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 _____	C 07/31/2018

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

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F 000	INITIAL COMMENTS Correction date 9/4/18 Complaint #75151-C was substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview and policy review the facility failed to always ensure correct medications administered to the correct resident for 2 of 5 total residents reviewed. In addition the facility failed to follow professional standards with medication administration for 2 of 5 resident reviewed. (Resident 2 & #5) The facility identified a census of 52 current residents. Findings include: 1. According to the MDS (minimum data set) dated 6/1/18 Resident #2 had diagnoses that included anemia, heart failure, diabetes mellitus, fracture, anxiety disorder and depression. The MDS identified the resident had a BIMs (brief interview for mental status) of 15 which indicated intact cognition. According to the MDS the resident required limited assistance with ambulation in the corridor and supervision with dressing. The MDS identified the resident	F 658		

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 9/10/18 VSimmons

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F 658	Continued From page 1 required use of a walker and wheelchair. The care plan dated 2/26/18 directed staff to notify health care provider if interventions unsuccessful or if current complaint a significant change from resident's past experience of pain. Review of the Nursing 2018 Drug Handbook revealed the following indications and dosages for acetaminophen: Maximum dose for immediate-release 3,250 mg (milligrams)/24 hours unless under health care provider supervision, when up to 4000 mg/24 hours may be used. Maximum dose for ER (extended-release) 3,900 mg/24 hours. Review of the Medication Review Report dated 3/1/18 revealed the following order: a. ACETA (Acetaminophen) 8 hour tablet extended release 650 mg give 1 tablet by mouth in the afternoon for pain. b Acetaminophen 8 hour tablet 650 mg give 2 tablet by mouth an the morning and at bedtime for pain related to pain. Review of the Clinic Referral dated 3/27/18 revealed the order for Lortab 5/325 mg every 6 hours as need for pain Review of the Verbal Order dated 3/30/18 revealed the order for lortab 5/325 mg 2 tablet 3 times a day for pain and lortab 5/325 mg 1 tablet every 6 hours as needed for pain.. as needed for pain. do not exceed 3,000 mg of acetaminophen in a 24 hour b. Hold acetaminophen ER (until after resident no loner taking lortab) 3 times a day. c. Acetaminophen 325 mg every 6 hours as needed for breakthrough pain. do not exceed	F 658		

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F 658	Continued From page 2 3000 mg of acetaminophen in 24 hour period. d. Call with any acute changes or concerns. Review of the Clinical Note dated 3/31/18 revealed the following orders: a. lortab 5/325 mg 2 tablets 3 times a day Review of the MAR (medication administration record) dated 3/1/18 through 3/31/18 revealed the following days acetaminophen administered along with lortab: a. 3/27/18 ACETA 650 mg at PM, 1300 mg at AM & HS (hour of sleep), Lortab (ACETA 325 mg) at 1 PM &8:48 PM: Total ACETA 3,900 mg/24 hours. b. 3/28/18 ACETA 650 mg at PM, 1300 mg at AM & HS, Lortab (ACETA 325 mg) at 4:59 PM, 12:07 PM & 9:01 PM: Total ACETA 4,225 mg/24 hours. c. 3/29/18 ACETA 650 mg at PM, 1300 mg at AM & HS, Lortab (ACETA 325 mg) at 8:26 AM & 9:00 PM: Total ACETA 3,900 mg/24 hours. d. 3/30/18 ACETA 650 mg at PM, 1300 mg at AM & HS, Lortab (ACETA 325 mg) at 6:52 AM, 1:36 PM and 6:14 PM, Lortab (ACETA 650 mg) at 10:00 PM: Total ACETA 4,875 mg. e. 3/31/18 ACETA 650 mg at PM & 1300 mg at AM, Lortab (ACETA 650 mg) at 6:00 AM, 2:00 PM & 10:00 PM: Total ACETA 3,900 mg/24 hours. Review of the Communications sheet dated 4/24/17 revealed the office made aware the resident accidentally given another resident's tuberculosis shot (test) to the right forearm. No advance reactions noted at this time and vitals stable. Review of the Medication Error Report dated 4/24/18 revealed the resident given another resident's tuberculosis shot.	F 658		

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F 658	Continued From page 3	F 658		

Review of the Nursing 2018 Drug Handbook revealed the following indications and dosages for acetaminophen: Maximum dose for immediate-release 3,250 mg/24 hours unless under health care provider supervision, when up to 4000 mg/24 hours may be used. Maximum dose for extended-release 3,900 mg/24 hours.

2. According to the MDS dated 3/5/18 Resident #5 had diagnoses that included depression, spinal stenosis, spondylolisthesis and muscle spasm. The MDS identified the resident had a BIMs score of 15 which indicated intact cognition. According to the MDS the resident required extensive assistance with bed mobility, toilet use and limited assistance with ambulation and dressing.

The care plan dated 3/2/18 directed staff to evaluate the effectiveness of pain interventions.

Review of the Telehealth Phone Encounter Note dated 3/3/18 at 11:00 AM revealed the resident possibly received roommates medication last night. The resident alert and oriented and stated she received someone else's medication and described some of her roommates medications. Received antibiotic and coumadin (blood thinner), oxycodone (narcotic analgesic) but also received roommates seroquel (anti-psychotic), simvastatin (cholesterol-lowering agent), docusate (stool softener), senna (laxative), famotidine (antihistamine) and oxbutynin. Evening and bedtime medications given together. Concerns related to seroquel and oxybutynin. New orders to obtain vital signs every 2 hours until the resident feels at baseline. Please call with any changes to resident status or changes in vital signs.

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F 658	Continued From page 4 Review of the physician communications dated 3/3/18 revealed the resident received simvastatin 40 mg, senna plus and 1 quetiapine fumarate (seroquel) 25 mg (milligram) at bed time last evening in a medication error. The resident had been tired for a period today but no other adverse reactions noted. Physician notified with order to do vital signs until the resident feeling better every few hours and the resident fine at this time. Review of the Incident report dated 3/2/18 at 7:44 PM revealed staff gave the resident her room mate's bedtime medications. There are no pictures or names on door. The resident made a statement that the medications at bedtime and she did not receive medication at bedtime. Review of the Weights and Vitals Summary dated 3/3/18 revealed vital signs taken at 2:33 PM. Temperature 98.1, pulse 93, Respirations 18 and pulse oximeter 97%. Review of the Progress Notes dated 3/3/18 at 12:05 PM revealed the resident stated she had been given the wrong medications last evening and not feeling well. Vital signs within normal limits. Talked with her about her medication orders and the possibility of mistakenly receiving room mates medications. At 2:52 PM the resident continued on skilled care with physical and occupational therapy due to post hospitalization resulting in weakness. The resident independent in the facility during the day with front wheeled walker. Utilizes call light for any needs and pleasant and cooperative with cares. Vital signs within normal limits. Complains of not feeling right and stated she had been given bedtime medication when she doesn't have any. The nurse insisted they were her pills so the resident	F 658		

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F 658	Continued From page 5 took them. At 3:17 PM physician called in regards to medication mix up and stated to check vital signs every 2 hours until feeling better. Call with any changes in vital signs or cognition. At 7:54 PM the resident received simvastatin 40 mg, senna plus and 1quetiapine fumarate 25 mg at bed time last evening in a medication error. The resident had been tired for a period today but no other adverse reactions noted. Physician notified with order to do vital signs until the resident feeling better every few hours and the resident fine at this time. Review of the Policy and Procedure titled Medication Administration dated 10/17 directed staff to do the following: a. Follow the 6 rights: right medication, right dose, right resident, right route, right time and right documentation.	F 658		
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. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and policy review the facility failed to always provide timely and complete assessment and intervention for residents with dehydration for 1 of 5 records reviewed (Resident #4). The facility identified a	F 684		

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F 684	Continued From page 6 census of 52 current residents. Findings include: 1. According to the MDS (minimum data set) dated 2/19/18 Resident #4 had diagnosis that included gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, thyroid disorder, dementia, acute pancreatitis and encephalopathy. The MDS identified the resident had a BIMs (brief interview for mental status) score of 9 which indicated moderate cognitive impairment. According to the MDS the resident the resident required extensive assistance with bed mobility, dressing, eating and toilet use. The care plan dated 2/28/18 directed staff to weigh weekly, encourage eating by providing food and fluids of her choice, cueing and assist as needed. The care plan also directed the resident preferred ice cream for all meals and able to voice choices. Review of the Laboratory report dated 3/19/18 revealed the following: a. BUN 42 (reference range 8-21) b Creatinine 2.2 (reference range 0.5 to 1.3) New physician orders received to encourage fluids and recheck BMP in 1 week On 3/26/18 the following laboratory values obtained: a. BUN 47 b. Creatinine 2.0 New physician orders received directing staff the resident needed to hydrate-encourage fluids. If the resident won't drink fluids, then she needed to be seen in the emergency room. Review of the Food and Fluid Intake form dated	F 684		

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F 684	Continued From page 7 3/23/18 through 4/5/18 revealed the following 24 hour fluid intakes: a. 3/23/18-570 cc (cubic centimeters) b. 3/24-480 cc c. 3/25-610 cc d. 3/26-450 cc e. 3/27-630 cc f. 3/28-600 cc g. 3/29-300 cc h. 3/30 600 cc i. 3/31 220 cc j. 4/1 330 cc k. 4/2-660 cc l. 4/3-420 cc m. 4/4-180 cc n. 4/5-240 cc Review of the Weights and Vitals Summary dated 4/5/18 revealed the resident had the following vital signs measurements: oxygen saturation: a. 3/25/18 at 7:30 PM 96% pulse: a. 3/25/17 at 7:30 PM- 66 b. 3/27/18 at 8:51 PM-66 c. 4/3/18 at 7:33 PM-66 d. 4/5/17 at 9:47 PM 33 respirations: a. 3/25/17 at 7:30 PM 20 b. 4/5/18 at 9:47 PM 18 temperature: a. 3/25/18 at 7:30 PM-97.4 degrees b. 4/5/18 at 5:48 PM-96 degrees Review of the Progress Notes dated 3/26/18 at 12:24 PM revealed an unsuccessful lab attempt to the right lower leg and a successful lab to the left antecubital space for BMP. Labs taken to the hospital for evaluation. On 3/17/18 at 1:37 PM	F 684		

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F 684	Continued From page 8	F 684		

physician responded the resident needed to hydrate. If she refused, to send her to the ER (emergency room). Staff report the resident grabbed at her own glass today to drink. On 3/28/18 at 9:15 AM the resident weights, orders and notes reviewed at a meeting with dietary, activities, therapy, social worker and nursing. The resident started on Megace last week and intakes have been mostly 0 to 25 %. Will update physician regarding appetite and whether to pursue feeding tube. The resident had been working with therapy, tolerating well however, sleeping a lot of the day. On 4/1/18 at 5:57 AM the resident had no void during the shift. On 4/4/18 at 9:55 AM received fax back from Physician stating to continue with the Megace and update again in 1 week. On 4/5/17 at 5:43 PM the resident had abnormal vital signs, altered mental status, food and/or fluid intake, functional decline. On 4/5/18 at 6:30 PM the Physician notified about resident's condition due to the resident only responsive to painful stimuli, low blood pressure and low pulse. Due to the resident a full code, Physician suggested to send her to the emergency room (ER). Family aware of the resident being sent to ER, also family aware of the transport. Ambulance notified and the resident transported to the ER.

Review of the Emergency Room Report dated 4/5/18 revealed the resident had the following diagnosis: urinary tract infection with altered mental status, dehydration, hypercalcemia (calcium level above normal), hypernatremia (abnormally high concentration of sodium in blood), and low bicarb (blood pH is low). The ED report revealed the resident's intake and output will be recorded along with daily weights.

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F 684	Continued From page 9 The facility failed to complete timely assessments for the resident. During an interview with the Physician Assistant on 7/24/18 at 2:30 PM she stated the facility did as expected and did update her with a fax. The resident had a poor appetite and she ordered Megace. She talked to the facility about a possible feeding tube but wanted to see if the Megace worked. Review of the Policy and Procedure titled Interact Change In Condition Evaluation dated 5/16 directed staff to do the following: a. Review the resident's medical record including diagnoses, medications, recent progress notes form a medical doctor/nurse practitioner/physician's assistants and consultants, as well as the most recent interdisciplinary notes. b. Check with others staff members who have regular contact with the resident to obtain an accurate picture of the change in condition. c. Review advance directives if available. A conversation with a family member or healthcare proxy may be needed to clarify advance directives.	F 684		

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.

F658

1. Resident #2 Lortab order was corrected on 3/31/18 by the charge nurse. Resident #2 assessed for adverse reaction to TB site and nursed provided education by the DNS. Unable to correct to Resident #5, at time of incident proper notification and assessments completed.
2. All residents could be affected.
3. Nursing staff was re-educated on standards of care related to medication administration on 6/26/18 by PIP leader.
4. The DNS or designee will audit medication passes weekly X4 weeks, bi-monthly X4 months, monthly for 6 months the completed findings will be brought to the Quality Assurance committee for further recommendations.
5. Completion date: September 4th, 2018

F 684

1. Unable to correct to Resident #4.
2. All residents could have been affected.
3. The DNS re-educated nursing staff on proper resident assessments and documentation on 3/21/18 and 6/1/18.
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: August 1st, 2018