STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165186	A. BUILDING _____ B. WING _____	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319 INDIANOLA, IA 50125

(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: 12-27-20 A COVID-19 Focused Infection Control Survey (FIC) was conducted by the Department of Inspection and Appeals in conjunction with an investigation of facility reported incident 93420-I and complaints 88586-C and 92826-C on September 23-October 13, 2020. The facility was found to be in noncompliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: 86 The facility reported incident was substantiated. Both complaints were substantiated. The following deficiencies relate to the Code of Federal Code of Regulations (42-CFR) Part 483, Subpart B-C.	F 000		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to provide bathing services in accordance with acceptable professional standards to maintain good personal hygiene for 4 of 4 residents reviewed who are unable to carry out the activity independently. (Residents #1,#2,#3, #7) The facility reported a census of 86 residents.	F 677		

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.

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F 677	Continued From page 1 Findings include: The Minimum Data Set (MDS) with an assessment reference date of 12/22/19 indicated Resident #1 with a Brief Interview for Mental Status (BIMS) score of 10 indicating a moderately impaired cognitive status. Resident #1 required extensive assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #1 had diagnosis which included Alzheimer's disease, Non-Alzheimer's dementia, adult failure to thrive, hypertension and malnutrition. Record review revealed Resident #1 was admitted on 12/16/19 and did not receive her first bath or shower until the 8th day of her stay. The Minimum Data Set (MDS) with an assessment reference date of 7/3/20 indicated Resident #2 with a Brief Interview for Mental Status (BIMS) score of 12 indicating a moderately impaired cognitive status. Resident #2 required limited assistance with transfers, mobility and eating and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #2 had diagnosis which included Non-Alzheimer's dementia, bipolar disorder and schizophrenia. Record review revealed Resident #2 should receive a bath on Mondays, Wednesday and Fridays. Documentation of bathing provided by the facility for August through October 5th, 2020 found Resident #2 was not provided a bath or shower opportunity on 8/26, 8/31, 9/9 and 9/23. The Minimum Data Set (MDS) with an assessment reference date of 7/14/20 indicated	F 677		

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F 677	Continued From page 2 Resident #3 with a Brief Interview for Mental Status (BIMS) score of 1 indicating a severely impaired cognitive status. Resident #3 required limited assistance with transfers and mobility and extensive assistance with dressing, toilet use and personal hygiene needs. Resident #3 had diagnosis which included Alzheimer's disease. Record review revealed Resident #3 should receive a bath on Mondays and Thursdays. Documentation of bathing provided by the facility from August through October 5th, 2020 found Resident #3 was not provided a bath or shower opportunity on 8/31 or 9/7. The Minimum Data Set (MDS) with an assessment reference date of 12/23/19 indicated Resident #7 with a Brief Interview for Mental Status (BIMS) score of 12 indicating a moderately impaired cognitive status. Resident #7 required extensive assistance with transfers, mobility, dressing, toilet use and personal hygiene needs. Resident #7 had diagnosis which included Diabetes mellitus, atrial fibrillation and hypertension. Record review revealed Resident #7 was admitted on 9/17/20 and scheduled for showers on Monday and Thursday. Review of the bathing records found Resident #7 did not receive a shower on 9/24 and 9/28.	F 677		
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	F 689		

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F 689	Continued From page 3 §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 staff interviews, the facility failed to provide adequate supervision and proper use of assistance devices to mitigate a resident's risk for elopement (when a resident leaves the facility without staff knowledge or permission). The facility failed to ensure kitchen doors remained securely locked at all times, failed to check a door alarm properly to ensure all residents are accounted for and failed to have policies and procedures in place to address what to do when responding to a door alarm. (Resident #3). These conditions constituted an Immediate Jeopardy to resident health and safety. The facility reported census was 86 residents. Findings include: According to the Minimum Data Set (MDS) assessment with assessment reference date of 7/14/20, Resident #3 had a Brief Interview for Mental Status (BIMS) score of 1 indicating a severely impaired cognitive status. Resident #3 the resident walks independently with limited assistance and requires extensive assistance with dressing, toilet use and personal hygiene needs. Resident #3's diagnosis includes Alzheimer's disease. Resident #3's plan of care indicates Resident #3 has potential for elopement related to dementia with interventions which include using a wander guard to alert and assist staff with resident's	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 4 movements and whereabouts. Resident #3 is also at risk for falls related to loss of left eye and unsteady gait at times with interventions which include ensuring resident is wearing appropriate footwear and providing a safe environment. Incident report dated 9/19/20 at 4:05 p.m. indicated Resident #3 was found outside in parking lot. Wander guard in place. No injury noted. In an interview on 9/24/20 at 10:26 a.m. Staff A, cook, stated on Saturday 9/19/20 at around 3:00 p.m. she had left the kitchen to check on menus for each hall. As she was returning to the kitchen (3:21 p.m. per video), the walkie talkie alerted that a door alarm was sounding. Staff A stated the alert did not identify what door was sounding. As she got to the kitchen, she realized it was a kitchen door leading to the dock. Staff A stated she went to the door and coded it to exit, then looked outside, did not see anyone, cleared the alarm and returned to work. Staff A stated at around 4:05 p.m. she was in the dining room and saw a resident outside through the dining room window. At first she thought it may have been someone from assisted living, but then realized it was Resident #3. Staff A stated she paged for assistance and staff responded immediately and brought Resident #3 back inside. Staff A stated she has been employed since January 2018 and has viewed training video on elopement and clearing alarms, but did not realize she needed to initiate a resident head count when a door alarm sounds and there is no known reason. In an interview on 9/24/20 at 11:04 a.m. Staff B, certified nurse aide, stated on the afternoon on 9/19/20, she was walking toward the front	F 689		

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F 689	Continued From page 5	F 689		

entrance to go on break, when she heard over the walkie that a resident was outside. Staff B ran outside and found Resident #3 standing near the garage area. Resident #3 stated he was tired from walking and lowered himself onto the ground, laying down in the grass. Nurses were aware and responded promptly. Staff B stated they paged the nurses and requested a wheelchair. Resident #3 was assisted into a wheelchair and propelled back inside without any apparent injury.

In an interview on 9/24/20 at 11:15 a.m. Staff C, certified nurse aide, stated on the afternoon on 9/19/20, she and Staff B were heading to the front door to go on break at around 4:05 p.m. when they heard over the walkie that Resident #3 was outside. They rushed outside to the resident. Resident #3 stated he was tired from walking so long and sat down in the grass. Nurses were on their way and they called for a wheelchair. Staff C stated Resident #3 was assisted into a wheelchair and brought inside. Staff C stated she did not see any injuries. Staff C stated Resident #3 frequently wanders the facility and has set off door alarms.

In an interview on 9/28/20 at 12:23 p.m. Staff D, registered nurse, stated on the afternoon of 9/19/20, Resident #3 was restless and redirected per care plan with offering of a snack. Resident #3 was sitting at the nurse's station. Staff D stated the pharmacy had delivered medications and she was in the process of putting them away when she heard over the radio that Resident #3 was outside. Staff D stated she grabbed the transport chair and responded. Staff D stated Resident #3 indicated he was tired and was sitting in the grass. Staff D stated Resident #3

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F 689	Continued From page 6	F 689		

was assessed and found without injury and then brought back into the facility. Staff D stated since COVID there are fewer areas for Resident #3 to go to. Resident #3 used to go to the dining room for food, but she has never known him to go into the kitchen. Staff D stated standard protocol when door alarms sound are to determine who set the alarm off, check outside as needed and with no explanation as to the cause of the door alarm, staff are to conduct a resident head count.

In an interview on 9/24/20 at 9:30 a.m. the Administrator stated on Saturday 9/19/20 she received a call reporting Resident #3 had eloped and was discovered outside. Resident #3 was escorted back into the building and found without injury. Resident #3 was immediately place on 15 minute checks. The Administrator stated she was in Des Moines and did not arrive at the facility until after 6:00 p.m. The Administrator stated she gathered statements and reviewed the facility video. The video indicated at 3:00 p.m. Resident #3 is observed entering the dining room through closed doors and walks into the kitchen. There is no camera view of the kitchen exit door onto the dock. The Administrator stated Staff A reported she was not in the kitchen when the door alarmed, but when she returned at 3:21 p.m. according to video, she responded to the door, looked outside, did not see anyone and cleared the alarm. Staff A reported at around 4:05 p.m. she was in the dining room and saw Resident #3 outside through the dining room window and paged for assistance. The Administrator stated staff education on proper door alarm response was initiated that evening and everyone but two staff were re-educated by 9/22/20, and the 2 staff that weren't will be educated before they are working with residents. Kitchen staff were

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F 689	Continued From page 7 instructed to keep the kitchen door closed and locked when no one was in the kitchen and signs were posted with those instruction. Stop signs were also placed on the kitchen and exit doors. On Sunday 9/20/20 the kitchen door was adjusted to lock automatically when closed and on Monday 9/21/20 the interior kitchen door had a coded lock installed. The Administrator stated elopement drills are conducted monthly. Review of facilities Elopement and Alarms: Bed, Chair and Door policy and procedures found no instructions related to what to do when responding to a door alarm. Review of Elopement Education 9/19/20 provided by Administrator on door alarm response education directed: If a door alarm is sounding, the door must be checked immediately. You must ensure that a resident did not go out the door unseen. If an alarm is sounding, you need to check the area of the sounding alarm and check outside. You must immediately initiate a resident head count and all missing residents must be searched for until found. DO NOT clear or silence the door alarm without locating the reason the alarm is sounding. The facility was notified of the IJ on 9/25/20, although the facility was cited for past non-compliance because the facility had abated the IJ effective 9/22/20 prior to the surveyor's site visit to investigate the elopement. The facility abated the IJ by taking the following actions: 1. Educated all staff by 9/22/20. 2. Resident #3 placed on 15 minute checks on 9/19/20	F 689		

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F 689	Continued From page 8 3. The kitchen door was adjusted to lock automatically when closed on 9/20/20. 4. The interior kitchen door had a coded lock installed on 9/21/20. 5. The facility will continue to conduct elopement drills monthly.	F 689		
F 712 SS=C	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure residents are seen by a physician at least every 30 days for the first 90 days after admission and at least once every 60 days there after for 2 of 4 residents reviewed. (Resident #2, #3). The facility reported census is 86 residents.	F 712		

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F 712	Continued From page 9 Findings include: According to Resident #2's Admission Record, she was admitted on 4/19/19. Review of Resident #2's physician progress notes found an initial visit was conducted on 4/26/19. Resident #2 was again visited on 5/24 and 6/24, but was not seen in July for her last 30 day visit within ninety days. Sixty day visits occurred on 8/26 and 10/21. There was no recorded December visit. Resident #2 was not seen again until 1/3/20 which exceeded the 60 days plus 10 day window to be considered timely. All other visits to date were completed in a timely manner. According to Resident #3's Admission Record, he was admitted on 12/16/19. Review of Resident #3's physician progress notes found an initial visit was conducted on 12/23/19. Resident #3's first visit following admission was on 2/10, which exceeded the 30 days plus 10 day window to be considered timely. All other visits to date were found timely.	F 712		
F 947 SS=C	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.	F 947		

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F 947	Continued From page 10 §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 staff interview and record review, the facility failed to provide sufficient in-service training to ensure the competency of their staff. The facility reported census was 86 residents. Findings include: In an interview on 10/6/20 at 11:00 a.m. the Administrator stated all staff are expected to review monthly on-line training videos through Relias. In addition there are periodic in-service training. The Administrator provided this surveyor all 2019 training records for 10 sampled Certified Nursing Assistants (CNA's). Review of 10 CNA training records, reveled 5 aides, with over a year of service, did not receive the minimum (12 hours) in-service training required per year in 2019. (Staff L, M, N, O, P)	F 947		