STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165187	A. BUILDING _____ B. WING _____	05/10/2018

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GOOD SAMARITAN SOCIETY - WEST UNION	201 HALL STREET WEST UNION, IA 52175

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F 000	INITIAL COMMENTS Correction date 6/6/18 The following deficiencies relate to the facility's annual health survey and the investigation of incident #75519. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000	F000 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of 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 facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual.	6/6/18
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to provide a referral for the Level II Pre Admission Screening and Resident Review (PASRR) evaluation and determination for 1 of 1 resident reviewed (Resident # 31). The facility census was 46	F 644		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debra Vanderstitt — TITLE: Administrator — (X6) DATE: 6/6/18

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.

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F 644	Continued From page 1 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/4/18, documented Resident #31 had a diagnosis of psychotic disorder other then Schizophrenia. The MDS listed indicators of psychosis as delusions (misconceptions or beliefs that are firmly held, contrary to reality). The PASRR Level I screen dated 10/31/14, directed no further Level I screen was required unless you are known to have or are suspected of having a major mental illness or an intellectual or developmental disability and exhibit a significant change in treatment needs. The PASRR listed no major mental illness. During interview on 5/9/18 at 1:57 p.m., the Social Worker reported there was no additional PASRR documentation after the 10/31/14 PASRR. The Social Worker stated dementia was the primary diagnosis for the resident and wound not need another PASRR. During interview on 5/9/18 at 3:30 p.m., the Social Worker reported completing a new PASRR after calling Ascend (state designee for evaluation of Level II PASRR). The Social Worker reported Ascend stated a new diagnosis was a significant change and a Level II PASRR determination and evaluation was expected.	F 644	F 644 Ascend was contacted and new PASRR was completed 5/13/18 for resident #31. An "Exemption from PASRR" was noted due to Dementia. All new mental health diagnosis will be communicated to the Social Worker by the HIM so a new PASRR can be initiated. Compliance will be monitored with PASRR audits by the Social Worker monthly x3, followed by twice a year with results reviewed at QAPI meetings for further recommendations.	6/6/18
F 655 SS=B	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		

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F 655	Continued From page 2 §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- (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.	F 655	F655 A baseline care plan for resident #29 was developed and reviewed with the resident and family on 4/10/18. For all new residents an initial care plan that is easily understood by the resident and/or their representative will be developed within 48 hours of admission and a copy provided which will include goals, summary of medications and dietary instructions and services and treatments to be administered by the facility and personnel acting on behalf of the facility. Audits of care plan completion and reviews with resident/representative for all new admits will be completed monthly for 3 months then every 6 months and then yearly to follow. Results to be reviewed at QAPI meetings for any further recommendations.	6/6/18

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F 655	Continued From page 3 (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 provide a copy of the initial care plan to the resident or their representative as required. (Resident #29) The facility census was 46 residents. Findings include: 1, Review of the EMR (Electronic Medical Record) for Resident #29 with an admission date of 3/26/18 revealed no documentation the resident or their representative was provided a written copy of the initial care plan that was easily understood by the resident or their representative as required. During interview on 5/9/18 at 12:10 p.m., the Director of Nursing and Social Worker state they were not aware of the regulation that required a written copy of the resident care plan be given to the resident or their representative.	F 655		
F 689 SS=G	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:	F 689		

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F 689	Continued From page 4 Based on record review and staff interview the facility failed to transfer a resident as ordered leading to a fall that resulted in a leg fracture (Resident # 18). The facility census was 46 residents. Findings include: Review of the MDS (Minimum Data Set) assessment dated 3/22/18 revealed Resident #18 had a BIMS (Brief Interview for Mental Status) score of 04 indicating severe cognitive impairment, she could not ambulate, needed extensive assistance of 2 staff members for bed mobility, and extensive assistance of 2 staff members to transfers. Review of the current care plan for Resident #18 at the time of the fall on 4/13/18 revealed interventions which directed staff to utilize a slide board with 2 staff assist for transfers or to use a total mechanical lift if the resident had weakness and unable to use the slide board. During an interview 5/8/18 at 12:05 p.m., Staff A (CNA) stated on the morning of 4/13/18 at about 6:00 a.m. she was getting ready to give Resident #18 a shower. Staff A called for assistance to transfer the resident to the shower chair. Staff B (CNA) arrived and they attempted to pivot Resident #18 from her bed onto the shower chair. The shower chair brakes were not locked and it slid back and they had to lower Resident #18 to the floor. Staff A stated they lowered Resident #18 to the floor very gently and did not feel the resident could have been injured so they called for another CNA to come and assist getting the resident off the floor and into the shower chair without notifying a nurse to assess the resident.	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 5 Staff A indicated Staff C (CNA) arrived and they transferred Resident #18 into the shower chair and there were no visible signs of any injury. During an interview 5/8/18 at 12:50 p.m. Staff C verified that on the morning of 4/13/18 she was called to come and assist to transfer Resident #18. When Staff C arrived the resident was sitting on the floor with her legs extended out in front of them and there was no apparent signs of any injury. Staff C assisted Staff A and B in lifting Resident #18 off the floor and into the shower chair. Staff C was unaware Staff A and B had not notified the nurse and there was no nursing assessment prior to moving the resident. During an interview 5/8/18 at 1:25 p.m. Staff B (CNA) verified that on the morning of 4/13/18 around 6:00 a.m. she heard Staff A call for assistance to transfer Resident #18. Staff B responded and assisted Staff A in pivoting Resident #18 from the bed to the shower chair, Staff B was aware Resident #18 required a slide board to transfer. Staff B indicated they did not have time to get the slide board as Resident #18 was already starting to slide on the edge of the bed. The shower chair brakes were not locked and the chair slid away so they gently lowered Resident #18 to the floor. Staff B verified the resident did not hit anything on the way to the floor and her legs remained out in front of her. Staff B felt Resident #18 could not have been injured. Staff C was called to assist in getting Resident #18 off the floor and into the shower chair without notifying a nurse to assess the resident first. During an interview 5/9/18 at 9:35 a.m. Staff D (CNA) stated that prior to her leg fracture	F 689		

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F 689	Continued From page 6 Resident #18 required 2 staff assistance with a slide board to transfer. However, the slide board did not work for showers because her skin did not slide well on the board. The mechanical lift was used for transfers in and out of the shower chair. The progress notes had no documentation of a fall on 4/13/18 or any incident that required the resident to be lowered to the floor. The notes on the morning of 4/19/18 indicated staff observed the resident's right knee was swollen and discolored. Staff assessed and notified the medical provider who assessed the knee and ordered X-rays which revealed a distal femur (above the knee) fracture on the right leg. The hospital transferred Resident #18 for evaluation/consultation with an Orthopedic Surgeon. The Orthopedic Surgeon consultation dated 4/20/18 found a pathologic distal femur fracture on the right that may have occurred from the fall on 4/13/18. Review of follow up documentation provided by the facility to the surveyor on 5/8/18 found the CNA's involved received education on 4/19/18, 4/20/18, and 4/21/18 prior to working back on the floor. The facility also completed audits the week of 4/22/18 to ensure staff followed residents care plans for proper transfers.	F 689		