aspiration or choking because of his swallowing problem, impulsivity and cognitive deficits. The therapist also stated she would expect her recommendations be followed and placed on the resident's Care Plan unless the resident was	F 689		

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F 689	Continued From page 3 re-evaluated and the recommendations she made were no longer appropriate. The therapist stated supervision should be provided with snacks and trays served to residents in their rooms. Review of the resident's record revealed no other speech therapy evaluation or treatment after 10/26/16. The Progress Notes entry, completed by Staff A, registered nurse (RN) on 12/4/17 at 1:40 p.m. indicated she was summoned to the resident's room by the far west hall charge nurse at 1:26 PM. Staff A identified the resident as non-responsive and blue in color. The far west hall charge nurse was present and performed the Heimlich maneuver without success so back blows were done. The treatment nurse in the room did a finger sweep of the resident's mouth to remove the visible food and also performed the Heimlich maneuver without success. The charge nurse suctioned the resident's mouth with no success. The resident had no palpable pulse. The emergency responders pronounced the resident deceased at 1:40 p.m. as the resident had no pulse, respirations or measurable blood pressure. On 12/15/17 at 8:46 AM Staff D, certified nursing assistant (CNA), was interviewed and stated she was assigned to the hallway where Resident #4 resided and the only CNA assigned to that hallway due to a staff call-in. She assisted residents with transportation to and from the dining room for breakfast and lunch and then remained in the dining room for both meals. Staff D stated Staff A told her she passed out [served] the resident room trays for her hall. Staff D	F 689		

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F 689	Continued From page 4 stated Resident #4 normally sat at a table at the back of the dining room in front of where the nurses keep their medication carts, but the resident had been experiencing loose stools so he remained in his room for breakfast and lunch. Staff D stated she picked up resident room trays after lunch. She had a conversation with the resident's roommate. She looked over and saw the resident's whole body as blue in color. Staff D stated she asked the resident if he was okay; she got no response so she went to the nursing desk right around the corner from the resident's room and alerted Staff C, licensed practical nurse (LPN) who went immediately to the resident's room. Staff D stated Staff C attempted to do the Heimlich maneuver on the resident but Staff C is small in stature and could not get her arms around him as the resident sat in a recliner. Staff C performed back blows on the resident and then Staff B, LPN (licensed practical nurse), also came into the room. Staff D stated the resident was observed eating cookies all day and had crumbs on his shirt and all the cookies were gone. Staff D stated she would assume the resident needed to be supervised while eating in his room because the resident normally sat in the supervised area of the dining room. On 12/14/17 at 5:11 PM, Staff C (licensed practical nurse) was interviewed and stated she was summoned to the resident's room by Staff D. Staff C stated she observed the resident sitting in the recliner and she observed his skin color to be blue. Staff C stated she attempted to do the Heimlich Maneuver with the resident seated in the recliner but unsuccessful because she is short in stature. She performed back blows. Staff C stated she left to get the suction machine and did a finger sweep of the resident's mouth as	F 689		

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F 689	Continued From page 5 the chewed food and liquids were coming from the resident's mouth. Staff C stated she suctioned the resident without success and the resident had no carotid or apical pulse at this time. The staff previously checked and the determined the resident had requested no DNR (do not resuscitate). On 12/15/17 at 8:03 AM Staff B (licensed practical nurse) was interviewed and stated the Dietary Services Manager (DSM) called for her to come to the resident's room. Staff B stated she observed the resident as blue in color. Staff C was already in the room and Staff A was also coming down the hall from the opposite direction. The resident sat slightly forward in the recliner with food and fluid coming out from his mouth. Someone in the room said "He is choking". Staff B stated the staff lowered the resident to the floor. Staff B stated she could not get her arms around the resident so she performed the Heimlich without response. The resident had no pulse by palpation and auscultation (listening with stethoscope). Staff B stated she was the only staff member to perform the Heimlich maneuver. Staff C did a finger sweep of the resident's mouth because there was food in the resident's mouth. Staff C also suctioned the resident without success. EMS (Emergency Medical Services) responded and placed the resident on a monitor (to record heart rhythm) and pronounced the resident deceased. Staff B stated the resident normally sat in the dining room in the assisted area. A nurse supervises the dining room and the other charge nurses assists in the dining room. Staff B stated she also will assist in the dining room. Staff B stated if a resident's Care Plan directed a resident to be supervised when eating and the resident required a room tray, then the	F 689		

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F 689	Continued From page 6 staff needed to sit with the resident while they are eating, even if the resident fed themselves. On 12/14/17 at 4:40 PM Staff A (registered nurse) was interviewed and stated the overnight nurse had reported the resident had loose stools so she made decision to keep the resident in his room for breakfast and believed he had ate in his room the day before too. She stated she observed the resident eating cookies without difficulty when she administered his/her medications scheduled for 8:00 AM. Staff A stated she delivered the resident's room tray at lunch which consisted of regular toast, Jell-O and broth and other liquids. She stated the resident was seated upright in a recliner. Staff A stated around 12:55 PM Staff C called for her to come to the resident's room. Staff B was also present in the room. The resident was unresponsive. Staff B and C attempted to perform the Heimlich after staff lowered the resident to the floor in order to get behind the resident. Staff A stated the resident had beige-colored food in the oral cavity and Staff C removed it with a finger sweep. Staff A called 911 and the EMS responders verified the resident had no pulse, respirations or blood pressure. Staff A stated the staff supervised the resident from the hallway while he ate in his room. Staff A stated only 1 CNA assigned to that hall. Review of the surveillance camera footage of the resident's hallway showed Staff A delivered room trays to the resident and his roommate at 1:01 PM and 1:02 PM and no other staff present in the hallway. Staff A stated she called the resident's physician's nurse to inform her of the resident's death but did not explain the circumstances surrounding the resident's death.	F 689		

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F 689	Continued From page 7 On 12/20/17 at 10:27 AM, the resident's physician was interviewed and stated he called the facility for additional information regarding the resident's death after the surveyor left him a message on 12/15/17. The physician stated the facility had not informed him of the circumstances surrounding the resident's death until he requested the facility send him the resident's progress notes for review. The physician stated he had already completed the resident's death certificate prior to his knowledge of the incident but could say that it is highly suspected the resident expired because of choking and considered the death to be unexpected. The physician asked if the resident should have been supervised while eating. The resident's Care Plan and speech therapist documentation was discussed at this time. The physician stated that all recommendations and documentation from all licensed therapists is sent to him and is reviewed and he does sign them so it would have technically been a physician order to supervise the resident as directed by the speech therapist. The physician stated he is also the facility's medical director and the issue has been addressed with the facility management staff. Note: At the time of the complaint investigation, the complaint was coded at a "J" immediate and serious jeopardy. By 12/18/17, the facility had adequately addressed the jeopardy and the grid placement was lowered to the "D" level. The staff were educated to monitor and supervise for swallowing difficulties and aspiration at meals in the dining room and and a staff member must be with resident the entire time if they remain in their room for meals. The Director of Nursing reviewed all of the resident's Care Plans on 12/14/17 and identified all residents with	F 689		

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F 689	Continued From page 8	F 689		

aspiration or swallowing concerns that required staff observation while eating. A list of residents requiring supervision was developed and placed in the nursing communication binders on 12/14/17. The Director of Nursing would do audits and results reported to the quality assurance committee.

As of the 1/30/18 exit conference, the facility continued to need to:
Finish in-service employees of the need to monitor and supevise residents with swallowing difficulties and potential for aspiration when eating meals in their rooms (staff to stay with resident) and staff present in the dining room to ensure supervision of residents with swallowing difficulties.
Continue to monitor to ensure the staff are with residents when eating in their rooms.

2. Resident #2 had a MDS with a reference date of 11/8/17. The MDS indicated the resident had diagnosis that included oropharyngeal dysphagia, cerebrovascular accident (stroke) and non-Alzheimer's dementia. The MDS indicated the resident could feed self after set up.

The Care Plan identified the resident could feed self independently and required a dysphagia Level II diet. The Speech Therapy Daily Treatment Note dated 11/16/17 documented the resident swallowing as safe but usually required moderate cues to use compensatory strategies. The note directed nursing staff to monitor the resident closely for pneumonia because of at high risk for aspiration.

On 12/28/17 at 9:40 AM the speech therapist was interviewed and stated Resident #2 had

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F 689	Continued From page 9 significant cognitive deficits, declined thickened liquids and a modified diet, and should not eat unsupervised. 3. Resident #3 had a MDS with a reference date of 9/27/17. The MDS identified diagnosis that included oropharyngeal phase dysphagia for Resident #3. The MDS indicated the resident required set-up and supervision with eating. The Care Plan identified a potential nutritional problem on 11/20/16 related to oropharyngeal dysphagia and directed the staff members to monitor the resident for chewing and swallowing difficulties. The Care Plan contained the nursing rehab plan, initiated on 5/7/14. On 11/2/17 the plan directed the staff to ensure the resident swallowed twice with every bite (a dry swallow after the first swallow), alternate solids and liquids (a drink after a couple of bites) and for the resident to remain alert during meals (eyes open). The Speech Therapy Treatment Note dated 11/2/17 documented the resident aspirates across all diet consistencies due to Zenker's diverticulum. The document titled Nursing's Shift-to-Shift Huddle Care Plan Updates and Need to Knows, dated 12/14/17, listed 10 residents, which included Residents #2 and #3, with swallowing difficulties/aspiration. The listed residents required supervision at meals whether in the dining room or in their rooms. Observation on 12/28/17 at 12:55 PM identified no nursing staff in the dining room and Residents #2 and # 3 and 9 other residents still eating lunch.	F 689		

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F 689	Continued From page 10 Observation revealed Staff E, dietary aide, in the dining room recording resident meal consumptions. Staff E stated she had received Heimlich maneuver training during employee orientation but would not feel comfortable in responding to a choking resident. She stated if a resident choked she would leave the area and summon a nurse. Staff E stated there is a list of residents who require supervision while eating and she thinks that Resident #2 and #3 required supervision and acknowledged they are still eating at this time. Review of the posting presented by the DON at 2:40 PM on 12/28/18, directed the following: All staff will be trained or re-trained in the Heimlich by 1/5/17 [18]. If you observe a resident that appears to be choking and need to alert another staff member, page overhead for assistance STAT (immediately-No delay). A licensed nurse should be in the dining room to observe and monitor for a choking incident and to monitor residents for change in chew/swallow ability. If this is not possible, a system will be in place to alert the licensed nurse to concerns and provide a person in the dining room who is knowledgeable in performing the Heimlich maneuver.	F 689		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730	Correction to affected individual: Staff J performance evaluation completed 1/4/18. Staff H performance evaluation completed 2/19/18. Staff G performance evaluations will be completed on 2/22/18. Staff I is no longer an employee at the center. Action to protect individuals in similar situations: Director of Nursing will complete three employee performance evaluations a week	

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F 730	Continued From page 11 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) receive a yearly performance evaluations for 4 of 4 sampled CNA's employed greater than 1 year (Staff G, H, I and J). The facility identified a census of 53. Findings include: 1. The personnel file for Staff G, CNA, documented a hire date of 7/28/16. The personnel file failed to contain a yearly performance evaluation. 2. The personnel file for Staff H, CNA, documented a hire date of 7/16/13. The personnel file failed to contain a yearly performance evaluation since the most recent evaluation completed on 8/5/15. 3. The personnel file for Staff I, , CNA, documented a hire date of 10/20/15. The personnel file failed to contain a yearly performance evaluation since the most recent evaluation completed on 10/20/16. 4. The personnel file for Staff J, CNA, documented a hire date of 8/24/10. The personnel file failed to contain a yearly performance evaluation since the last one completed on 10/20/16. During interview on 12/28/17 at 4:05 PM the Administrator stated she is not sure why the evaluations were not completed but would make sure they are completed.	F 730	until all employees have a current employee performance evaluation. Measures taken to ensure problem does not occur Managers and employees will participate in an annual performance evaluation and a mid-year performance check in using the performance model. Managers will meet with employees at least annually to formally review and document the entire years performance. Monitor performance: Audits will be completed weekly x 4 weeks to ensure 3 performance evaluations are completed until current employees are current and then monthly to ensure employees evaluations are completed timely. Correction date 2/22/2018	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on personnel file reviews and staff interview, the facility failed to assure all certified nursing assistants (CNA's) received 12 hours of inservice education annually for 3 of 4 sampled CNA's employed 1 year or greater (Staff G, H, and I). The facility reported a census of 53. Findings include: 1. The personnel file for Staff G, CNA, documented a hire date of 7/28/16. Review of the inservice records for 12/1/6-12/1/17 revealed Staff G received only 11 hours of inservice education.	F 947	Correction to affected individuals: Staff G, H employee file reviewed, Staff I is no longer employed Action to protect individuals in similar situations: Staff educated on 2/21/18 in regards to the calendar of scheduled monthly in-services and learning topics, as well as timeframe for completion. Measures taken to ensure problem does not occur: Staff was educated 2/21/18 in regards to regulations around 12 hours of education a year. Corrective action will be taken on staffs that do not complete the required learning activities. Monitor performance: Audits will be completed monthly by staff development coordinator or designee to ensure monthly in-services are being completed. Correction Date: 2/21/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165191	A. BUILDING _____ B. WING _____	C 01/30/2018

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

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F 947	Continued From page 13 2. The personnel file for Staff H, CNA, documented a hire date of 7/16/13. Review of the inservice records for 12/1/16-12/1/7 revealed Staff H received only 4 hours of inservice education. 3. The personnel file for Staff I, , CNA, documented a hire date of 10/20/15. Review of the inservice records for 12/1/16-12/1/7 revealed Staff H received only 8.5 hours of inservice education. During interview on 12/28/17 at 4:05 PM the Administrator stated she feels the CNA's have received more inservice education time that what is documented but acknowledged the facility had changes in the Administrator, Director of Nursing and Staff Development Coordinator positions recently and she planned to keep better track of education time and content going forward.	F 947		