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 10/31/11 MW	10/14/2011

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 The following deficiencies are the result of the recertification survey completed 10/11/11-10/14/11. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C. Correction Date 10/26/11	F 000	**Allegation of Compliance:** Preparation and execution of this response and plan of correction does not constitute an admission by the provider of the truth of 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 purpose 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 7305 of the Operations Manual.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure residents with urinary incontinence received complete incontinent care (Resident # 2 and Resident #5). The facility reported a census of 38 residents. Findings included: 1. A Minimum Data Set (MDS), with an assessment reference date of 9/20/11, indicated Resident #2's diagnosis included: Diabetes Mellitus, Renal insufficiency and Dementia and recorded the resident's weight at 264 pounds. The same MDS revealed the resident had severely impaired cognition, required extensive assistance from staff with transfer, walking in his/her room, toilet use and personal hygiene. The MDS documented the resident as always incontinent of urine.	F 312	**F312:** 1. Staff member T and staff member G completed Skills Check list for providing incontinent care successfully on 10-21-11. 2. All incontinent residents could be affected. 3. All staff has been alerted regarding the requirements for incontinence care per skills checklist on 10-27-11 by the DNS. More in depth competency checks will be initiated on 10-27-11 by nursing staff. 4. Random Incontinent care audits to be done once a week x 4 weeks, twice a month x 1 month and then monthly x 3 months by the DNS/DNS Designee at which time it will be taken to QA committee for further recommendations. 5. 10-21-11.	

Jag 10/28/11 OK

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steve Chadick per Dana Reese	Administrator Designee	10-27-11

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 312	Continued From page 1 Observation on 10/12/11 at 7:26 A.M. revealed the resident sat in a recliner chair in his/her room and Staff T (Certified Nursing Assistant-CNA) prepared to complete the resident's perineal care. Without assisting the resident to a standing position (while the resident sat in his/he recliner chair) Staff T, with gloved hands, used a perineal wipe and wiped from front to back down the resident's right groin. Staff T folded the perineal wipe, wiped down the resident's left groin, folded the perineal wiped and wiped down the resident's right groin. Staff T obtained a fresh wipe and wiped under the resident's abdominal fold. During the observation Staff T did not wipe down the front of the resident's penis, retract the resident's foreskin and/or did not wipe the tip of the resident's penis. Observation on 10/12/11 at 1:57 P.M., revealed Resident #2 sat in a recliner in his/her room and Staff T prepared to complete perineal care. Staff T assisted the resident to a standing position and removed the resident's incontinence pad and identified the incontinence pad as wet. With gloved hands Staff T used a perineal wipe, wiped from front to back down the resident's left groin, folded the wipe.and wiped down the resident's left groin. Staff T folded the wipe, and again wiped down the resident's right groin, folded the cloth and wiped down the resident's left groin. Staff T did not wipe down the resident's penis. , retract the resident's foreskin and/or wipe the tip of the resident's penis. During interview on 10/12/11 at 2:04 P.M., Staff T confirmed the resident's incontinent pad had been "...really...:" wet when she removed the pad	F 312		

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F 312	Continued From page 2 on 10/12/11 at 1:57 P.M. During interview on 10/13/11 at 11:20 A.M., the facility MDS Coordinator (identified by the facility as in charge while the Director of Nursing on vacation), stated she expected staff to wiped down the penis and expected foreskin to be retracted and/or wipe around the tip of a penis with all perineal care. During interview on 10/13/11 at 11:30 A.M., the facility Staff Development Coordinator (Registered Nurse- present during perineal care on 10/12/11 at 1:57 P.M.) confirmed Staff T had not wiped the tip of the resident's penis during his/her perineal care. During interview on 10/14/11 at 8:15 A.M., the facility MDS Coordinator confirmed thorough frontal perineal care could not be done while a resident sat in a recliner chair. 2. Resident #5's, September 29, 2011, Minimum Data Set (MDS) documented the resident required extensive assistance of two staff for transfers, ambulation, and toilet use. Staff documented the resident always incontinent of urine and frequently incontinent of bowel. During observation on October 12, 2011 at 1:31 p.m. Staff G, Certified Nursing Assistant transferred the resident from a wheelchair to a commode using an EZ Stand mechanical lift. Staff G removed an incontinent pad which contained urine and smears of bowel movement. While seated on the commode the resident had a large bowel movement. The CNA stood the resident again using the mechanical lift and washed the resident in front. The CNA used one	F 312		

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F 312	Continued From page 3 wipe to wash the resident in back. After the first wipe stool could be seen on the wipe. Stool remained visible even after the CNA folded the wipe and continued to wash over the rectal area repeatedly. The CNA never washed the buttocks or the upper thighs. Staff A4 Licensed Practical Nurse (LPN) then applied Calmoseptine to an open area on the resident's coccyx.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to identify and appropriately treat a pressure sore for one resident (Resident #5). The facility reported a census of thirty eight residents. Findings included: Resident #5's September 16, 2011 Care Plan listed diagnoses including but not limited to mental slowness, osteoarthritis right knee, Chronic Eczema with itching of legs and chest and borderline anemia. On May 18, 2011 at 1:45 p.m. staff documented	F 314	**F314:** 1. Resident #5's pressure ulcer has been healed as of 9-19-11. 2. All residents with skin issues could be affected. 3. Professional meeting for all nurses held on 10-20-11 to educate on Stages of pressure ulcers, assessment, care planning, and prevention guidelines as well as communication by Staff Development Nurse. 4. 4 Random care plans to be audited for Skin integrity, Prevention and appropriate interventions weekly x 4 weeks, twice a month x 1 month, and then monthly x 3 months by DNS/DNS Designee at which time it will be taken to QA committee for further recommendations. 5. 10-20-11	

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F 314	Continued From page 4 in the Interdisciplinary Progress Notes (IDP) a 0.2 by 0.2 centimeter dark red area with pink (unmeasured) surrounding and the little toe pink and intact. The record lacked any documentation indicating staff attempted or the resident refused assessment of the toes again until May 23, 2011, however the Bathing Record documented a whirlpool bath given on May 19, 2011. The Care Plan lacked any direction to staff in regard to the new skin impairment. The Care Plan directed staff to check proper fit of footwear to prevent pressure areas to toes. The record lacked any documentation indicating staff followed the Care Plan, assessed possible causes of the wound or began any treatment. On May 23, 2011 at 3:30 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to assess the toes. The record lacked any documentation indicating staff attempted or the resident refused assessment of the toes again until May 29, 2011, however staff documented on the Bathing Record a whirlpool bath given on May 24, 2011. On May 29, 2011 at 6:05 p.m. staff documented in the IDP notes the resident refused to let her look at the toes. The record lacked any documentation indicating staff attempted or the resident refused assessment of the toes again until June 1, 2011 however, staff documented on the Bathing Record a whirlpool bath given on May 31, 2011. On June 1, 2011 at 2:40 p.m. staff documented in the IDP Notes the reddened area on the left great toe had grown larger and measured 1 by 1 cm. with a 0.2 cm. scab. The little toe no longer	F 314		

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F 314	Continued From page 5 appeared red. Still the Care Plan lacked any direction to staff in regard to the worsening wound. The record lacked any documentation indicating staff attempted or the resident refused assessment of the toe again until June 7, 2011 however, staff documented the resident received a whirlpool bath on June 3, 2011. On June 7, 2011 at 3:05 p.m. staff documented in the IDP Notes the left great toe remained with a red area and a small scab. The left small toe had a small area of redness. The record lacked any measurement of the areas. On June 10, 2011 at 7:00 p.m. staff documented in the IDP Notes the resident refused two attempts to look at the toes, however staff documented a whirlpool bath given the same day. On June 11, 2011 at 6:45 p.m. staff documented in the IDP Notes the left great toe remained with a red area and scab and the left small toe with a small red area. The record lacked any measurements of the areas. On June 14, 2011 at 9:30 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to look at the toes, however staff documented a whirlpool bath given the same day. On June 15, 2011 at 7:25 p.m. staff documented in the IDP Notes the resident refused to allow assessment of the toes. The record lacked any documentation indicating staff attempted or the resident refused assessment again until June 18, 2011, however staff documented a whirlpool bath given on June 17, 2011.	F 314		

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F 314	Continued From page 6 On June 18, 2011 at 10:00 p.m. staff documented in the IDP Notes the resident refused to allow assessment of the toes. On June 21, 2011 at 3:00 p.m. staff documented in the IDP Notes the left great toe remained red with small scab on top of the toe and the small toe had a red area on the lateral aspect. The record lacked any measurement of the areas. The record lacked any documentation indicating staff attempted or the resident refused assessment again until June 25, 2011. On June 25, 2011 at 9:35 a.m. staff documented a late entry for June 24, 2011 stating the resident refused to allow the nurse to examine the toes. The record lacked any documentation indicating staff attempted or the resident refused assessment again until June 30, 2011. On June 30, 2011 at 7:00 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to assess the toes. On July 1, 2011 at 6:40 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to assess the toes. The record lacked any documentation indicating staff attempted or the resident refused assessment again until July 5, 2011 however, staff documented a whirlpool bath given on July 2, 2011. On July 5, 2011 at 3:50 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to assess the toes, however staff documented a whirlpool bath had been given that same day. The record lacked any documentation indicating staff attempted or the resident refused	F 314		

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F 314	Continued From page 7 assessment again until July 20, 2011 however, staff documented whirlpool baths given on July 8, 2011; July 12, 2011 and July 19, 2011. On July 20, 2011 at 7:50 p.m. staff documented in the IDP Notes the resident refused to allow assessment of the toes. The record lacked any documentation staff attempted or the resident refused assessment until July 22, 2011. On July 22, 2011 at 10:30 a.m. staff documented in the IDP Notes the resident had a raised area of the left great toe which measured 0.8 by 0.4 cm. with pink surrounding the area and noted a small pin point dark drainage in the center. The resident complained of discomfort with cleansing of the area. The record lacked any mention of the little toe. On July 22, 2011 staff received an order from the physician to apply a corn pad to the area and to have the wound nurse see the resident if it became more reddened. Still the record lacked any documentation indicating staff assessed possible causes of the wound or checked the resident's shoes as the Care Plan directed. On July 25, 2011 at 7:25 p.m. staff documented in the IDP Notes the resident denied pain and refused to have the toes examined. On July 26, 2011 at 10:30 a.m. staff documented in the IDP Notes the corn pad changed but lacked any assessment of the wound. On July 28, 2011 at 7:00 p.m. staff documented in the IDP Notes the resident refused to allow assessment of the toe. At 8:00 p.m. staff documented the corn pad adhered to the resident's sock and stated the sock removed and	F 314		

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F 314	Continued From page 8 the corn pad remained in place. Still the record lacked any assessment of the wound. On July 30, 2011 at 10:30 a.m. staff documented in the IDP Notes the left great toe corn pad applied and described the area raised with white edges and pink in the center. The record lacked any measurement of the area. On August 1, 2011 staff documented in the IDP Notes at 1:30 p.m. the resident refused to allow the nurse to change the corn pad. On August 2, 2011 at 9:30 p.m. staff documented in the IDP Notes the resident refused to allow the nurse to observe the toe. On August 4, 2011 at 1:05 p.m. staff documented in the IDP Notes the left great toe had 0.8 by 0.4 cm. pink wound base without drainage. Staff documented the surrounding skin macerated, the area cleansed and a corn pad applied. On August 7, 2011 at 9:10 a.m. staff documented in the IDP Notes the left foot great toe measured 0.8 by 0.3 cm and had macerated edges. Staff documented the corn pad changed. On August 10, 2011 at 10:00 a.m. staff documented in the IDP Notes the corn pad changed to the left great toe and measured the area 0.2 by 0.2 cm. with minimal redness surrounding and minimal discomfort noted. At 8:00 p.m. staff documented the left great toe still sore. The record lacked any documentation indicating staff attempted or the resident refused assessment again until August 18, 2011, however staff documented a whirlpool bath given on	F 314		

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F 314	Continued From page 9 August 12, 201 and August 16, 2011. On August 18, 2011 at 9:40 a.m. staff documented in the IDP Notes the left great toe 2 by 2 cm pink skin with 0.3 by 0.3 cm. dark center with white surrounding area. On August 21, 2011 at 12:45 p.m. staff documented in the IDP Notes the left great toe had a 0.2 by 0.2 cm. area of pink discoloration and had no open area or drainage noted. On August 22, 2011 at 10:10 a.m. staff documented in the IDP Notes the resident stated the left great toe hurt that morning. On August 23, 2011 at 9:45 a.m. staff documented in the IDP Notes the resident 's left great toe 1 by 0.9 cm. white with pink surrounding a center 0.5 by 0.1 cm. brown area without drainage. Staff replaced the corn pad. On August 26, 2011 at 10:15 a.m. staff documented the left great toe 1 by 1.1 cm. white area with a brown center which measured 0.3 by 0.3 cm. Staff replaced the corn pad. On August 29, 2011 at 7:00 a.m. staff documented in the IDP Notes the left great toe had a 0.6 by 0.6 cm. dry scab area on a slightly raised non reddened area without drainage. On August 30, 2011 the Enterostomal Nurse (wound) saw the resident and documented he/she had a pressure/sheer/friction area on the left great toe prominent joint related to a tight shoe. She ordered staff to discontinue the corn pad, apply Polymem to the site daily and to	F 314		

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F 314	Continued From page 10 encourage the resident to cut an opening in the shoe or have the family purchase a wider shoe which would be less constricting over the affected area. On September 12, 2011 the ET nurse documented the resident got new shoes on September 9, 2011. Staff documented the area healed on September 19, 2011 The resident's record lacked any documentation indicating facility staff ever assessed causal factors of the wound from May 18, 2011 until the wound nurse determined on August 30, 2011 the wound resulted from pressure of a tight shoe. During interview on October 12, 2011 at 12:32 p.m. the MDS Coordinator stated staff only completed Wound Flow Sheets for residents with ulcers. Staff had not used the flow sheets until the Wound Nurse determined the wound caused by pressure. The MDS Coordinator confirmed no documentation could be found to indicate facility staff had ever assessed the area for causal factors.	F 314		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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	F428: 1. Pharmacis[redacted]initiated GDR requests to the Primary Physician of Resident #1 and Resident #4 on 10-13-11. 2. All residents requiring GDR could be affected. On 10-13-11 nursing staff reviewed all residents on psychopharmacological meds to check for the need of GDR. 3. Pharmacists and DNS have agreed on new system compliance 2 x per month x 4 months by DNS/DNS Designee and then taken to QA committee for further recommendations. 5. 10/26/11	

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F 428	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility consultant pharmacist failed to recommend gradual dose reductions to an attending Physician and/or the Director of Nursing for 2 of 9 active residents reviewed (Resident #1 and Resident #4). The facility reported a census of 38 residents. Findings included: 1. According to a medication record, dated 10/1/2011, Resident #1's diagnosis included Depression. A Minimum Data Set (MDS), with an assessment reference date of 8/24/11, indicated Resident #1 had moderately impaired decision making skills and experienced feeling down, depressed or hopeless only 2-6 days during the 2 week assessment period. A Resident Care Area Assessment (CAA), with an assessment reference date of 8/24/11, triggered an area of Psychotropic Drug Use and documented no mood or behaviors reported. The same CAA documented the need to monitor the resident for adverse effects of an antidepressant. A Comprehensive Care Plan, dated 9/2/11, revealed a problem for potential for adverse consequences related to drug use. The care plan lacked any approaches to monitor for adverse effects as noted in the resident's CAA. Physician's Orders signed by a Physician on 9-15-11 revealed an order for Zoloft	F 428		

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F 428	Continued From page 12 (antidepressant) originally ordered 11-17-2010. Review of the facility Pharmacist monthly medication reviews completed November 18, 2010 - October 6, 2011 lacked any mention of the resident's Zoloft use for a prolonged period of time or advice to attempt a dosage reduction. 2. An MDS with an assessment reference date of 8/29/22 indicated Resident #4's diagnosis included Depression. A Comprehensive Care Plan dated 8/19/11 revealed a problem for potential for adverse consequences related to medication use. The care plan lacked any approaches to monitor for adverse effects of his/her medication use. Physician Orders signed by a Physician on 9/11/11 revealed an order for Zoloft originally ordered 12/14/10. Review of the facility Pharmacist monthly medication reviews completed December 30, 2010 - October 6, 2011 lacked any mention of the resident's Zoloft use for a prolonged period of time or advice to attempt a dosage reduction. During interview on 10/12/11 at 2:30 P.M., the facility consultant Pharmacist stated he had taken over the pharmacy consultant approximately 6 months prior and had been unable to find any tracking done regarding the above medications by the preceding Pharmacist regarding dosage reductions. The Pharmacist confirmed no recommendations had been made by himself regarding a dosage reduction to a Physician since taking over the consulting. 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 _____	10/14/2011

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F 428	Continued From page 13 stated he had not considered a dosage reduction of Antidepressant medications a priority.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	**F441:** 1. Staff member A4 was given a Counseling notice completed 10/26/11 regarding use of barriers for infection control purposes. 2. All residents could be affected. 3. All nurses educated on barriers for infection control purposes as well as reviewing policy and procedures on 10-20-11 by Staff Development Coordinator. 4. Random audit of barrier use to be done 1 x per week for 4 weeks and then twice a month for 1 month; and then 1 x per month x 3 months by the DNS/DNS designee then taken to QA committee for further recommendations. 5. 10-26-11	

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F 441	*Continued From page 14* infection. This REQUIREMENT Is not met as evidenced by: Based on observation and interview, the facility failed to ensure services provided minimized the risk of infection for the residents of the facility. The facility reported a census of 38 residents. Findings included : During observation on 10/11/11 at 10:34 A.M., Staff A 4 prepared to administer Resident # 11 an injectable medication Lovenox. Staff A 4 carried a plastic sharps container from a medication cart and a box that contained a vial of Lovenox into the resident's room. Staff A 4 placed the sharps container and Lovenox box on a sink countertop without a barrier. Staff A 4 prepared the injectable Lovenox and carried the sharps container from the sink countertop to a footstool made of a cloth material. Staff A 4 administered the resident's Lovenox, picked up the sharps container and the Lovenox box and placed both directly on top of a med cart without a barrier. Staff A 4 then placed the Lovenox box in a bottom drawer of a med cart directly next to bottles of medication in the drawer. Staff A4 left the sharps container stored on top of a med cart without any sanitization process. During interview on 10/13/11 at 11:20 A.M., the facility Minimum Data Set (MDS) Coordinator (*identified as in charge while the facility Director* of Nursing on vacation) stated she expected staff to use a barrier when carrying medication and/or	F 441		

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F 441	Continued From page 15 supplies from a med cart to a resident's room and visa-versa. A facility procedure for infection control revealed a standard precaution for staff to assume every person is potentially infected or colonized with organisms that could be transmitted in healthcare settings. During interview on 10/13/11 at 1:05 P.M., the facility Minimum Data Set (MDS) Coordinator confirmed 4 active cases of Methicillin Resistant Staphylococcus Aureus (MRSA) in the facility.	F 441		