STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
12/15	165249	A. BUILDING 12/14/09 mw B. WING	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS Correction Date 12/04/09 The following deficiencies relate to the facility's annual health survey peformed November 10 & 12-13, 2009. (See Code of Federal Regulations (42CFR) Part 483, Subpart B -C)	F 000	**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.	
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility resident rights the facility failed to maintain dignity for one (1) of thirteen sampled residents (Resident #13). The facility reported a current census of forty-five (45). Findings included: Review of Resident #13's Comprehensive Care Plan documented diagnoses which included after care of bimalleolar fracture, hypertension, and lower leg edema. The Minimum Data Set (MDS), dated 10/27/09, assessed Resident #13 with no memory impairment and independent decision making, and required extensive staff assistance for activities of daily living (ADLs) such as mobility/transfer, dressing, personal hygiene and bathing. Review of Resident #13's Comprehensive Care	F 241	**F241** 1. Staff B and D were re-educated regarding resident dignity on 11-13-09 by the DNS. 2. All residents could be affected.	

Jag 12/11/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Smith	RN, DNS	12/4/09

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 241	Continued From page 1 Plan, dated 11/4/09, identified a problem of self care deficit and directed staff to assist with mechanical standing lift, and shower twice per week. Observation 11/12/09 at 8:06 a.m. showed Staff B, Certified Nursing Assistant (CNA) propelled Resident #13 from the shower room to his/her room. The residents buttocks were fully exposed, with the bath towel draped over the resident's front side. A male housekeeper was in the same hallway in and out of rooms. Observation 11/13/09 at 8:04 a.m. showed Staff D, housekeeper, with Resident #13 in his/her room. The door was open and Resident #13 was sitting up at the side of his/her bed with the lower half of his/her body exposed. A male resident was observed wheeling himself down the hallway. An interview was conducted with Resident #13 on 11/13/09 at 8:06 a.m. Resident #13 stated he/she had not observed residents in the hallways exposed, and would not want to be exposed in the hallway. Review of the facility resident rights documented, the resident has the right to personal privacy and confidentiality, and personal privacy includes personal cares. The facility resident rights continued to document the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	3. Shower ponchos were ordered by the DNS on 11-13-09 and arrived at the center on 11-19-09 to be used on those residents being transferred to the shower room by staff. All staff in-service on dignity issues was performed on 11-18-09 and 11-23-09 by Staff Development. An additional in- service is scheduled for 12-10-09 to cover resident's rights. 4. Auditing of the use of the ponchos and residents privacy in rooms to be completed weekly x3 weeks, then monthly x3 by the DNS or DNS designee, and then taken to QA for review.	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 2 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow facility policy in planning care for one resident receiving renal dialysis treatments (Resident #9). The facility reported a census of forty five residents). Findings included: The Cumulative Diagnosis List documented Resident #9 had diagnoses including but not limited to End Stage Renal Disease. The record documented the resident's admission date June 16, 2009. During initial tour of the facility on November 10, 2009 at 9:35 a.m., the Social Worker stated the	F 279	**F279** 1. On 11-13-09 call was placed to the Renal Center by the DNS requesting emergency information on resident #9. Resident's care plan was updated at that time. 2. Any residents on dialysis can be affected. On 11-13-09 DNS reviewed all physician orders to identify any other residents on dialysis and there are no others at this time. 3. Residents will be reviewed at time of admit and any current residents with order changes by the DNS or DNS designee for dialysis treatment and care plans will include approaches specific for dialysis emergencies. Staff education on emergency procedures and developing/amending care plans for dialysis residents was performed on 11-13-09 by the DNS. Additional education by the dialysis center is scheduled for 12-15-2009. 4. Audits of new admits with dialysis orders or current residents with order changes will occur monthly x3 months by the DNS or DNS designee then taken to QA for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 3 resident received renal dialysis treatments weekly on Monday, Wednesday and Friday. The dialysis treatments had been initiated prior to admission to the facility. A facility policy/protocol sheet titled "Dialysis Services" directed staff as follows: "At a minimum, the plan of care, protocols and procedures as they relate to the patient(s)/resident(s) dialysis, shall include: 1. Procedures for medical and non-medical emergencies, including, but not limited to complications, equipment failure, etc. 2. Follow-up care, observation, and monitoring; 3. Medications; 4. Nutritional needs and fluid restrictions; 5. Patient(s)/resident(s) education/instruction; and 6. Emotional and social well-being. " The resident's care plan, initiated July 17, 2009, documented under alteration in bowel/bladder elimination the resident received dialysis three times weekly and restrict fluids to 1500 cubic centimeters daily; under self care deficit directed staff to keep the dialysis cath site covered during whirlpool or shower; under impaired skin, to keep the dialysis cath site dry and under potential for fluid volume deficit and monitor the resident for edema or ascites; to monitor the site for increased redness, warmth, drainage or foul odor; under alteration in health to monitor for fever, nausea and vomiting . The care plan lacked any direction to staff in relation to possible emergencies associated with renal dialysis and the resident's dialysis catheter site. During interview on November 12, 2009 at 3:38 p.m. the Director of Nursing (DON) confirmed the	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 279	Continued From page 4 care plan lacked any guidance related to emergency procedures and did not fully address follow-up care, medications, or resident education. She stated a plan to revise the care plan.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy and procedure the facility failed to use professional standards for a dressing change for one (1) of twelve (12) active sampled residents (Resident #1). The facility reported a current census of forty-five (45). Findings included: Review of a History and Physical, dated 10/26/09, documented diagnoses which included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), transischemic attacks (TIAs), and impaired fasting glucose. The Minimum Data Set (MDS), dated 10/14/09, assessed Resident #1 with impaired long and short memory, moderately impaired in decision making and required extensive staff assistance for activities of daily living (ADLs) such as mobility/transfer, dressing and personal hygiene. The MDS documented Resident #1 had no skin impairment. Observation during initial tour on 11/10/09	F 281	**F281** 1. Staff C was re-educated on infection control measures regarding dressing changes on 11-14-09 by the Staff Development RN. 2. All residents requiring dressing changes could be affected. DNS reviewed all treatment sheets on 12-15-2009 to identify those residents. 3. Re-education regarding proper dressing change technique will be reviewed at a professional nurses meeting on 12-15-2009 by the DNS. 4. Audits to be completed on a random number of residents requiring dressing changes weekly x3 weeks, then monthly x3 by the DNS or DNS designee then taken to QA for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 281	Continued From page 5	F 281		

showed Resident #1 in his/her wheelchair in the med room near the nurse's station with Staff C, Licensed Practical Nurse (LPN). The resident had no socks or shoes on, and an open area to his/her left heel which was resting directly upon the padded foot rest of the wheelchair. Staff C appeared to be gathering supplies for a dressing change.

Observation 11/12/09 at 10:23 showed Staff C, LPN, gathered supplies for a dressing change to the residents left heel ulcer, and donned gloves. Staff C then opened a foam dressing, closed the package and laid the foam dressing directly upon the top of the package (label side), and placed a piece of Mefix tape to one side. Staff C removed the dressing, and changed gloves. She then cleansed the wound with normal saline and a 4x4. She measured the open heel wound with a paper tape measure by placing the paper tape measure directly upon the wound and measured "4 in length x 5 in width". The LPN then placed the foam dressing directly upon the open wound, and secured with Mefix tape.

During an interview with the Director of Nursing Services on 11/12/09 at 10:42, the DNS stated the foam dressing should not rest on the outer aspect of the package if it would come into contact with the resident's skin.

The facility policy and procedure titled Wound Dressing Change directed staff to: create field with equipment/dressing wrappers (use sterile technique if required). Open all supplies and pour solutions if ordered. Put on gloves. Assess wound and surrounding area to ensure the selection of the appropriate sized dressing. Cleanse the skin and wound thoroughly with normal saline using

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 281	Continued From page 6 guaze wipes, wound cleanser or ordered antiseptic solution. Allow the skin to dry completely before applying the dressing. Remove dressing from inner wrapper: avoid finger contact with the dressing.	F 281		
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 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 record review and staff interview, the facility failed to record/ perform the functional maintenance programs as planned for 3 of 12 active sampled residents (Resident #4, #5, and #8). The facility reported a census of 45. Findings include: 1. According to the Minimum Data Set (MDS) assessment, dated 08/25/09, Resident #4 required extensive assistance with bed mobility, transfer, locomotion and dressing. The MDS documented Resident #4 did not ambulate. The MDS also documented Resident #4 demonstrated limitation in range of motion (ROM) to one hand with partial loss of voluntary movement, and bilateral legs with with partial loss of voluntary movement. The Interdisciplinary Assessments and Summary Reviews, dated 06/15/09, documented Resident	F 318	**F318** 1. Staff involved with the functional maintenance programs on residents #4, 5, and 8 were re-educated regarding completeness and documentation of programs on 11-13-09 by the DNS. 2. All residents care planned to receive functional maintenance programs could be affected. The DNS reviewed all care plans to identify these residents on 11-13-09. 3. Staff re-education regarding the completeness and documentation of functional maintenance programs completed on 11-16-09 by the DNS. The Rehab Nurse and DNS to attend seminar on Restorative Nursing on 12-10-09. Charge nurses were informed by the DNS to check for completeness of programs prior to staff leaving shift on 11-16-09. 4. Audits of functional maintenance programs to be done weekly x3 weeks, and then monthly x3 by the DNS or DNS designee then brought to QA for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 318	Continued From page 7	F 318		

#4 demonstrated for the quarterly assessment no changes in functional ROM or voluntary movement. Resident #4 was on a functional maintenance program (FMP) 6 times a week for passive range of motion (PROM) and the program was appropriate for the resident at the time.

The Interdisciplinary Assessments and and Summary Reviews, dated 09/02/09, documented for the quarterly assessment Resident #4 had contractures of the right hand and bilateral legs. The review also documented Resident #4 was on a functional maintenance program for ROM and the program was appropriate.

An Addendum to Resident #4's Care Plan, with a date ordered of 02/02/09, directed FMP 6 times a week for PROM to all extremities for 5 repetitions, take to the farthest point and hold ankle, knee, hip, elbow, shoulder, hand and wrist. The FMP was to be done on the 2-10 p.m. shift.

The Restorative Plans/Approaches, with a date ordered 02/02/09, recorded Resident #4 received PROM:

a. 1 time the week of 02/01/02 to 02/07/09.
b. 3 times the week of 02/08/09 to 02/14/09, and refused 1 time.
c. 4 times the week of 02/22/09 to 02/28/09, and refused 1 time.
d. 4 times the week of 03/01/09 to 03/07/09, and refused 1 time.
e. 4 times the week of 03/08/09 to 03/14/09.
f. 5 times the week of 03/15/09 to 03/21/09.
g. 4 times the week of 03/22/09 to 03/28/09, and refused 1 time.
h. 3 times the week of 03/29/09 to 04/04/09, and refused 1 time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 318	Continued From page 8 i. 3 times the week of 04/05/09 to 04/11/09. j. 3 times the week of 04/12/09 to 04/18/09. k. 4 times the week of 04/19/09 to 04/25/09. l. 3 times the week of 04/26/09 to 05/02/09. m. 3 times the week of 05/03/09 to 03/09/09. n. 2 times the week of 05/10/09 to 05/16/09. 0. 1 time the week of 05/17/09 to 05/23/09, and refused 1 time. p. 5 times the week of 06/07/09 to 06/13/09. q. 5 times the week of 06/14/09 to 06/20/09. r. 3 times the week of 06/28/09 to 07/04/09. s. 1 time the week of 07/05/09 to 07/11/09. t. 4 times the week of 07/12/09 to 07/18/09. u. 1 time the week of 07/19/09 to 07 25/09, and refused 2 times. v. 4 times the week of 07/26/09 to 08/01/09, and refused 1 time. w. 4 times the week of 08/09/09 to 08/15/09. x. 1 time the week of 08/16/09 to 08/22/09. y. 3 times the week of 08/23/09 to 08/29/09. z. 5 times the week of 09/13/09 to 09/19/09. aa. 3 times the week of 10/04/09 to 10/10/09, and refused 2 times. bb. 4 times the week of 10/11/09 to 10/17/08, and refused 1 time. cc. 3 times the week of 10/18/09 to 10/24/09, and refused 2 times. dd. 4 times the week of 10/25/09 to 10/31/09. ee. 4 times the week of 11/01/09 to 11/07/09. 2. According to the Minimum Data Set (MDS), assessment dated 10/20/09, Resident #5 required extensive assistance with bed mobility, dressing and eating. The MDS documented Resident #5 was dependent on staff for transfer, toilet use and personal hygiene. The MDS documented Resident #5 demonstrated a limitation of ROM to one side of his/her neck with	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 318	Continued From page 9 partial loss of voluntary movement, bilateral arms with partial loss of voluntary movement, and partial loss of voluntary movement of his/her legs. The Interdisciplinary Assessments and Summary Reviews, dated 10/27/09, documented for the quarterly assessment Resident #5 demonstrated limitation with partial loss to neck, shoulders and elbow, and inability to lift legs. Resident #5 was on a FMP 6 times a week for lower extremity strengthening, PROM to left shoulder and AROM left elbow. An Occupational Therapy Rehab Screening, dated 09/30/08, documented Resident #5's upper extremity ROM was limited in bilateral shoulders, left greater than right. A Physical Therapy Rehab Screening, dated 05/22/09, documented Resident #5's right ankle was fused, and he/she demonstrated limited strength in his/her bilateral lower extremities. The Comprehensive Care Plan, dated 10/30/09, directed staff to provide a FMP for Resident #5, 6 times a week for strengthening. The Restorative Plans/Approaches with a dates ordered 06/29/09, 09/28/09, 11/23/07, 01/03/08, and 02/02/09 recorded Resident #4 received his/her FMP: a. 2 times the week of 02/01/09 to 02/07/09. b. 5 times the week of 02/15/09 to 02/21/09. c. 4 times the week of 03/01/09 to 03/07/09. d. 3 times the week of 03/15/09 to 03/21/09. e. 3 times the week of 03/22/09 to 03/28/09. f. 1 time the week of 03/29/09 to 04/04/09, and refused 2 times. g. 4 times the week of 04/12/09 to 04/18/09.	F 318		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 318	Continued From page 10 h. 5 times the week of 04/19 to 04/25/09. i. 3 times the week of 04/26/09 to 05/02/09, and held 1 time. j. 4 times the week of 05/03/09 to 05/09/09. k. 4 times the week of 05/10/09 to 05/16/09. l. 4 times the week of 05/24/09 to 05/30/09. m. 4 times the week of 06/21/09 to 06/27/09. n. 4 times the week of 06/28/09 to 07/04/09. o. 5 times the week of 07/12/09 to 07/18/09. p. 4 times the week of 07/26/09 to 08/01/09. q. 3 times the week of 08/02/09 to 08/08/09. r. 4 times the week of 08/30/09 to 09/05/09. s. 3 times the week of 09/06/09 to 09/12/09. t. 5 times the week of 09/13/09 to 09/19/09. u. 5 times the week of 09/20/09 to 09/26/09. v. 5 times the week of 09/27/09 to 10/03/09. w. 4 times the week of 10/04/09 to 10/10/09. x. 4 times the week of 10/11/09 to 10/17/09, refused 1 time. y. 3 times the week of 10/18/09 to 10/24/09, refused 2 times. z. 3 times the week of 10/25/09 to 10/31/09, refused 1 time. 3. According to the Minimum Data Set (MDS) assessment, dated 10/06/09, Resident #8 was rarely or never understood and required extensive to total assistance from staff for locomotion, eating and personal hygiene. The Medication Records sheet, dated 11/01/09, documented Resident #8's diagnoses included, but were not limited to a history of bilateral bimalleolar ankle fractures, pulmonary atelectasis and history of seizures. The Interdisciplinary Assessments and and	F 318		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 318	Continued From page 11 Summary Reviews, dated 10/08/09, documented Resident #8 was on an FMP for PROM 6 times a week. The Restorative Plans/Approaches, with the date ordered 04/08/08, recorded Resident #8 received his/her FMP: a. 2 times the week of 02/01/09 to 02/07/09. b. 4 times the week of 03/08/09 to 03/14/09. c. 4 times the week of 03/15/09 to 03/21/09. d. 5 times the week of 03/22/09 to 03/28/09. e. 4 times the week of 03/29/09 to 04/04/09. f. 4 times the week of 04/05/09 to 04/11/09. g. 3 times the week of 04/12/09 to 04/18/09. h. 5 times the week of 04/19/09 to 04/25/09. i. 1 time the week of 07/05/09 to 07/11/09. j. 4 times the week of 07/12/09 to 07/18/09. k. 5 times the week of 07/19/09 to 07/25/09. l. 5 times the week of 09/13/09 to 09/19/09. m. 4 times the week of 09/27/09 to 10/03/09. n. 4 times the week of 10/04/09 to 10/10/09. o. 5 times the week of 10/11/09 to 10/17/09. p. 5 times the week of 10/18/09 to 10/24/09. During Concerns and Findings on 11/13/09, Staff E stated she had been auditing the restorative program and she thought they were doing pretty well. She also stated there had been staff turnover and it didn't always get charted when it was done. The Director of Nursing stated they usually had the 2-10 shift do the ROM exercises.	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.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 323	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of Minimum Safety Data Sheets (MSDS) the facility failed to assure hazardous chemicals kept secured from confused residents. The facility reported a census of forty five residents. Findings included: On November 10, 2009 at 9:16 a.m. the door to the Activity Restroom stood open. An unlocked cabinet held a can of End Bac II Spray Disinfectant. On November 12, 2009 at 1:37 p.m. the door to Clean Utility Room in the 100 hall stood unlocked. A basin on the counter in the utility room held two cans of End Bac II Spray Disinfectant. The cans had labels directing to Keep Out of the Reach of Children. The MSDS sheet for End Bac II Disinfectant Spray directed "Avoid contact with skin and eyes. Wash thoroughly after handling. Avoid breathing vapors or mists. Keep away from open flames, hot surfaces and sources of ignition. CONTENTS UNDER PRESSURE. Do not puncture or incinerate. FOR COMMERCIAL AND INDUSTRIAL USE ONLY. " The Director of Nursing identified a list of thirty residents who had cognitive impairment and remained independent in mobility either by means of ambulation or in a wheel chair.	F 323	**F323** 1. Disinfectant was no longer in the activity restroom on 11-12-09 when the environmental walk through was performed by the surveyor. This is when the center staff was first notified of the 11-10-09 discovery. The 2 cans of disinfectant in the clean utility room were immediately removed upon discovery by the Director of Environmental Services who accompanied the surveyor on the environmental walk through. 2. All residents could be affected by improper storage of chemicals. 3. An all staff in-service regarding proper storage of chemicals will be performed on 12-10-09 by the Staff Development RN. 4. Audits of rest rooms and utility rooms will be performed weekly x3 weeks, then monthly x3 by the DNS or DNS designee and then taken to QA for review.	
F 329	483.25(l) UNNECESSARY DRUGS	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 329 SS=D	Continued From page 13 Each resident's drug regimen must be free from 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 monitor therapeutic labs for the administration of anticoagulant therapy for 1 of 3 sampled residents on Coumadin (Resident #8). The facility reported a census of 45. Findings include: According to the Minimum Data Set (MDS) assessment, dated 10/06/09, Resident #8 was	F 329	**F329** 1. Resident's physician was updated of resident #8 not receiving labs on 11-13-09 by the DNS. New orders received and lab drawn. Results from lab and physician orders obtained on 11-13-09. 2. All residents on Coumadin could be affected. Resident's physician orders were reviewed by the DNS on 11-18-09 to identify these residents for appropriate lab orders and their physicians notified of any concerns. 3. Professional nurses will be re-educated regarding appropriate labs for new admits and current residents receiving new orders by the DNS on 12-15-2009. 4. Audits of random physician orders checking for appropriate labs to be performed monthly x3 months by the DNS or DNS designee then taken to QA for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 329	Continued From page 14 rarely or never understood and required extensive to total assistance from staff for locomotion, eating and personal hygiene. The Medication Records sheet, dated 11/01/09, documented Resident #8's diagnoses included, but were not limited to history of bilateral bimalleolar ankle fractures, pulmonary atelectasis and history of seizures. The Comprehensive Care Plan, dated 10/16/09, identified the problem potential for adverse consequences related to Resident #8's current medication regime. The approaches included to monitor for adverse consequences of all medications, medications per physicians's order, and labs per physician's orders. The Medication Records sheets, dated 01/01/09 to 11/01/09, for Resident #8 documented he/she was on the medication Coumadin, an anticoagulant (blood thinner). The Medication Records sheets for Resident #8 documented the following: a. 01/20/09 Increased Coumadin to 2.5 milligrams (mg) 4 days a week and Coumadin 2 mg 3 days a week. b. 02/18/09 Increased Coumadin 2.5 mg daily. c. 03/13/09 Increased Coumadin to 5 mg daily. d. 04/01/09 Continued Coumadin 5 mg daily. e. 05/01/09 Continued Coumadin 5 mg daily. f. 06/01/09 Continued Coumadin 5 mg daily. g. 07/01/09 Continued Coumadin 5 mg daily. h. 08/01/09 Continued Coumadin 5 mg daily. i. 09/01/09 Continued Coumadin 5 mg daily. j. 10/01/09 Continued Coumadin 5 mg daily. k. 11/01/09 Continued Coumadin 5 mg daily. The Medication Record for Coumadin	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 329	Continued From page 15 documented side effects: bleeding/bruising, petechiae. A laboratory report, dated 01/20/09, included the results for Resident #8's protime (PT)/ international normalized ratio (INR) (tests used to monitor the effectiveness of blood thinning drugs such as Coumadin). The results were 12.6 and 1.2. The report showed a reference range for the PT 9.2 to 12.2 and the INR 2.0 to 3.0. A lab report dated 02/17/09 showed Resident #8's PT 12.8 and his/her INR 1.2. A lab report dated 03/11/09 showed Resident #8's PT 14.3 and his/her INR 1.2. A lab report dated 03/24/09 showed Resident #8's PT 22.5 and INR 2.0. The report directed no change, recheck 1 month. The clinical record lacked a lab report after 03/24/09. The Interdisciplinary Progress Notes dated 04/21/09 at 1:45 p.m. documented "....lab tech here this a.m." The clinical record lacked any indication of what was done or follow up. During an interview on 11/13/09 at 7:55 a.m. Staff E stated Resident #8 did not have an order for a PT/INR. Staff E stated she would check on the last PT/INR done on Resident #8. Staff E returned with a PT/INR for 04/21/09. Staff E stated she had the lab fax it to her. Staff E stated she would find the facility copy to show they followed up. The lab report, dated 04/21/09, showed Resident	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 329	Continued From page 16 #8's PT 28.9 and INR 2.6. A call was placed to Resident #8's physician's office on 11/13/09 at 9:03 a.m. The physician's nurse returned the call and stated Resident #8 should have had a PT/INR monthly. She stated a monthly PT/INR is pretty standard. She added that occasionally if a resident is on Coumadin for a long time the physician will extend the PT/INR to 6 weeks, but that is the longest time the physician will go. During concerns and findings on 11/13/09 at 9:10 a.m. the Director of Nursing stated the April PT/INR was the last one done on Resident #8. She stated they had called the physicians's office and received an order for a monthly PT/INR and they would draw one today. At the time of the exit conference on 11/13/09 the facility had not produced a copy of the 04/21/09 PT/INR results showing they had followed up.	F 329		
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 353	Continued From page 17 section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a group interview the facility failed to answer call lights in a timely manner for 5 of 6 residents. The facility reported a census of 45. Findings include: During group interview on 11/12/09 at 1:00 p.m. 5 of 6 residents identified by the facility as interviewable (able to give reliable information) stated call lights had not been answered in a timely manner. Two residents stated they had a clock on the wall and they timed the response to answering the lights. One resident stated he/she had a watch to time the response. They all stated it takes up to 1/2 hour to answer the lights. They all agreed night time was the worst and after supper was awful. Two other residents agreed. One resident stated he/she was unable to get to the bathroom on time due to the slow response. The same resident stated he/she went out in the hall in his/her wheelchair and yelled for help, and that got them there. Another resident stated he/she got tired of waiting and put him/herself to bed and then got chewed	F 353	**F353** 1. All staff were immediately re-educated in writing regarding timeliness of answering call lights posted by the DNS on 11-13-09. 2. All residents could be affected. 3. Staff re-education regarding timeliness of answering call lights will be performed on 12-10-2009 by Staff Development. This issue had been self identified on 7-2-09. Nursing schedules were reviewed by the DNS, audits were being done by the charge nurses and staff re-educated. Resident council minutes were monitored by the Social Services designee monthly. 4. Auditing of random call lights will be done weekly x3 weeks, then monthly x3 by the DNS or DNS designee the taken to QA for review.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 353	Continued From page 18 out for it. ~~F 363~~ SS=D ~~483.35(c) MENUS AND NUTRITIONAL ADEQUACY~~ Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility menus the facility failed to serve the appropriate serving for three (3) residents who received a pureed diet. The facility reported a current census of forty-five (45). Findings included: Review of the therapeutic menu for the noon meal on Tuesday showed residents who received a pureed diet would receive: #8 scoop of breaded fish, #8 scoop of french fries, #16 scoop of green beans, a half slice of pureed bread with margarine and a piece of pureed orange caramel cake. Observation of the noon meal on Tuesday 11/10/09 at 11:07 a.m. showed the following: a. Staff A placed four - four ounce scoops of green beans in the robotcoupe, added 10 tablespoons of chicken broth plus 8 teaspoons of chicken broth and four tablespoons of puree appeal into a robotcoupe and pureed until desired consistency. She then poured the pureed beans into a metal container, covered with aluminum foil	F 353 F 363	Plan of Corrections F363 Menus and Nutritional Adequacy Pureed Diet Addendum to Pureed Diet Policy and Procedures has been written and added to the Dietary Policy and Procedure Manual. DDS has re-trained each cook on the revised procedure. An in-service will be held on Wednesday, December 16 to review this procedure. Each cook will demonstrate the ability to puree food according to the revised procedure. Audits of the preparation and service of pureed foods will be completed one time per week for 2 months. After that time, audits will be completed one time per month for the remainder of a year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 363	Continued From page 19 and placed in the oven b. Staff A placed four servings of fish into the robotcoupe to puree. She then added 16 ounces of chicken broth, four tablespoons and four teaspoons of puree appeal and pureed to desired consistency. The pureed fish was then poured into a metal container, covered with aluminum foil and placed in the oven. c. Staff A placed three - four ounce servings of french fries into the robotcoupe to grind. She then added 1 1/2 cups of chicken broth and pureed to desired consistency. The pureed french fries were then poured into a metal container, covered with aluminum foil and placed into the oven. After Staff A served the three (3) pureed meals as directed on the therapeutic menu, the following pureed food remained: a. Two of the #8 scoop of pureed fish remained in the pan. b. One and one half of a #16 scoop of pureed beans remained in the pan. The remaining portions were measured and confirmed by the Dietary Supervisor. Review of the noon meal for Thursday showed residents who received a pureed diet would receive a #8 scoop serving of pureed baked chicken, a #8 scoop of mashed potatoes with 2 ounces of gravy, four ounces of creamed corn, a half slice of bread and margarine, and four ounces of diced pears. Observation of the noon meal on Thursday 11/12/09 at 11:00 a.m. showed the following: a. Staff F placed three (3) one half scoops of corn into the robotcoupe with 3 teaspoons of	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 363	Continued From page 20 margarine, three (3) tablespoons plus three (3) teaspoons of corn juice and one (1) tablespoon of puree appeal and pureed to desired texture. Staff F then stated she had already pureed the chicken and pears and placed the chicken into the oven, and pears were already on the tables. After Staff F served the three (3) pureed meals as directed on the therapeutic menus, the following pureed food approximately one and one quarter cup (1 1/4 cup) of pureed chicken remained. Staff F then stated oh I used extra chicken, and I pureed 12 ounces instead because I usually puree an extra serving just in case. She then added I didn't think about that when I pureed the corn and only did three (3). The facility Dietary Supervisor stated the facility didn't have a policy and procedure on pureed diets, but dietary staff were to use the recipes which direct portions. The facility Dietitian was interviewed on 11/12/09 at 12:18 p.m. and confirmed they should be using the recipes, and when used should be close to the same portion on the menu (for example use a #8 scoop). She then stated if they aren't using the recipes and using different amounts to add to pureed food, staff should measure the total volume and dish into equal portions. During the dietary observations, neither Staff A or Staff F used the recipes for the pureed meals.	F 363		
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is	F 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 364	Continued From page 21 palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve pureed bread in a palatable manner for three (3) residents who received pureed diet. The facility reported a current census of forty-five (45). Findings included: Review of the therapeutic menu for Tuesday 11/10/09 showed residents who received pureed diet would receive a half slice of pureed bread. Observation of the pureed menu on 11/10/09 at 11:07 a.m. showed Staff A, dietary staff, mix 1/4 cup bread crumbs with 1 1/2 cups of hot water in a measuring cup for the pureed bread. She then poured the bread crumb mixture into three bowls of equal portions and added a dollop of margarine on top. Two (2) ounces of the bread crumb mixture remained in the measuring cup. When asked about the pureed bread, Staff A stated they used the bread crumbs with additional water for a bread serving. She stated she had not tasted the bread crumb mixture before. The surveyor and Staff A tasted the remaining bread crumb mixture, and both agreed it was horrible. Staff A then stated, "whew." The bread crumb mixture was then served to the residents who received pureed bread. During the noon meal observation on 11/12/09, Staff F, dietary staff stated she used the bread	F 364	F364 Food Addendum to Pureed Diet Policy and Procedures has been written and added to the Dietary Policy and Procedure Manual. Puree Appeal will be added and used as a thickening agent in quantities that provide the nutritional equivalent to the planned bread serving. DDS has re-trained each cook on the revised procedure. An in-service will be held on Wednesday, December 16 to review this procedure. Each cook will demonstrate the ability to puree food according to the revised procedure. Audits of the preparation and service of pureed foods will be completed one time per week for 2 months. After that time, audits will be completed one time per month for the remainder of a year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 364	Continued From page 22 crumbs with 3/4 cups of hot water and a dollop of margarine on top and had already been placed on the table. She stated she had not tasted the bread crumb mixture before. The Dietary Supervisor stated the facility did not have a policy and procedure for pureed foods, but did have menus the staff were to follow for proper pureed food. Review of the menu for pureed bread directed staff to use a slice of white bread or soft roll mixed with milk and commercial thickener.	F 364		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve meals in a sanitary manner. The facility reported a current census of forty-five (45). Findings included: Observation of the noon meal preparation on 11/10/09 at 11:07 a.m. showed Staff A, dietary staff prepare the various therapeutic diets. Observation showed the following: a. During the observation, Staff A washed	F 371	F371 Sanitary Conditions Staff has been re-trained on appropriate hand washing procedures. An in-service will be held on Wednesday, December 16 to review this procedure. All staff will demonstrate the ability to properly wash their hands. Procedure for preparation of sanitizer bucket has been revised. DSS has trained staff on the procedure. An in-service will be held on Wednesday, December 16 to review this procedure. Staff has been re-trained on handling of food contact and non-food contact surfaces during food preparation and service. An in-service will be held on Wednesday, December 16 for additional training.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 371	Continued From page 23 her hands, pulled out paper towels and began to dry her hands, turned off the faucet with the same paper towel, and then completed drying her hands with the same paper towel used to turn off the faucet. Staff A repeated the same hand washing technique four times over the course of the observation. b. Staff A closed the oven door with her right foot three times. c. Staff A used a wet rag from the sanitizer bucket to cleanse the counter surfaces. Observation of the sanitizer bucket showed grayish, slimey water. The Dietary Supervisor stated the water should be changed before used, and proceeded to change the water. d. Staff A placed her right thumb and/or right forefinger, middle finger and ring finger on the upper surface of each plate prior to serving. The facility Dietary Supervisor was notified of the hand washing and dietary serving and confirmed the observations. During an interview with the facility Dietitian, the Dietitian stated dietary staff should not use their foot to close the oven doors.	F 371	Audits of hand washing, serving, and use of sanitizer bucket will be completed one time per week for 2 months. After that time, audits will be completed one time per month for the remainder of a year. F465 Environmental Conditions Snack cart has been **cleaned/replaced.** Staff has been re-trained on appropriate food storage procedures. An in-service will be held on Wednesday, December 16 to review this procedure. Audits of food storage will be completed one time per week for 2 months. After that time, audits will be completed one time per month for the remainder of a year.	
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 pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	Manufacturer of cupboards and drawers has been contacted by Housekeeping staff to determine appropriate procedure for sealing wood surfaces that have become scratched. Oven hood has been cleaned by maintenance staff and will be included on the monthly maintenance schedule. Fire extinguisher has been added to cleaning schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 428	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record and drug regimen review the pharmacist failed to identify a resident on anticoagulant therapy without the monitoring of therapeutic levels for 1 of 3 sampled residents on Coumadin (Resident #8). The facility reported a census of 45. Findings include: According to the Minimum Data Set (MDS) assessment, dated 10/06/09, Resident #8 was rarely or never understood and was dependent on staff for locomotion, eating and personal hygiene. The Medication Records sheets, dated 01/01/09 to 11/01/09, for Resident #8 documented he/she was on the medication Coumadin, an anticoagulant (blood thinner). The clinical record contained laboratory results of Resident #'s protime (PT)/ international normalized ratio (INR), (tests used to monitor the effectiveness of blood thinning drugs such as Coumadin). Results were documented for: a. 01/20/09. b. 02/17/09. c. 03/11/09. d. 03/24/09. The clinical record lacked a lab report after 03/24/09. The Interdisciplinary Progress Notes, dated 04/21/09 at 1:45 p.m., documented ".....lab tech here this a.m." The clinical record lacked any indication of what was done or follow up.	F 428	**F428** 1. Resident's physician was updated of resident #8 not receiving labs on 11-13-09 by the DNS. New orders received and lab drawn. Results from lab and physician orders obtained on 11-13-09. 2. All residents on Coumadin could be affected. Resident's physician orders were reviewed by the DNS on 11-18-09 to identify these residents for appropriate lab orders and their physicians notified of any concerns. 3. DNS talked with the pharmacist on 11-17-09 regarding monthly medication review process. Pharmacist will review all charts for appropriateness of labs for all meds. 4. Audits of random charts regarding pharmacist review will be performed monthly x3 by the DNS or DNS designee then brought to QA for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 428	Continued From page 25 During an interview on 11/13/09 at 7:55 a.m. Staff E stated Resident #8 did not have an order for a PT/INR. Staff E stated she would check on the last PT/INR done on Resident #8. Staff E returned with a PT/INR for 04/21/09. Staff E stated she had the lab fax it to her. A call was placed to Resident #8's physician's office on 11/13/09 at 9:03 a.m. The physician's nurse returned the call and stated Resident #8 should have had a PT/INR monthly. She stated a monthly PT/INR is pretty standard. She added that occasionally if a resident is on Coumadin for a long time the physician will extend the PT/INR to 6 weeks, but that is the longest time the physician will go. During concerns and findings on 11/13/09 at 9:10 a.m. the Director of Nursing stated the April PT/INR was the last one done on Resident #8 (6 plus months). She stated they had called the physicians's office and received an order for a monthly PT/INR and they would draw one today. A review of the drug regimen review for Resident #8 showed the pharmacist dated and signed the form 03/07/09, 04/14/09, 05/12/09, 06/17/09, 07/21/09, 08/18/09, 09/30/09, and 10/28/09. In June (2 months from last check, 3 months from the last lab report in the clinical record) and September (5 months from last check, 6 months from the last lab report in the clinical record) all the boxes were checked including #17, Anticoagulant without blood clot test monthly. The pharmacist did not identify the irregularity. During an interview on 11/13/09 at 10:37 a.m. the Director of Nursing acknowledged the pharmacist	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 428	Continued From page 26 did not identify the lack of a PT/INR for Resident #8.	F 428		
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain sanitary conditions in the kitchen area. The facility reported a current census of forty-five (45). Findings included: During the initial kitchen tour on 11/10/09 at 9:07 a.m. the following was observed: a. A snack cart stored in the dry storage area had a large brownish stain on the lower shelf of the cart. Two (2) plastic baggies of cookies unzipped and opened were stored on the cart. b. Four (4) of four (4) drawers of the south side cupboards had exposed wood. Three (3) of the four (4) drawers had utensils used for cooking resident meals which rested directly upon the exposed wooden areas. Exposed wood would be unsantiziable. c. Cupboards above the microwave of the south side cupboards had exposed wood. The cupboard contained measuring cups and metal containers used for resident meal preparation. The outer aspect of the cupboards had tacky debris along the edges which was able to be peeled off by surveyor finger. d. The cupboards under the microwave on	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165249	A. BUILDING _____ B. WING _____	11/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 465	Continued From page 27 the south side cupboards had dusty debris on the shelves. e. The north side cupboards which contained plastic containers had exposed wood along the edges of the shelves. f. The east side cupboards which contained cooking pans and baking pans had exposed wood. The pans were stored upside down directly upon exposed wood. One cooking pan had water under it, which the dietary supervisor immediately dried upon surveyor observation. g. The upper cupboard on the north side cupboards which contained peanut butter had exposed wood on the edge of the shelf. h. The oven hood directly above the cooking stove and oven had excessive dusty/grimey debris. Dusty debris was noted to be hanging off fire extinguishers and also from the edge of the oven hood. The Dietary Supervisor stated she had last cleaned it during her training which was approximately a month and a half ago. The above observations were confirmed by the Dietary Supervisor. Review of the "Cook's Cleaning Schedule" documented the east side cupboards wer last cleaned on 10/19/09. The north side cupboards were last cleaned on 11/2/09, and the south side cupboards were last cleaned on 11/2/09.	F 465		