STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING 1K on 2/9/09 B. WING	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY NEWELL, IA 50568

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F 000	INITIAL COMMENTS The following deficiencies are the result of the recertification and licensure survey performed January 5 through 8, 2009Correction . Self reported Incident # 21085 was investigated and not substantiated. See Code of Federal Regulations (42CFR), Part 483, Subpart B-C. Date 2/9/09	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	see attached POC	

2/6/09 updated dag

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: see email for signature | TITLE | (X6) DATE: 2/2/09

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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and family the facility failed to inform the resident's family and physician of an incident involving the resident for three of twelve residents reviewed (Resident #1, Resident #6 and Resident #7.) The facility reported a census of forty eight residents. Findings included: 1. Facility staff reported on December 3, 2008 staff found a "smiley face" drawn on the resident's back in red ink or marker. During interview on January 7, 2009 at 10:47 a.m. Staff A27 stated a Certified Nursing Assistant had pointed it out to her just before she left at the end of the 2:00 p.m. to 10:00 p.m. shift. She stated the mouth was about the size of an elongated dime with two dots for eyes. The facility's investigative report stated the resident's family and physician had been notified. During interview on January 5, 2008 at 11:12 a.m. the resident's spouse stated he/she had not been informed about the face found drawn on the resident's back. During interview on January 7, 2009 at 10:40 a.m. the spouse stated again he/she had not been informed of the markings on the resident's back. He/she stated, "I'm sure I would have remembered that." During interview on January 5, 2008 at 11:15 a.m.	F 157		

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F 157	Continued From page 2 the Staff BB stated she didn't know which nurse had informed the resident's spouse. She thought they had just told the spouse the resident had a red mark on his/her back. She stated staff had probably not told the spouse the mark had the form of a smiley face because the resident's spouse would have found it offensive. The resident's record lacked any documentation indicating the resident's physician had been informed of the smiley face drawn on the resident's back. During interview on January 8, 2009 at 12:37 p.m. Staff D, Registered Nurse, stated she had contacted the resident's physician's office and they could find no record the physician had been informed of the incident. 2. According to the Minimum Data Set, with the assessment reference date of 9/28/08, Resident #6 had long and short term memory problems and required cues/supervision when making decisions regarding tasks of daily life. Resident #6 required limited assist with transfers and extensive assist with ambulation. A Daily Skilled Note, dated 10/7/08,documented a certified nursing assistant had reported Resident #6 had bruises on the right knee, purple dark bruises surrounded the bottom side of the knee cap. The chart lacked documentation of physician and family notification of the bruises. During observation of cares on 1/6/09 at 8:45 a.m. it was noted Resident #6 had a dark purple bruise on the left hand between the third and fourth knuckle.	F 157		

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F 157	Continued From page 3 The chart lacked documentation of the bruise when reviewed on 1/6/09. On 1/7/08 after the facility had been made aware of the bruise an entry had been made in the Interdisciplinary Progress Notes at 9:50 a.m. indicating the resident had a 4 centimeter by 1.7 centimeter purple discoloration on the left hand knuckle. The entry noted a message had been left for the residents daughter. The charting lacked documentation of physician notification. During interview on 1/8/08 at 11:45 a.m. the Director of Nursing stated she would expect staff to notify the physician and family. 3. According to the Minimum Data Set (MDS), with the assessment reference date of 9/30/08, Resident #7 had a short term memory problem. Resident #7 had required extensive assist with dressing and personal hygiene. The MDS showed the resident had a diagnoses of arthritis. A telephone order for Resident #7, dated 11/7/07, ordered a hot pack as needed to areas of discomfort. The Interdisciplinary Progress Notes, dated 10/25/08 at 9:50 a.m., documented the resident had a pink area 4 centimeters by 2 centimeters, skin intact, left open to air. The resident said it had been from the hot pack. The entry on 10/29/08 at 9:00 a.m. noted the burn on the back of the residents neck scabbed. During interview on 1/8/08 at 9:00 a.m., the Director of Nursing stated that the physician and the resident's family had not been notified of the burn.	F 157		

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F 157	Continued From page 4 The facilities procedure for burns directed staff to notify the physician immediately and to notify the family of the incident.	F 157		
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, review of resident records and staff interview the facility failed to limit the use of a physical restraint for one of twelve residents reviewed (Resident #1). The facility reported a census of forty eight residents. Findings included: Resident #1's, December 9, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short and long term memory and problems with decision making. The resident required extensive assistance for transfers, bed mobility, dressing, eating, hygiene and bathing. The resident did not ambulate. The resident's January 1, 2009 Medication Administration Record (MAR) listed diagnoses including Parkinson's disease, mixed dementia: Alzheimer's, Diabetes Mellitus, atrial fibrillation, atherosclerotic coronary vascular disease, glaucoma and hypothyroidism. On entrance to the facility staff reported Resident #1 used a seat belt alarm restraint. During	F 221	see attached	

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F 221	Continued From page 5 interview on January 8, 2009 at 11:03 a.m. the Director of Nursing confirmed the resident could not remove the seat belt on cue. During observation on January 5, 2009 at 8:03 a.m., the resident sat in a wheelchair in the facility dining room feeding him/herself with a belt restraint/alarm in place. Staff sat at the resident's side assisting other residents. During observation on January 6, 2009 at 7:59 a.m., the resident sat in a wheelchair in the dining room fed by Staff H. Staff H confirmed the belt was latched. During observation on January 7, 2009 at 7:44 a.m. the resident sat in a wheelchair in the dining room feeding him/herself independently. Staff E stood at a medication cart facing the resident five feet away. The belt restraint remained in place. At 8:09 a.m. the resident continued feeding him/herself independently. Staff sat at the table assisting other residents. The belt restraint remained in place. At 12:18 p.m. the resident sat in a wheelchair in the dining room with the belt restraint in place. Staff sat at the table assisting other residents. The resident's Physical Restraint Review, dated October 1, 2008, stated: 13. Describe approaches taken to modify/eliminate restraint use (i.e., release during supervised times/meals and activities: utilize less restrictive devices, gradually increase the time for ambulation and muscle strengthening activities, etc.) Released at meals-when in recliner. On January 7, 2009 staff documented, Removed at meal times with staff seated next to him/her. Removed when in recliner with personal alarm on	F 221		

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F 221	Continued From page 6 while up in recliner. The resident's care plan lacked any direction to staff to remove the restraint at meal times. During interview on January 7, 2009 at 2:22 p.m. Staff D stated she would have expected the care plan to direct staff to remove the seat belt restraint/alarm during meals and when staff had the resident closely supervised.	F 221		
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide interventions to reduce the risk of infection for one resident with recurrent urinary tract infections (Resident #1). The facility further failed to change a soiled pad and provide proper incontinent care for one resident (Resident #5). The facility reported a census of forty eight residents. Findings included: 1. Resident #1's December 9, 2008 Minimum Data Set (MDS) assessment tool documented the resident had impairment of short and long term	F 315	See attached	

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F 315	Continued From page 7 memory and problems with decision making. The resident required extensive assistance for transfers, bed mobility, dressing, eating, hygiene and bathing. The resident did not ambulate. The resident's January 1, 2009 Medication Administration Record (MAR) listed diagnoses including Parkinson's disease, mixed dementia: Alzheimer's, Diabetes Mellitus, atrial fibrillation, atherosclerotic coronary vascular disease, glaucoma and hypothyroidism. Review of the resident's clinical record revealed Physician's Orders received on August 20, 2008; September 22, 2008; October 21, 2008; November 24, 2008; December 8, 2008 and January 5, 2009 for Macrobid, an antibiotic medication, prescribed for treatment of urinary tract infections. The resident's October 3, 2008; December 5, 2008 and December 19, 2008 Comprehensive Care Plans directed staff to keep a water pitcher in the resident's room, offer fluids with cares and as needed, to offer snacks from the hydration cart and to monitor for dehydration. The care plans stated goals that the resident's urinary tract infection would be resolved or the resident would not develop a urinary tract infection. During observation on January 6, 2009 at 9:26 a.m. Staff A18 and Staff J assisted the resident with transfer and toileting in his/her room. Staff did not offer the resident fluids. At 1:31 p.m. the same staff assisted the resident to transfer from the wheelchair to the recliner and did not offer the resident fluids. During observation on January 7, 2009 at 6:34 a.m. Staff A18 and Staff FF assisted the resident	F 315		

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F 315	Continued From page 8 to transfer out of the reclining chair into the wheelchair, took the resident to his/her room and assisted with toileting. Staff did not offer fluids. At 8:09 a.m. the same staff assisted the resident to transfer from the wheelchair to the recliner. Staff did not offer fluids. At 1:30 p.m. Staff FF and JJ assisted the resident to transfer from the wheelchair into the recliner. Staff did not offer fluids. The resident's record lacked any documentation staff had requested an order for cranberry tabs or vitamin C which may decrease the resident's risk for urinary tract infection. The record lacked any request for a urology consultation. 2. Resident #5's, November 11, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short term memory and problems with decision making. The resident required total assistance of staff with transfers, dressing, eating and personal hygiene. The resident did not ambulate. The resident's, January 2009, Medication Administration Record (MAR) documented diagnoses including mixed dementia-Parkinsonism, Alzheimer's with behavior, major depressive disorder, generalized anxiety disorder, old myocardial infarction with arteriosclerotic heart disease. During observation on January 6, 2009 at 8:53 a.m. Staff A20 and Staff H stood the resident in a mechanical standing lift and pulled down the resident's pants to check for incontinence. Staff H stated the pad was dry. The incontinent pad had smears of stool present. Staff H stated the resident had received a rectal suppository that morning. The staff pulled up the resident's soiled	F 315		

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F 315	Continued From page 9 pad, pants and assisted the resident to lie down on the bed. At 11:30 a.m. Staff H came and stated the resident's pad remained dry and so had not been changed. She/he stated a plan to check the pad again after the noon meal. During observation on January 7, 2009 at 6:13 a.m. Staff A10 provided treatment to an open area on Resident' #5's sacrum. Staff JJ assisted the Staff A10. Staff A10 removed the resident's incontinent pad and washed the resident's lower back, buttocks and rectal area. Staff A10 stated the pad had been wet with urine. Staff applied a clean pad but did not wash the resident's lower abdomen or any parts on the front of the body which had been in contact with urine on the incontinent pad. During observation on January 7, 2009 at 8:32 a.m. Staff A20 and Staff JJ assisted the resident with morning care. Staff A10 observed. Staff JJ removed the resident's incontinent pad. Staff A20 stated the pad had been wet. Staff washed the resident's groin, lower abdomen and frontal areas of the body which had been in contact with the wet incontinent pad. Staff failed to wash the buttocks or any posterior areas of skin. When asked why staff had not washed the buttocks/posterior Staff JJ stated she had not wanted to wash off the cream which had been applied earlier by Staff A10. When asked why the frontal areas had not been washed earlier when the resident had been incontinent at the time of the treatment to the sacrum Staff A10 stated she had only washed the areas she needed to treat.	F 315		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318	see attached	

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F 318	Continued From page 10 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, family and staff interviews the facility failed to ensure residents with limited range of motion (ROM) received the appropriate treatment and services to increase the range of motion and/or to prevent further decrease in range of motion for two (2) of twelve (12) residents reviewed (Resident # 3 and Resident #5). The facility reported a census of forty eight (48). Findings Included: 1. Resident #5's, November 11, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short term memory and problems with decision making. The resident required total assistance of staff with transfers, dressing, eating and personal hygiene. The resident did not ambulate. The resident's, January 2009, Medication Administration Record (MAR) documented diagnoses including mixed dementia-Parkinsonism, Alzheimer's with behavior, major depressive disorder, generalized anxiety disorder, old myocardial infarction with arteriosclerotic heart disease. A Plan of Treatment for Rehabilitation/Physical Therapy form, dated December 18, 2008, stated "Evaluation only". The therapist recommended to increase nursing assistance with range of motion exercises from three times to at least five	F 318		

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F 318	Continued From page 11 days weekly. The resident's care plan directed staff to assist the resident with gentle range of motion three times a week on the second shift. During interview on January 6, 2009 at 3:18 p.m. Staff TT stated staff assisted the resident with range of motion exercises twice daily every day. The CNA stated on second shift staff assisted the resident with the exercises at about 4:00 p.m. every day. Staff Q also present, nodded in agreement. During interview on January 6, 2009 at 3:21 p.m. the resident's spouse stated he/she was with the resident in the facility every day from 10:30 a.m. until about 7:00 p.m. when staff put the resident to bed. The spouse stated he/she had never seen staff assist the resident with stretching or exercises. During interview on January 7, 2009 at 11:46 a.m. Staff D stated staff had not followed the Physical Therapists recommendations to increase the frequency of range of motion exercises because they thought the resident was doing OK. At 2:09 p.m. when asked if the facility did any measured assessment of residents' range of motion for comparative assessment she stated she hadn't seen any but would check. The record lacked any such assessment. During interview on January 7, 2009 at 1:26 p.m. the Physical Therapist who wrote the recommendations stated staff had not discussed with her any reasons for failing to increase the frequency of the resident's range of motion exercises.	F 318		

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F 318	Continued From page 12	F 318		

2. According to a November 28, 2008, Diagnosis Description form, Resident #3 ' s diagnosis included Mental Retardation, Anoxic Brain Damage at Birth, Seizure Disorder, Chronic Pain and Depression.
The Minimum Data Set (MDS), with an assessment reference date of December 12, 2008, indicated Resident #3 had impaired memory and decision making skills. The MDS further indicated the resident required total assistance of staff for bed mobility, extensive assistance from staff with transfers and locomotion, had limited range of motion in both arms and listed a wheelchair as being the resident's primary mode of locomotion.
A Comprehensive Care Plan, dated December 10, 2008, identified a problem of impaired physical mobility. The care plan listed a plan and approach as functional maintenance program 6 X (times) per week for GROM (gentle range of motion) take to farthest point - hold for count of 5X5 REPS (repetitions) as Res.(resident) tolerates. The care plan listed the frequency code as " SHIFT 4 "
During interview on January 8, 2009 at 9:15 AM, the facility MDS Coordinator clarified GROM as meaning range of motion of all extremities and " SHIFT 4 " as meaning shifts 6:00 AM-2:00 PM and 2:00 PM-10:00 PM.
During interview on January 7, 2009 at 9:15 AM, Staff N stated he/she did not know if the resident's GROM of extremities were provided on the day shift or the afternoon shift.
During interview on January 7, 2009 at 9:40 AM Staff M stated he/she did not know what shift the GROM of the resident's extremities were to be done on "I ' ve only done it once. " Staff M

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F 318	Continued From page 13 stated he/she would have to check with the MDS Coordinator to find out when the GROM should be done. During interview on January 8, 2009 at 7:52 AM, Staff R looked at the resident's care plan to determine when the GROM of the resident's extremities should be done. Staff R stated he/she could not tell when the GROM should be done according to the care plan and stated he/she would have to check with someone. On January 8, 2009 at 8:20 AM, Staff R stated he/she had checked with the MDS Coordinator and had been told GROM of Resident #3 ' s extremities should be done on the 2:00 PM-10:00 PM shift. During interview on January 8, 2009 at 9:15 AM, the MDS Coordinator confirmed not until January 8, 2009 had the care plan been clarified regarding the GROM schedule. The MDS coordinator further confirmed " SHIFT 4 " had been entered in error on the care plan, caused confusion on the part of the CNA ' s and the GROM had " ...obviously not ... " been done for the resident.	F 318		
~~F 323~~ SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide interventions and supervision to prevent falls for four of twelve	F 323	See attached	

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F 323	Continued From page 14 residents reviewed (Resident #1, Resident #6, Resident #7 and Resident #9). The facility reported a census of forty eight residents. Findings included: 1. Resident #1's, December 9, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short and long term memory and problems with decision making. The resident required extensive assistance for transfers, bed mobility, dressing, eating, hygiene and bathing. The resident did not ambulate. The resident's, January 1, 2009, Medication Administration Record (MAR) listed diagnoses including Parkinson's disease, mixed dementia: Alzheimer's, Diabetes Mellitus, atrial fibrillation, atherosclerotic coronary vascular disease, glaucoma and hypothyroidism. Staff documented on Incident Details Reports the resident experienced sixteen falls between his/her admission to the facility on September 26, 2007 and December 23, 2008. According to staff documentation in the incident reports and Interdisciplinary Progress Notes the resident removed alarms and/or positioning devices eleven times. Five times devices had not been properly applied or did not work due to dead batteries. The resident's October 3, 2008; December 5, 2008 and December 19, 2008 Comprehensive Care Plans directed staff to place a floor mat next to the resident's bed, to apply a personal (clip) alarm to the resident when in bed or the reclining chair and to place the clip out of the resident's reach, to apply a seat belt in the wheelchair and noted the resident "independently removes seat	F 323		

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F 323	Continued From page 15 belt and personal alarm". The October 3, 2008 and December 5, 2008 care plans directed the resident had a "sensory alarm". The December 5, 2008 and December 19, 2008 care plans directed staff to apply a Sentinel (motion sensor) alarm in bed. Staff documented on December 3, 2008 at 6:05 a.m. the resident found on the floor in his/her room. Staff documented the resident's alarm did not sound. He/she had unclipped the personal alarm. Staff documented after the fall they replaced the batteries in the resident's motion sensor (Sentinel) alarm. Staff documented on December 4, 2008 at 10:45 p.m. staff found the resident in his/her room on the floor mat next to the bed. Staff noted the personal alarm had been unclipped and the sentinel alarm had been on the wrong settings and did not go off. The incident report stated a plan to have the CNAs (certified nursing assistants) check the resident's alarms at change of shift. The care plan lacked any addition directing staff to check the resident's alarms at the change of shift. Staff documented on December 9, 2008 at 1:45 a.m. staff found the resident in the hallway, seated on the floor. Staff noted the resident had unclipped the personal alarm and the Sentinel alarm had not been on. The incident report stated a plan to check all alarms upon change of shift and on all rounds. The resident's care plan lacked any addition directing staff to check the resident's alarms at the change of shift. Staff documented on December 23, 2008 at 9:55 p.m. the resident found on the mat next to the	F 323		

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F 323	Continued From page 16 bed with his/her gown off. Staff documented the sensory (motion sensor) alarm had sounded. The incident report and care plan lacked any new interventions in relation to this fall. During interview on January 6, 2008 at 9:48 a.m. the Director of Nursing (DON) stated she had ordered new, more difficult to remove, clip attachments for residents' alarms on December 22, 2008. She stated she had not previously purchased, or sought to purchase, more secure clips for resident's alarms. 2. Resident #9's, October 21, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short term memory and problems with decision making. The resident required extensive assistance of staff for transfers, bed mobility, ambulation in the hallway, dressing, bathing and personal hygiene. The resident did not walk in the room. The resident's, January 2009, MAR documented diagnoses including but not limited to mixed dementia, Alzheimer's with behavioral disturbance, major depressive disorder with psychotic behavior, generalized anxiety disorder, osteoporosis and lumbosacral degenerative disk disease. The resident's, December 5, 2008, Comprehensive Care Plan documented the resident at risk for injury related to falls due to an unsteady gait, dementia and medication use. The care plan directed one to two staff to assist the resident with transfers, to apply a personal body (clip) alarm to the resident at all times and to apply a sensory movement (motion sensor) alarm at bedtime. Staff documented on an Incident Details report on	F 323		

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F 323	Continued From page 17 December 23, 2008 at 9:00 p.m. the resident found on the floor sitting beside the toilet in his/her room, hanging on to the railing in the bathroom. Staff documented a plan to apply a personal alarm when in the restroom and staff stay with the resident. The resident's care plan lacked any new additions in response to the resident's fall. During interview on January 7, 2009 at 11:21 a.m. the DON stated residents who used mobility alarms at all times should not be left alone on the toilet. During interview on January 8, 2009 at 9:13 a.m. the DON stated at the time of the fall on December 23, 2008 the resident had transferred to the toilet independently. Staff believed the resident had removed the alarm. The DON confirmed no new interventions had been added in response to the fall which might reasonably decrease the resident's risk for falls under similar circumstances. 3. According to the Minimum Data Set with the assessment reference date of 9/28/08 Resident #6 had long and short term memory problems and required cues/supervision when made decisions regarding tasks of daily life. Resident #6 had required limited assist with transfers and extensive assist with ambulation. A Daily Skilled Note dated 10/7/08 noted that a certified nursing assistant reported that Resident #6 had bruises on the right knee cap, purple dark bruises surrounded the bottom side of the knee cap.	F 323		

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F 323	Continued From page 18 During observation of cares on 1/6/09 at 8:45 a.m. noted a dark purple bruise on Resident #6's left hand between the third and fourth knuckle. The facility lacked documentation of any investigations of the bruises or interventions in place to attempt to prevent further bruises. During interview on 1/8/09 at 11:45 a.m. the Director of Nursing stated she would expect staff to complete an investigation of the bruises and document in the Interdisciplinary Progress Notes. 4. According to the Minimum Data Set with the assessment reference date of 9/30/08 Resident #7 had long and short term memory problems. Resident #7 required extensive assist with dressing and personal hygiene. The Interdisciplinary Progress Notes dated 10/25/08 noted at 9:25 a.m. Resident #7 had a pink area 4 centimeters by 2 centimeters, skin intact, left open to air, resident said it had been from the hot pack. The entry on 10/29/08 at 9:00 a.m. noted the burn on the back of the residents neck had scabbed. The residents chart lacked documentation of interventions put in place to prevent another burn from a hot pack. During interview on 1/9/08 at 9:00 a.m. the Director of Nursing stated the facility had not completed an incident report or investigation of the residents burn.	F 323		
F 329 SS=D	483.25(i) UNNECESSARY DRUGS Each resident's drug regimen must be free from	F 329	See attached	

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F 329	Continued From page 19 unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assess risks and benefits related to use of psychoactive medications or attempt a gradual dosage reduction of psychoactive medications for one of twelve residents reviewed (Resident #9). The facility reported a census of forty eight residents. Findings included: Resident #9's October 21, 2008 Minimum Data Set (MDS) assessment tool documented the	F 329		

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F 329	Continued From page 20 resident had impairment of short term memory and problems with decision making. The resident's January 2009 MAR documented diagnoses including but not limited to mixed dementia: Alzheimer's with behavioral disturbance, major depressive disorder with psychotic behavior, generalized anxiety disorder, osteoporosis and lumbosacral degenerative disk disease. The resident's MAR documented the resident recieved Zyprexa, an antipsychotic medication, 1.25 milligrams (mg) daily six days per week and Nortriptyline, an antidepressant medication, 2.5 mg. four times daily since February 26, 2008. The MAR documented the resident recieved Lorazepam, an antianxiety medication, 1 mg. at bedtime since June 24, 2008 and Buspar, an antianxiety medication, 5 mg. twice daily since April 11, 2008. The record lacked any indication staff had attempted a dosage reduction had been attempted or requested since initiation of the psychoactive medications. The record lacked any risk benefit analysis in relation to use of the psychoactive medications or any documentation indicating staff had conducted a review for the continued necessity of the dosages of medication or considered the possibility of tapering the dosages of the medications. During interview on January 8, 2009 at 12:39 p.m. the DON confirmed no gradual dosage reduction had been requested or attempted in relation to the resident's psychoactive medications. She further confirmed no assessment of the risks to the resident related to use of the medications had been done in relation to possible benefits related	F 329		

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F 329	Continued From page 21 to their use.	F 329		
F 356 ~~SS=C~~	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to post hours for licensed staff and unlicensed nursing staff on duty. The facility	F 356	Due attached	

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F 356	Continued From page 22 reported a census of forty eight (48) residents. Findings include: On January 5, 2009, upon entrance to the facility, observation revealed a document posted on a clipboard on the counter of the nurses' station. The document titled Daily Nursing Staffing had not been completed for the day shift, dated January 5, 2009. During interview on January 5, 2009 at 7:00 AM, Staff E confirmed the daily nursing staffing posting had not yet been completed. Staff E further stated the day shift schedule included the times of 6:00 AM-2:00 PM, identified his/herself as being responsible for filling out the posting and stated the posting would be completed when he/she had time to get it done. Further review of the Daily Nursing Staffing documents revealed incomplete postings for the following dates/shifts between December 1, 2008 -January 5, 2008: December 3, 12, 19, 25, 27, 2008 -day shift December 21, 2008 and January 1, 2009- evening shift December 18, 19, 23, 31, 2008 - night shift, for a total of eleven (11) incomplete shifts. The documents further revealed no recorded census for twenty eight (28) shifts during the period of time from December 1, 2008-January 5, 2009. During interview on January 5, 2009 at 12:20 PM the facility Director of Nursing (DON) confirmed the incomplete daily nursing staffing and further stated there had been no system in place to audit the postings.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed	F 428	See attached	

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F 428	Continued From page 23 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure pharmacy reviews identified irregularities in the medication regime for three of twelve residents reviewed (Resident #1 and Resident #6 and Resident #9). The facility reported a census of forty eight residents. Findings included: 1. Resident #1's, December 9, 2008, Minimum Data Set (MDS) assessment tool documented the resident had impairment of short and long term memory and problems with decision making. The resident's, January 1, 2009, Medication Administration Record (MAR) listed diagnoses including Parkinson's disease, mixed dementia: Alzheimer's, Diabetes Mellitus, atrial fibrillation, atherosclerotic coronary vascular disease, glaucoma and hypothyroidism. Review of the resident's MAR's revealed staff administered prn (as needed) doses of Lorazepam (an antianxiety medication) 103 times during the 89 days between August 21, 2008 and November 18, 2008. During the same time staff administered Vicodin, a narcotic analgesic (pain medication) 100 times. Staff most frequently	F 428		

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F 428	Continued From page 24 administered the medications between 7:00 p.m. and 3:00 a.m. On November 18, 2008 at 2:20 p.m. staff reported to the resident's physician via facsimile (FAX Communication to Physician) the resident had been receiving prn Lorazepam and Vicodin nightly due to increased anxiety and restlessness. Staff requested and received an order to change the scheduled dose of Lorazepam from 4:00 p.m. to 5:00 p.m. During the 48 days between November 19, 2008 and January 5, 2009 staff administered prn Lorazepam 60 times. Staff administered Vicodin 53 times. Again, staff most frequently administered the medication between 7:00 p.m. and 3:00 a.m. Pharmacy reviews dated September 24, 2008; October 21, 2008; November 18, 2008 and December 16, 2008 failed to identify any irregularities in the resident's drug regimen review. The pharmacist signed the drug regimen review forms monthly. Each quarter the pharmacist made a mark designating no problems identified with daily use of prn medications for more than 30 days. 2. Resident #9's October 21, 2008 Minimum Data Set (MDS) assessment tool documented the resident had impairment of short term memory and problems with decision making. The resident's January 2009 MAR documented diagnoses including but not limited to mixed dementia: Alzheimer's with behavioral disturbance, major depressive disorder with psychotic behavior, generalized anxiety disorder,	F 428		

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F 428	Continued From page 25 osteoporosis and lumbosacral degenerative disk disease. The resident's MAR documented the resident received Zyprexa, an antipsychotic medication, 1.25 milligrams (mg) daily six days per week and Nortriptyline, an antidepressant medication, 2.5 mg. four times daily since February 26, 2008. The MAR documented the resident received Lorazepam, an antianxiety medication, 1 mg. at bedtime since June 24, 2008 and Buspar, an antianxiety medication, 5 mg. twice daily since April 11, 2008. The record lacked any indication staff had attempted a dosage reduction had been attempted or requested since initiation of the psychoactive medications. The pharmacist's monthly drug regimen reviews failed to identify antipsychotic and antidepressant medication used for excessive duration. The pharmacist's reviews failed to address the use of antianxiety medications in any manner. 3. The Physicians Orders showed that Resident #6 had a diagnoses of Major Depressive Disorder with psychotic features. Medication orders dated 5/12/08 included Effexor XR (an antidepressant) 187.5 milligrams every day and Zyprexa (an antipsychotic) 1.25 milligrams two times a day and 2.5 milligrams to be taken at bedtime. The January Medication Administration Record included Effexor XR 187.5 milligrams every day and Zyprexa 1.25 milligrams two times a day and 2.5 milligrams taken at bedtime. The monthly pharmacy review did not include	F 428		

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F 428	Continued From page 26 review for the continued necessity of the current medication doses or of attempts at tapering the dosages.	F 428		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation and chart review the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for 1 of 12 residents, (Resident #6). The facility reported a census of 48 residents. Findings include: According to the Minimum Data Set with the assessment reference, date of 9/28/08, Resident #6 required extensive assist with personal hygiene. Resident #6 had a diagnoses of Methicillin Resistant Staph Aureus (MRSA). During observation on 1/6/09 at 8:45 a.m. Staff A18, a certified nursing assistant, had assisted the resident onto a bedside commode. Resident	F 441	See attached	

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GOOD SAMARITAN SOCIETY - NEWELL	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 441	Continued From page 27 #6 had used their hand and wiped a large amount of clear colored nasal drainage from their nose and wiped it on their pants. Staff A18 handed the resident a dry hand towel which the resident used to wipe their nose more. Staff A18 the clipped the call light to the residents shirt and encouraged the resident to turn the light on when done on the commode. Staff A18 left the residents room without assisting Resident #6 wash their hands.	F 441		

Good Samaritan Society: Newell

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.

F157

1. For resident #1, family was notified on 01/06/09 and Dr. was notified on 01/07/09. For resident #6, family was updated on 01/08/09 and primary physician was updated on 01/07/09 regarding bruise. For resident #7, Dr. was notified on 01/27/09 and family was notified on 01/28/09. Nursing staff counseled on follow-up of resident condition.
2. All residents have the potential of incidents.
3. Nursing staff were in-serviced on 01/15/09 by DNS on procedure for physician and family notification. Procedure was amended to assure that incident reports are completed on all resident incidents, regardless of how minuscule it is.
4. DNS/designee will complete resident chart audits for 1 week x 1 month, then monthly x3. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009.

F221

1. For resident #1, care plan was updated on 01/07/09 to read "to remove seat belt at meal times" and for "staff to be seated next to resident when seat belt is off."
2. A care plan review was done to determine all residents with restraints.
3. Nursing staff were in-serviced on 01/08/09 by Staff Development on our restraint release procedure.
4. DNS/designee will complete restraint audits for 1 week x 1 month, then monthly x3. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009.

F315

1. For resident #1, care plan was updated on 01/08/09 to include use of vinegar water with peri-care and cranberry juice x2 daily. Doctor was updated and facility received an order for urology consult.
For resident #5, immediate education was done with the staff involved on 01/07/09.
2. A care plan/ MDS review will be done to identify all in need of assistance with peri-care.
3. Nursing staff were in-serviced on 01/08/09 by Staff Development on proper peri-care procedure.
Peri-care education is also completed annually during the C.N.A. Skills Fair.
4. DNS/designee will complete peri-care audits for 1 week x 1 month, then monthly x3. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009

F318
1. For resident #5, care plan was updated on 01/29/09 for range of motion to be completed 6x/week at HS. For resident #3, care plan was clarified on 01/06, 01/08/ and 01/29/09 for GROM to include all extremities at HS, shift 2.
2. Programs for all residents were reviewed Rehab Coordinator and consultant on 01/21/09 and updated as needed.
3. Rehab/Restorative Consultant was here on 01/21/09 to educate and give direction to Rehab Coordinator. An in-service was held on 01/08/09 by Staff Development for all nursing staff that included discussion of restorative and functional maintenance programs.
4. Rehab nurse/designee will complete audits of C.N.A. competency and completion of the restorative program weekly x1 month, then monthly x3 months. Then it will be reported to the QA committee and Rehab coordinator for further follow-up as needed.
5. February 9, 2009

F323
1. For resident #1, a new clip was applied to this resident's personal alarm on 01/06/09. A UMP bed sensor was ordered and placed on resident's bed. For resident #9, a new clip was applied to this resident's personal alarm on 01/06/09. For resident #6, nursing staff were in-serviced on 01/15/09 on amended procedure to assure that incident reports are completed on all resident incidents, regardless of how minuscule it is.
For resident #7, nursing staff were in-serviced on 01/15/09 on amended procedure to assure that incident reports are completed on all resident incidents, regardless of how minuscule it is. Also, order for hot packs was discontinued on 01/27/09 when resident returned from hospital.
2. All residents have the potential for accidents.
3. Professional nurses in-service was held on 01/15/09 by DNS regarding completion of incident reports and accident follow-up and prevention.
4. DNS/designee will complete resident chart audits for 1 week x 1 month, then monthly x3. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009.

F329
1. For resident #9, psychiatrist was consulted and orders were changed on 01/26/09.
2. A MAR review was completed on 02/02/09 to identify all residents that have psychotropic drugs.
3. DNS was educated on 01/28/09 by Staff Development regarding the use of the Gradual Dose Reduction Calendar.
4. Psychotropic meds will be reviewed monthly during Behavior Committee meetings for possible reduction.
5. February 9, 2009

F356
1. Immediate professional nursing staff education was completed on 01/05/09 by DNS regarding completion of the Daily Nursing Staff Posting and again on 01/15/09 during a professional nurse's meeting.
2. DNS/designee will weekly monitor completion of Daily Nursing Staff Posting. Results will

be reported to the QA committee for further follow-up as needed.
3. February 9, 2009

F428
1. For resident #1, Dr. was updated on 01/06/09 with an order change to a scheduled pain medication at HS. This new pain medication has caused usage of the Lorazepam as a prn to decline. For resident #9, psychiatrist was consulted and orders were changed on 01/26/09. The use of a Gradual Dose Reduction Calendar has been started for this resident. Consulting pharmacist was educated on 01/20/09 on the need for antidepressants, antipsychotic and antianxiety medications to be reviewed monthly. For resident #6, consulting pharmacist was educated on 01/20/09 on the need to review possible changes to current medications or tapering of dosages.
2. A MAR review was done on 02/02/09 to identify all residents that receive psychotropic/pain prn medications.
3. Consulting pharmacist was educated on 01/20/09 by DNS regarding the need for more extensive review of resident medications. Also the professional nurses were educated on 01/15/09 regarding the continued use of prns and when to get update the physician regarding such.
4. DNS/designee will complete MAR audits for 1 week x 1 month, then monthly x3. DNS/designee will stay in contact with consulting pharmacist monthly regarding further need in dose reductions or other medication changes. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009.

F441
1. For resident #6, staff were educated on 01/08/09 regarding the need to wash resident hands after bodily fluid contact or excretion.
2. All residents need their hands or other body parts washed after bodily fluid contact or excretion.
3. Staff were educated on 01/08/09 regarding the need to wash resident hands after bodily fluid contact or excretion.
5. 4. DNS/designee will complete resident hand-washing audits for 1 week x 1 month, then monthly x3. Then it will be reported to the QA committee for further follow-up as needed.
5. February 9, 2009