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 _____	C 11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY 7 NEWELL, IA 50568

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F 000	INITIAL COMMENTS The following deficiencies are a result of the investigation of complaint #50449-C and #50426-C. Complaint 50449-C was substantiated. Complaint 50426-C was substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

12-16-14 PG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to immediately notify the resident's legal representative or an interested family member when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for 2 of 4 resident records reviewed (Resident #2 and #4). Resident #4 eloped from the facility and the facility failed to immediately notify the responsible party or the physician. Resident #2 rolled from bed and the facility did not immediately notify the physician or family. The resident required examination in the emergency room, later the same day, to rule out injury. Facility census was thirty-seven (37) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 9/16/14, assessed Resident #4 with a brief interview for mental status score of " 13 " (no cognitive impairment) The MDS did not identify wandering behavior. The MDS identified the resident required extensive staff assistance with transfers, ambulation and locomotion on and off the unit while in a wheelchair. A physician note dated 6/18/14, identified the resident could not care for his/herself at home and required 24 hour care. The resident ' s mental status declined. The resident assessed	F 157		

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F 157	Continued From page 2 the resident with diagnoses that included: Confusion and Falls. The physician identified the resident was suitable for nursing home admission. The resident ' s record identified that he/she admitted to the facility on 6/19/14. A brief interview for mental status score dated 6/26/14 identified the resident with a score of " 10 " (moderate cognitive impairment). Nursing monthly documentation dated 9/20/14 and 10/19/14 identified the resident with confusion. The ARNP (advanced registered nurse practitioner) saw the resident on 10/14/14 and identified the resident as " confused but cooperative " and oriented times one with questionable memory. Nursing progress notes dated 10/24/14 at 10:27 a.m. revealed the resident told staff that he/she needed to get his/her hair done that morning so he/she could go get a job either at Walmart or the University. The entry identified the resident as pleasantly confused. Nursing progress notes dated 10/25/14 at 1 p.m. late entry and written by Staff G (registered nurse) revealed a dietary staff reported the staff went to leave and saw the resident outside. The resident stated he/she was going outside with a friend and then the friend got a phone call. Staff discussed safety with the resident. Staff Interviews with staff working 10/25/14 when the incident occurred: On 11/6/14 at 9:50 a.m. Staff A (dietary aide) stated she left for a dental appointment and saw Resident #4 in the wheelchair outside the facility. Staff A stopped her truck and asked the resident what he/she was doing. The resident stated he/she wanted to go home. Staff A told the resident that he/she was home and needed to go back inside. The resident said, " OK " and Staff	F 157		

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F 157	Continued From page 3 A brought him/her in and told Staff G (charge nurse) that the resident was out front in the driveway by the speed bump. Staff A stated the resident appeared dressed appropriately. When Staff A saw the resident, he/she was trying to get over the speed bump in the wheelchair. Staff A stated she didn't know if the resident had company. Time cards showed that Staff A left at 11:40 a.m. on the day of the incident. Review of the resident's record identified a social service progress note dated 11/7/14 at 1:12 p.m. that identified the social worker informed the resident's family of the resident going outside on 11/7/14 (13 days after the incident). A progress note dated 11/10/14 at 1:08 p.m. identified the facility notified the physician of the resident outside without supervision on 10/25/14 (16 days after the incident). 2. A Minimum Data Set (MDS) with assessment reference date of 10/16/14 assessed Resident #2 with a brief interview for mental status score of "15" (no cognitive impairment). The resident admitted to the facility 9/2/14 following surgery for a left femur fracture. The resident required extensive assistance with bed mobility, transfers, dressing, toileting and bathing. The resident could not ambulate. An incident details report dated 9/17/14 at 6:45 a.m., identified staff heard the resident yell for help and found the resident on the floor. The resident stated he/she rolled over and fell out of bed. The resident received a 2.7 centimeter (cm.) skin tear to the left elbow and a 4 cm. by 2.5 cm. bruise to the left elbow. The resident did not complain of pain. The incident details report written by Staff B (licensed practical nurse) identified the facility	F 157		

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F 157	Continued From page 4 notified the physician on 9/17/14 at 9:20 a.m. and notified the resident's responsible party at 9:40 a.m. On 11/10/14 at 10:46 a.m. Staff B stated she left a message at the physician's office concerning the incident. She stated she called the responsible party's house first and when she got no answer, she called the responsible party's cell phone at 9:40 a.m. leaving a message. Facility phone records identified that Staff B tried to call the responsible party's house phone on 9/17/14 at 9:36 a.m. Phone records identified that in Staff B's attempt to call the cell phone, on 9/17/14 at 9:37 a.m., that she dialed the wrong prefix but the correct last 4 numbers. The resident's record identified the resident went to dialysis the day of the incident (9/17/14). When the resident presented with back pain, the dialysis physician had the resident examined in the emergency room. Nursing daily skilled notes dated 9/17/14 at 5:50 p.m. revealed the Director of Nursing spoke with the dialysis nurse who stated they sent the resident to the emergency room due to complaints of back and leg pain. Daily skilled notes dated 9/18/14 at 5:15 p.m., that x-ray did not show any new fracture and the metal plate and screw device remained intact and without change.	F 157		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 281		

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F 281	Continued From page 5 facility failed to meet professional standards of quality by failing to note physician orders for 3 of 4 residents (Resident #1, #2 and #4). Resident #1 returned from the hospital and the facility did not implement new physician orders. The facility discontinued one of Resident #4's antibiotics. The record did not contain a physician order that discontinued the antibiotic. Resident #2 had physician ordered treatment to a surgical site. The facility failed to have documentation that showed they provided the treatment. The resident also had Keflex (antibiotic) ordered 9/30/14 and the facility did not begin the order until 8 p.m. on 10/2/14. The medication was available in the emergency kit. The facility census was thirty-seven (37) residents. Findings include: 1. Hospital records identified Resident #1 returned to the facility from the hospital on 9/22/14 following a hospital stay in observation for back pain after a fall. Discharge orders revealed an order for Tums (calcium) 500 milligrams daily. The facility failed to note the Tums order. On 11/10/14 the Director of Nursing notified the physician of the omission. The physician directed staff to keep the Tums PRN (as needed) and discontinue the "Tums daily" order. The resident also returned with an order for Zofran (for nausea) 4 milligrams (mg.) as needed every four hours. The facility failed to note the every 4 hour as needed time interval. The medication administration record (MAR) contained the order "Zofran every 6 hours PRN". The Director of Nursing completed an incident	F 281		

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F 281	Continued From page 6 details form on 11/10/14 (after surveyor identification of the errors) on 11/10/14. The report stated "Review of admit orders dated 9/22/14 found Tums order scheduled daily omitted and PRN order remained. Zofran PRN changed to every 4 hours from 6 hours and not changed on MAR". On 11/10/14 at 4:22 p.m. the Director of Nursing stated the physician signed routine physician orders on 9/25/14 that identified the Tums as "PRN". However the record failed to identify that the physician ever discontinued the daily Tums order. 2. A physician order sheet contained an order dated 7/16/14 for Macrobid (antibiotic) 100 milligrams (mg.) twice a day for Resident #4 to treat a urinary tract infection. A physician order form identified the physician ordered Cipro (antibiotic) 250 mg twice a day for 7 days on 7/18/14. The July 2014 medication administration record identified the facility quit administering the Macrobid to the resident when the resident started the Cipro. The record lacked a physician order that showed the physician discontinued the Macrodantin. 3. A Minimum Data Set (MDS) with assessment reference date of 10/16/14, assessed Resident #2 with a brief interview for mental status score of "15" (no cognitive impairment). The resident admitted to the facility 9/2/14 following surgery for a left femur fracture. The resident required extensive assistance with bed mobility, transfers, dressing, toileting and bathing. The resident could not ambulate. A clinic referral record, dated 9/16/14 identified	F 281		

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F 281	Continued From page 7 the left hip incision site as clean dry and intact. The resident had a large amount of serous drainage from the area where they removed staples. The physician directed the facility to change dressings to the area three times a day (TID) and begin Keflex (antibiotic) 500 milligrams (mg) four times a day for 10 days. The September 2014 medication administration record identified the facility started the Keflex on 9/17/14 at noon. The MAR indicated the Keflex was for "postsurgical precautions". The resident received the Keflex until the last dose given at 8 p.m. on 9/27/14. The record lacked evidence the facility changed dressings TID to the incision site as ordered. Nursing progress notes, dated 9/23/14 at 5:33 p.m. revealed the physician ordered Penicillin VK (antibiotic) 250 milligrams (mg.) two times a day for wound healing related to aftercare following surgery until 9/30/14. The facility initiated the medication 9/23/14 as ordered. When interviewed on 11/14/14 at 10:10 a.m., the Director Of Nurses stated when the resident saw the physician on 9/16/14, they cultured the incision wound drainage and the physician ordered the Penicillin VK in response to the results of the culture. A clinic referral form dated 9/30/14 identified the resident returned to the physician. The form identified the incision had minimal drainage and the resident had no complaints of pain. The physician directed staff to continue daily dressing changes and paint Betadine (antiseptic) around and in the open area. The record lacked evidence the facility changed dressings and applied Betadine as ordered. The physician directed staff to continue the	F 281		

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F 281	Continued From page 8 Penicillin VK 250 mg. twice a day for 14 days and continue Keflex 500 mg. four times a day for 14 days. The October 2014 MAR identified the facility did not initiate the Keflex until 10/2/14 at 8 p.m. On 11/10/14 at 2:39 p.m. the Director of Nursing stated the Keflex was available in the emergency drug kit and she didn't know why it wasn't started right away. The facility initiated Penicillin VK on 10/1/14 on the PM (evening) shift. A clinic referral form dated 10/15/14 identified the resident saw the physician assistant who identified the left femur fracture was stable and directed staff to continue the Keflex 500 mg. for 30 days. A prescription form dated 10/16/14 identified that the diagnosis for the antibiotic use was "Infection surgical wound".	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, the facility failed to ensure each resident received adequate supervision to prevent accidents for two (2) of four (4) residents reviewed that sustained pain or injury during or following a transfer. Resident #1 required one	F 323		

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F 323	Continued From page 9	F 323		

staff, gaitbelt and a walker for ambulation. Staff let go of the gait belt and left the resident unattended when staff went to get the resident's glasses. The resident fell and required an observation hospital stay for pain issues related to the fall. When the resident returned to the facility, he/she required skilled physical therapy. Resident #3 received two large skin tears during cares with staff and no arm protection in place. Facility census was thirty-seven (37) residents.

Findings include:

1. A Minimum Data Set (MDS) with assessment reference date of 6/24/14, assessed Resident #1 with no short or long term memory impairments. The resident required one staff to assist with bed mobility, transfers, ambulation, dressing, toileting, personal hygiene and bathing. The MDS identified the resident with diagnoses that included: Lumbosacral Spondylosis and Osteoporosis. The resident received scheduled pain medication and had one fall with injury since the previous assessment.

A care plan dated 7/2/14 identified the resident had limitations of completing his/her activities of daily living (ADLs) due to a sprain of left wrist and hand (prior to facility admission). The resident also had osteoarthritis of the lumbar spine which affected his/her ADL. The care plan directed staff to assist the resident with walking using a gait belt and front wheeled walker. The care plan identified the resident had an increased risk for injury related to history of falls.

a. An incident details form dated 9/20/14 at 7 a.m. revealed the resident fell during a staff assisted transfer from the toilet to the recliner chair. The

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F 323	Continued From page 10 report identified that the nurse aide stated she walked the resident out of the bathroom and let go of the gait belt to pick up the resident's glasses and the resident fell backward. Under the "equipment in use" section of the incident report, it indicated the walker was not in use when the resident fell. After the fall, the resident complained of low back pain and stated he/she hit their head. Staff sent the resident to the emergency room (ER) for x-rays. History and physical encounter notes dated 9/20/14 identified the resident presented to the Emergency Room (ER) with diffuse back pain after a fall at the nursing home. The CT scan (computerized tomography) findings did not show injury but the physician felt the resident was in too much pain to send the resident back to the nursing home. The pain was located along the entire spine posteriorly but the resident also experienced some lower rib pain bilaterally near the lower sternum area. The resident described the pain as severe and continuous and associated with movement. The resident denied pain prior to the fall other than chronic pain from multiple compression fractures. The CT showed all the compression fractures were old. The resident admitted to observation at the hospital for pain control. A physician progress note dated 9/21/14 identified the resident fell backwards onto his/her back at the nursing home. The resident hit his/her head but did not lose consciousness. The plan was to have physical therapy (PT) evaluate and treat and get the pain controlled on oral medications and a Fentanyl (narcotic patch) so the resident could return to the nursing home on 9/22/14.	F 323		

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F 323	Continued From page 11 On 9/22/14 the hospital report identified the resident would return to the nursing home that day when transportation was available. The resident moved better with less pain. b. An incident details form, dated 10/9/14 at 3:45 a.m. revealed staff observed a 3.5 centimeter (cm.) by 4.5 cm. dark purple bruise to the resident's left hip. The intervention was "staff education on awareness of hip placement when using the EZ stand". Staff Interviews: On 11/6/14 at 9:08 a.m. Staff M (nurse aide) stated she took the resident to the bathroom. She stated that Staff Q (nurse aide) was also in the room helping the resident's roommate. As Staff M walked the resident out of the bathroom, the resident asked Staff M to get his/her glasses. Staff M stated she let go of the gait belt to open the glasses and the resident fell. The resident landed on his/her bottom and went back. The resident said he/she hit their head on the door. Staff M stated it was her second day of employment at the facility and her first time down that hall. She was paired with Staff Q who was also a new employee. Staff M stated the resident did have his/her walker at the time of the fall. Staff M reported she did not know which staff was supposed to be training her that day and the other aide was in the 100 hall. Staff M ' s employee counseling notice documented she let go of Resident #1 ' s gait belt to pick up the resident ' s glasses from the side table. Staff M noted she was near the side table next to the resident. Staff Q also documented on the same notice as	F 323		

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F 323	Continued From page 12 Staff M the following information: she [Staff Q] had been assisting Resident #1 ' s roommate with his/her shoes when she looked up and Resident #1 was already on the floor. Staff Q stood up from assisting the roommate and to inform the nurse when Staff M approached her and stated she [Staff M] had told the nurse that Staff Q had been behind Resident #1, next to roommate ' s night stand during the incident. Staff Q documented that was not true because she [Staff Q] had been sitting on the floor during the time the resident fell [assisting the roommate]. On 11/6/14 at 10:02 a.m. Staff Q (nurse aide) stated she was sitting on the floor with her back to Resident #1 and Staff M. The resident asked for his/her glasses and instead of getting the glasses after she seated the resident, Staff M left the resident stand by the bathroom and walked across the room to get the glasses. She stated she knew this information, because that is what Staff M told her occurred immediately after the incident. She stated she had been trained 4 to 5 days on Resident #1's hall and felt comfortable working down the hall. On 11/10/14 at 9:15 a.m. the Director of Nursing stated she received a call at home regarding the incident. They sent Staff M home after the incident because she was unsafe to work with residents. Staff M was still under orientation and did not want to follow what she was told to do. Staff M knew she should stay with residents. Resident #1 admitted to the hospital for observation. The resident had back pain for a long time but the 9/20/14 fall exacerbated it. The resident came back and worked with PT on balance. The resident walks on tiptoe on one foot due to surgery years ago. The resident is now	F 323		

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	165249	A. BUILDING _____ B. WING _____	C 11/19/2014

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F 323	Continued From page 13 back to his/her prior level of function. Resident Observation and Interview: Observation showed, on 11/5/14 at 11:35 a.m., the resident seated in a recliner in his/her room. The resident reported he/she fell when the person that was with the resident let go of him/her and the resident fell and hit his/her head on the bed. The resident reported that he/she has had pain ever since and the fall occurred a couple months ago. On the same date at 3:57 p.m. observation showed one staff walk the resident to the bathroom with a gait belt and a walker. The resident wore gripper socks and walked on tip toe on the left foot. 2. A Minimum Data Set (MDS) with assessment reference date of 5/6/14 assessed Resident #3 with a brief interview for mental status score of "7" (severe cognitive impairment). The resident had physical and verbal behavior symptoms directed at others daily. The resident rejected cares daily. The resident required one staff to assist with dressing, personal hygiene, and bathing. The resident required two staff to assist bed mobility and toileting use; and required total assistance from staff during transfers. The resident used a wheelchair for mobility. The resident had diagnoses that included, Alzheimer ' s Disease and Psychotic Disorder. The care plan in place (dated 5/14/14) when the incident occurred did not identify any change in interventions after the 6/15/14 and 7/10/14 incidents. The care plan directed staff to ensure the resident wore arm protectors at all times as well as gerisleeves on in the morning and off at	F 323		

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F 323	Continued From page 14	F 323		

bedtime.

a. An incident details form dated 6/15/14 at 7 p.m. and written by Staff D (registered nurse) revealed staff readied the resident for transfer to bed via the Hoyer lift. The resident resisted the Hoyer lift. After staff got the resident to bed, they rolled the resident to remove the sling and noted a long 18 to 20 centimeter (cm.) skin tear on the resident's forearm. The incident details form identified it was unclear when the skin tear occurred. It could have occurred during the move or when staff removed the sling.

Staff S (nurse aide) wrote an undated statement which identified that after the resident transferred onto the bed and Staff D left the room, he took the resident's protective sleeves off and removed the sling from under the resident. After he removed the sling he observed blood on the resident's pillow case, gown and Staff S's hand. He looked and saw a large gash on the resident's right forearm. He called Staff D to come back into the room.

Staff D wrote an undated written statement regarding the incident that identified once he and Staff S (nurse aide) got the resident on the bed, they removed the straps from the machine. Staff S said he could remove the sling and the resident wore protective sleeves during the transfer. Staff D stepped out of the room and within a minute Staff S called Staff D back in the room. Staff D then saw the skin tear on the resident's right forearm. Staff S reported the resident got combative when he removed the Hoyer sling and when he took the sleeves off, he saw the injury. Staff D called the emergency room (ER) but when the ambulance arrived for transport they stated

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F 323	Continued From page 15 they did not think transfer to ER was necessary. b. An incident details form, dated 7/10/14 at 10:15 a.m. revealed the nurse aides reported they removed the resident's padded sleeves prior to repositioning to remove the Hoyer sling. The sling caught the resident's skin and caused a 4 cm. by 3 cm. skin tear just below the skin tear the resident received on 6/15/14. The facility educated the employee after the incident. c. Observation showed, on 11/5/14 at 1 p.m. the resident up in the wheelchair with a short sleeve shirt on and no arm protection. At that time, 2 staff entered the room to transfer the resident via Hoyer lift into bed. Prior to the transfer, staff applied Derma Sleeves to the resident's arms. The resident then transferred to bed via the Hoyer lift and two staff without incident. The care plan dated 10/28/14 identified the resident at risk for skin impairment related to fragile skin and pemphigus as evidenced by a history of blisters and bruises and skin tears. The care plan directed staff to assist the resident to wear long sleeves, apply gerisleeves in the morning and off at bedtime and Derma Sleeves with transfers. When questioned about the resident not wearing geri sleeves when the surveyor made the 11/5/14 observation at 1 p.m., the Director of Nursing stated on 11/10/14 at 2:39 p.m. that the resident refuses to wear gerisleeves and she would remove the intervention from the care plan. The Administrator stated via email on 11/14/14 at 3:51 p.m. that the intervention following both the 6/15/14 and 7/10/14 incidents was "staff	F 323		

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F 323	Continued From page 16 education".	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized for 1 of 4 residents reviewed (Resident #2). The facility reported a census of thirty-seven (37) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 10/16/14 assessed Resident #2 with a brief interview for mental status score of "15" (no cognitive impairment). The resident admitted to the facility 9/2/14 following surgery for	F 514		

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F 514	Continued From page 17 a left femur fracture. The resident required extensive assistance with bed mobility, transfers, dressing, toileting and bathing. The resident could not ambulate. A clinic referral record, dated 9/16/14 identified the left hip incision site as clean dry and intact. The resident had a large amount of serous drainage from the area where they removed staples. The physician directed the facility to change dressings to the area three times a day (TID) and begin Keiflex 500 milligrams (mg) four times a day for 10 days. Daily skilled notes identified a "GSS 487" form was available regarding assessment of the left surgical site on the following dates/shifts: 9/14/14 night shift 9/16/14 day shift 9/17/14 night and evening shift 9/19/14 night, day and evening shift 9/20/14 night and day shift 9/25/14 night and day shift 9/30/14 night and day shift 10/4/14 night and day shift The surveyor requested the GSS 487 forms to review the assessment of the left hip incision. On 11/14/14 at 3:51 p.m., the Administrator emailed that the check marks that identified GSS 487 forms were available were errors. Therefore no GSS 487 forms were available for review.	F 514		

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 center is now in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.

F 157

1. Staff G was re-educated on 12-5-14 by the Director of Nursing regarding the need to notify resident #4 family and physician for the elopement on 10/25/14. Staff B was re-educated on 12-5-14 by the Director of Nursing regarding the need to repeat notification attempts if unsuccessful after the incident involving resident #2.
2. All residents at risk for elopement could be affected. All resident's care plans were reviewed by Director of Nursing by 12-12-14 for elopement risk.
3. All Full time and part time staff have been re-educated by Director of Nursing by 12-12-14 regarding residents at risk for elopement and falls and the procedure of notification of family and physician if this happens per Good Samaritan Society policy/procedure. All PRN or Seasonal staff has been notified via phone and mail that they are to complete their re-retraining before next shift work.
4. Audits on 5 random residents' charts at risk for elopement and falls checking for proper notification post incident will be done by the Director of Nurses/Director of Nurses designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Committee for further recommendations.
5. Completion date: 12-12-14

F 281

1. The Director of Nurses re-educated the nurse working upon return of resident #1 from the hospital regarding the missed orders. On 11/10/14 the Director of Nurses contacted the physician for clarification and amendments made.
   The Director of Nurses re-educated the nurse who took the Cipro order but did not get a discontinue order for the Macrobid even though it was stopped by nursing staff for resident #4 on 12-5-14
   The Director of nurses re-educated all nurses from admit regarding resident #2 missed wound treatments on 12-5-14 The Director of Nurses re-educated the nurse who took the antibiotic order on 9/30/14 to start the medication right away by taking it out of the emergency kit on 12-5-14.
2. All residents could be affected.
3. All Full time and Part time nursing staff were re-educated by Director of Nursing by 12-12-14 regarding the need to follow physicians orders of treatments and medications immediately upon

receiving the order per Good Samaritan policy/procedure. All PRN or Seasonal staff has been notified via phone and mail that they are to complete their re-retraining before next shift work.

4. Audits on 5 random residents checking for order compliance will be done by the Director of Nurses/Director of Nurses designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Committee for further recommendations.
5. Completion date: 12-12-14

F 323

1. On 9-20-14, The Charge Nurse and Director of Nursing counseled and suspended staff M regarding the need to follow resident #1 care plan and not to let go of the gait belt on the date of the incident. The Charge Nurse and Director of Nurses re-educated the staff assisting resident #3 during the 7/10/14 incident regarding following the care plan of derma sleeve use with positioning; this employee also resigned their position.
2. All residents needing assistance could be affected. All residents care plans were reviewed for gait belt and derma sleeve interventions by Director of Nursing by 12-12-14.
3. All full time and Part time nursing staff were re-educated by Director of Nursing by 12-12-14 regarding the need to follow the residents care plans regarding the use of gait belts and derma sleeves for safety per Good Samaritan policy and procedure. All PRN or Seasonal staff has been notified via phone and mail that they are to complete their re-retraining before next shift work.
4 Audits on 5 random residents regarding the use of gait belts and derma sleeves will be done by the Director of Nurses/Director of Nurses designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Committee for further recommendations.
5 Completion date: 12-12-14

F 514

1. The Director of Nursing re-educated all nursing staff working with resident #2 from admit of 9/16/14 regarding the lack of treatment documentation to the surgical site.
2. All residents requiring surgical wound treatments could be affected. All residents care plans were reviewed on 12-12-14 by Director of Nursing identifying surgical wounds.
3. All full time and Part time nursing staff were re-educated by Director of Nursing by 12-12-14 regarding the need to document all treatments per physician order on the required forms per Good Samaritan policy and procedure. All PRN or Seasonal staff has been notified via phone and mail that they are to complete their re-retraining before next shift work.
4. Audits on 5 random residents with treatments to wounds for documentation compliance will be done by the Director of Nurses/Director of Nurses designee weekly x4, bi-weekly x2, monthly x3 then taken to the Quality Committee for further recommendations.
5. Completion date: 12-12-14

50.7

1. Staff G was re-educated by the Director of Nurses on 12-5-14 regarding resident #4 leaving the facility without the facility's knowledge and the need to notify administration and self-report to the state Department of Inspections and Appeals.

2. All residents at risk for elopement could be affected. All residents identified by the Director of Nurses through their care plans on 12-12-14

3. All nursing staff reeducated regarding the need to self-report to state any resident elopement from the facility without the facility's knowledge per regulation on 12-12-14.

4. Audits on all elopement incidents monitoring for need to self-report to state will be done by the Director of Nurses/Director of Nurses designee weekly x4, bi weekly x2, monthly x3 then taken to the Quality Committee for further recommendations.

5. Completion date: 12-12-14