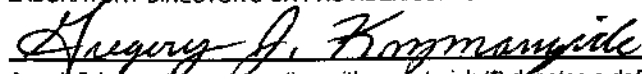


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165249	DEC 9 2004 (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/5/2004
NAME OF PROVIDER OR SUPPLIER NEWELL GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST HIGHWAY NEWELL, IA 50568		
(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 The following deficiencies are the result of the recertification survey completed November 1st -5th, 2004. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Correction Date <u>Dec 7, 2004</u> <i>per Action 12/23/04</i>	F 000	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 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 section 7305 of the state operations manual.		
F 365 SS=F	483.35(d)(3) DIETARY SERVICES Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to prepare and serve two (2) of two (2) pureed food products in a form to meet the need of the residents. Concerns noted for Resident #15 and Resident #16. The facility census included thirty-eight (38) residents. Findings included: 1. The facility identified two residents who required pureed diets. Review of a Dietary Note dated 9/21/04 documented Resident #15 required a pureed diet due to a history of chewing problems and swallowing problems. Review of a Dietary Note dated 8/24/04 documented Resident #16 required a pureed diet due to a history of chewing problems.	F 365	1. Food Service Supervisor immediately provided training for staff A concerning the appropriate way to prepare, heat and serve pureed food items. Completion date - 11/5/04 2. Consultant Dietitian provided training for all dietary staff through in-service education on the appropriate way to prepare, heat and serve pureed food items. Staff will be instructed to prepare hot pureed items immediately before meal service. Completion date - 12/16/04 3. Dietary staff will monitor pureed food items for temperature, texture, and appearance daily for one week, then weekly for the next month, then monthly for two months and then quarterly thereafter for one year. Results will be forwarded to QA Committee for follow-up. Staff responsible - QA Committee Completion date - on-going		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE



Administrator

11/30/04

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/5/2004	
NAME OF PROVIDER OR SUPPLIER NEWELL GOOD SAMARITAN CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST HIGHWAY NEWELL, IA 50568		
(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 365	Continued From page 1 Observation on 11/4/04 at 12:16 pm showed Staff A heated two separate bowls of pureed meat products in the microwave. After the meat had been heated, observation showed the meat with a thick dark-colored crusty layer around the edges. Observation showed the meat product served to Resident #15 and Resident #16 at the noon meal on 11/4/04. Observation showed the nursing staff fed the product to Resident #15 and Resident #16. Service of the meat product with the thick dark-colored crusted layer around the edges placed the residents, who had chewing or swallowing problem, at risk for choking.	F 365		
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and review of inservice information, the facility failed to prepare and serve a meal under sanitary conditions. The facility census included thirty-eight (38) residents. Findings included: 1. On 11/4/04 at 12:07 pm, observation showed Staff A initiated the service of the noon meal. Observation showed Staff A wore rubber gloves. Staff A opened a package of hamburger buns and used the last two buns. Staff A then opened a second bag of buns and removed two buns. Staff A placed one bun on top of the remaining	F 371	1. Food Service Supervisor immediately provided training for Staff A on an individual basis concerning the proper use of gloves and hand washing during food preparation and service. Completion date - 11/5/04 2. Consultant Dietitian will provide training for all dietary staff through inservice education on the proper use of gloves and hand washing during food preparation and service. Completion date - 12/16/04 3. Monitor use of gloves and handwashing during meal service daily for one week, then weekly for the next month, and then monthly for the next two months and quarterly thereafter for one year. Results will be forwarded to QA committee for follow up. Staff responsible - QA Committee Completion date - on-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165249	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/5/2004
NAME OF PROVIDER OR SUPPLIER NEWELL GOOD SAMARITAN CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 415 WEST HIGHWAY NEWELL, IA 50568		
(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 371	<p>Continued From page 2</p> <p>bags of buns. With the same gloved hands, Staff A then opened a paper package of cookies and served the cookies. At 12:15 pm Staff A opened a third package of hamburger buns and served the buns. At 12:16 pm Staff A opened the refrigerator door, with the same gloved hands, and obtained a bowl of pureed meat product. Staff A then opened the microwave door, with the same gloved hands, and heated the bowl of meat. Staff A proceeded to pick up a plastic diet card from the diet card caddy and laid the diet card onto the service counter. At 12:17 pm Staff A obtained a bowl of pureed meat product and a cup of soup from the refrigerator. Staff A wore the same gloves. Staff A then opened the microwave and obtained the temperature of a meat product. Staff A then placed the second bowl of meat product in the microwave. Staff A proceeded to the service area and continued to serve the meal. At 12:20 pm Staff A opened the cupboard door and obtained a bag of potato chips. Observation showed Staff A reached into the bag, removed potato chips, and placed them onto a plate and served them. Staff A then opened another package of cookies and served them. Staff A opened the microwave door and obtained a temperature of the second bowl of pureed meat product and served it.</p> <p>Observation showed Staff A wore the same pair of rubber gloves throughout the entire service of the meal. Staff A had touched numerous food products and contaminated objects during the service which potentially placed all residents at risk for consumption of contaminated food.</p> <p>Documentation showed the facility provided an inservice 9/25/03 which included the policy and procedures for surface sanitation, hand washing, usage of gloves, and proper service of food. The</p>	F 371			

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

165249

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

11/5/2004

NAME OF PROVIDER OR SUPPLIER

NEWELL GOOD SAMARITAN CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

415 WEST HIGHWAY
NEWELL, IA 50568(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 371 Continued From page 3
inservice included a ServSafe Employee Guide
which included instruction on proper glove use.
The instructions stated to change gloves before
starting a different task. Documentation showed
Staff A had attended the inservice.

F 371