STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0000 ✓ ok/cp	INITIAL COMMENTS Correction date: 8/16/25 A complaint investigation for Complaints 1697208, 1697210, 1697213, 1692719, 1697226, 2561277 and Facility Reported Incident 1692717 was conducted July 24, 2025 through July 29, 2025. Investigation of complaints #1697210, 1697213, 1697219, 1697226, 2561277 resulted in a deficiency. See code of Federal Regulations (42 CFR), Part 483, Subpart B-C.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F0550		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nathan Blackburn	Administrator	8/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0550 SS = D	Continued from page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, resident and staff interview, and policy review, the facility failed to speak to the resident in a manner that maintained dignity, failed to change a resident's stained shirt after putting the resident in bed (#4), and delayed feeding a dependent resident (#3). The facility reported a census of 88 residents. Findings include: 1. The Minimum Data Set (MDS) assessment for Resident #4 dated 6/5/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cerebrovascular accident (stroke), hemiplegia (one-sided weakness), and chronic obstructive pulmonary disease (COPD). It also indicated the resident required setup assistance for eating and oral hygiene, maximal assistance with upper and lower body dressing and personal hygiene, and was dependent with all other aspects of Activities of Daily Living (ADLs) and mobility. The undated Care Plan revealed the resident had an ADL self-care performance deficit related to a stroke and indicated she required one (1) person assistance with getting dressed. On 7/29/25 at 8:35 am, Resident #4 asked Staff E, Maintenance Mechanic (MM) to take her out to smoke. Staff E abruptly replied "No, it's not my time. My time is 2:30" and walked away. At 8:38 am, Resident #4 was observed sitting in a wheelchair across from the nurses' station wearing a shirt with a food stain down the center. She stated it	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0550 SS = D	Continued from page 2 happened during breakfast but stated it bothered her to be out in the hall in front of everyone with it stained. She said she would've liked to have had her shirt changed after breakfast. At 8:43 am, Staff A, Certified Nurse Aide (CNA) approached Resident #4 if she'd worn that shirt the previous day. Resident #4 replied it was the same color but was a different shirt. Staff A stated if it was the same shirt, she'd have to take her down to her room to change her. At 8:52 am, Staff A stated she asked Resident #4 about her shirt because of the stain on it. She also stated staff changes Resident #4's shirt when they lay her down after she goes outside to smoke. She confirmed the scheduled smoking time was 9:00 am. At 9:16 am, Staff A transferred Resident #4 to bed and exited the resident's room. At 9:18 am, Resident #4 was still wearing the stained shirt. At 9:55 am, Resident #4 stated she felt small and like she didn't matter when Staff E responded to her request to be taken outside to smoke. Resident #4 was still wearing the stained shirt. The facility policy titled "Resident Dignity-Rehab/skilled" revised 12/11/2024 indicated the purpose of the policy was: a. To maintain the dignity of all residents b. To promote, encourage, support and enhance the residents' self-esteem c. To promote a sense of self-worth d. To assist with respecting and ensuring resident rights On 7/29/25 at 3:30 pm, the Director of Nursing (DON) stated the staff should have said the designated department will take you out to smoke at 9:00 am. She also stated staff should have changed her shirt after putting her in bed. 2. The MDS of Resident #3 dated 4/24/25 identified a BIMS score of 15, which indicated intact cognition. The MDS coded the resident required maximal assistance for eating. The MDS documented diagnoses which included	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0550 SS = D	Continued from page 3 multiple sclerosis and quadriplegia. The Care Plan of Resident #3 identified an undated Focus area of Activities of Daily Living (ADL) self care performance deficit related to quadriplegic, multiple sclerosis. The Care Plan directed the resident was dependent upon 1 staff assist for eating and must be at a 90 degree angle. On 7/29/25 at 11:50 am, Resident #3 arrived at the dining room with a large number of other residents having already received their meals. At 11:55 am a staff member arrived and took the resident's order for lunch. Her food arrived at 12:05 pm. Within one minute, the Administrator sat down to assist the resident with her meal and stayed with her for the approximate 30 minutes it took for her to finish her meal. On 7/29/25 at 12:39 pm, Resident #3 stated that it was unusual that the Administrator was the one to assist her with her meals. She stated other staff members are supposed to help her with her meals but they don't make it to the dining room on time. She stated she is normally the last person to get served because she does not get served until someone is available to help her eat. She stated she had raised concerns about this in the past. She stated she felt the staff cared about the other residents more than they did her and it was only their job to take care of "the gray haired people" and felt because she is a younger resident she does not get as much help. She stated she had reported this to the Registered Dietitian (RD) who spoke to the Administrator about her concerns. On 7/29/25 at 1:08 pm, the Administrator stated she was not typically the one to feed Resident #3 but if there is nobody else available she will assist her. She stated the Restorative Aide frequently helps. The Administrator stated Resident #3 had not directly ever stated any concerns to her about her meal service. She stated she has brought other concerns to her and tends to be very vocal. The Administrator stated she was not aware of concerns with meals. On 7/29/25 at 1:23 pm, the RD stated Resident #3 had brought concerns to her about eating assistance. She stated the former Activities Director used to assist her a lot and she is no longer employed at the facility. She stated Resident #3 had known the Activities Director a long time and they spent much time together. She stated Resident #3 prefers to skip breakfast but eats lunch in the dining room daily. She stated she often prefers the evening meal in her room which has been problematic with which staff member was	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0550 SS = D	Continued from page 4 responsible for getting her tray from the dining room and bringing it to her to feed her. Trays are not served to residents who need feeding assistance unless a staff member is available to assist so the food stays warm. She stated the resident had brought concerns to her more than once and she offered to discuss it with the facility management which Resident #3 agreed to. She stated she reported the concern to both the Administrator and the Director of Nursing. She stated the resident is unable to feed herself so the facility must provide that service regardless of if she eats in the dining room or her room. Due to her diagnosis of multiple sclerosis, she will always need the assistance. On 7/29/25 at 1:34 pm, the Certified Dietary Manager (CDM) stated Resident #3 typically does not receive her meal until someone is available to assist her with feeding. She explained that the resident chooses not to sit at the feeding assistance table, and staff feed the residents at that table before assisting Resident #3. The CDM further stated that if Resident #3 opts to eat in her room, this causes an additional delay. She explained that the resident must wait until a CNA is available to leave the floor, retrieve her meal from the dining room, and then feed her. The CDM confirmed that on the day of the observation, Resident #3 was the last resident to be served lunch and stated this occurs fairly often. The CDM reported that she had previously discussed this concern with facility management, which led to the intervention of Resident #3's meal not being served to her until a staff member was available to assist in feeding her, in an effort to ensure the food remained fresh and at an appropriate temperature. On 7/29/25 at 1:50 pm, the RD stated she had located an email she had sent to the Administrator and the Director of Nursing regarding Resident #3's concerns about meal service. The email, dated 6/10/25, documented that Resident #3 was experiencing long wait times to be fed since the departure of the Activity Director. The email noted that the RD had spoken directly with Resident #3, who had expressed a preference for the RD to advocate on her behalf. Resident #3 conveyed that she felt forgotten during meals. The RD explained that the resident required total assistance with eating and drinking and preferred to sit at a specific table. However, the RD noted that even relocating her to the front of the dining room would not resolve the issue as the Restorative Aide was often responsible for feeding, assisting and monitoring 8-10 other residents during meals. She concluded by	F0550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0550 SS = D	Continued from page 5 asking the leadership team to collaborate to reach potential solutions to improve Resident #3's dining experience. The Director of Nursing replied to the email the same day stating she had just had a discussion in huddle regarding staff being present in the dining room for meals and would keep working on it. The Administrator also replied to the email stating she had checked on the presence of staff in the dining room the prior evening.	F0550		
F0725 SS = E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) 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: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) 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 observation, resident and staff interview, and policy review, the facility failed to respond to	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0725 SS = E	Continued from page 6 resident call lights within 15 minutes for 3 of 6 residents reviewed (#7, #8, #9). The facility also failed to document 15-minute resident checks for Resident #12. The facility reported a census of 88 residents. Findings include: On 7/26/25 at 8:20 PM, State Surveyors entered the facility and observed activated resident call lights (#1, #4, #7, and #8). At 8:23 PM, the State Surveyor was near the nurse's station but without a direct line-of-sight. Staff was overheard having personal conversations while visiting amongst themselves. At 8:25 PM, Resident #9's call light was activated. At 8:26 PM, two (2) staff members passed Residents #1, #4, and #7's rooms and left the unit. At 8:29 PM, a staff member turned off Resident #13's call light and entered Resident #11's room with a mechanical lift. At 8:32 PM, the resident call light notification device at the nurses' station revealed Resident #7's call light had been activated for 20 minutes. At 8:42 PM, a staff member was observed entering Resident #9's room. The resident call light notification device revealed her call light had been activated for 16 ½ minutes. At 8:43 PM, the resident call light notification device at the nurses' station revealed Resident #8's call light had been activated for 29 minutes. At 8:48 PM, Resident #4 stated evening shift is always short staffed in her opinion. At 9:02 PM, Staff F, Certified Medication Aide (CMA) and Staff G, Certified Nurse Aide (CNA) stated Resident #13 complained that evening about long call light response times.	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0725 SS = E	Continued from page 7 At 9:16 PM, Resident #13 confirmed she complained to staff about long call light response times on 7/26/25. She also stated it happens all the time and on 7/26/25, it took staff 45 minutes to respond to her call light. She stated staff has previously entered her room, turned off the call light, and left. At 9:28 pm, a staff member was observed walking past Resident #8's activated call light and responded to Resident #9's call light. On 7/28/25 at 3:14 PM, Resident #1 stated, she had to wait more than 15 minutes on 7/27/25 to get bathroom assistance after lunch because of lack of staff. 2. The Minimum Data Set (MDS) assessment for Resident #1 dated 7/10/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated completely intact cognition. It included diagnoses of hypertension, chronic obstructive pulmonary disease (COPD), difficulty walking, and abnormalities of gait and mobility. It indicated she was independent with eating and oral hygiene, required setup assistance with bathing and personal hygiene, supervision with toileting, upper body dressing and sitting-to-lying mobility, and moderate assistance with all other Activities of Daily Living (ADLs) and mobility. The undated Care Plan indicated the resident was non-ambulatory and preferred to use the commode for urinary elimination. It directed staff to encourage and assist the resident with repositioning frequently in bed and wheelchair. On 7/28/25 at 3:31 PM, Resident #4 stated it took staff so long to respond to her call light on 7/27/25 around 4:00 PM, she urinated on herself because she couldn't hold it any longer. 3.The Quarterly Minimum Data Set (MDS) assessment for Resident #4 dated 6/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated completely intact cognition. It included diagnoses of cerebrovascular accident (stroke), hemiplegia (one-sided weakness), and chronic obstructive pulmonary disease (COPD). It also indicated	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0725 SS = E	Continued from page 8 the resident required setup assistance for eating and oral hygiene, maximal assistance with upper and lower body dressing and personal hygiene, and was dependent with all other aspects of Activities of Daily Living (ADLs) and mobility. It also revealed she was incontinent or bladder and bowel. The undated Care Plan revealed the resident had bladder incontinence and directed staff to check and change her frequently. 4 4. The Quarterly MDS assessment for Resident #12 dated 7/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 07 out of 15, which indicated severely impaired cognition. It included diagnoses of cancer, coronary artery disease (narrowed heart arteries), diabetes mellitus, Alzheimer's disease, and non-Alzheimer's dementia with other behavioral disturbances. It indicated he was independent with eating and toileting, required setup assistance with oral and personal hygiene, and dressing, and supervision bathing. It also indicated he was independent with mobility. It further revealed the resident experienced hallucinations and delusions. The Care Plan dated 11/07/24 indicated the resident displayed inappropriate sexual advances towards another resident related to Fondling, Grabbing, Touching. A Care Plan revision dated 4/16/25 directed staff to perform 15-minute checks on resident while using monitor at nurses' station which room. is in line of site, and when outside of room resident is to be a 1:1. On 7/26/25 at 8:56 pm, a form titled "15-minute checks" was observed at the nurses' station. It was filled out through 8:30 PM. An observation started at 8:58 pm and at 9:11 pm, a staff member was observed checking on the resident. A room sensor beeped when anyone entered or exited the room. On 7/29/25 at 12:56 PM, a record review revealed missing 15-minute checks documentation for the following dates: a. 7/19/25 at 2:45 PM and 3:00 PM b. 7/20/25 at 2:30 PM and 2:45 PM c. 7/22/25 from 2:30 PM through 5:45 PM d. 7/24/25 from 6:15 PM through 11:45 PM	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0725 SS = E	Continued from page 9 e. 7/25/25 from 12:00 AM (midnight) through 5:45 AM f. 7/27/25 from 6:30 AM through 9:45 AM g. 7/28/25 at 12:15 PM Staff H, Registered Nurse (RN) stated the missing documentation could be due to the 15-minute checks being documented on a different sheet and not transferred over to the current papers. He also stated missing documentation could be it just wasn't done. He stated he felt the resident could be put on hourly checks due to current physical limitations but is currently still on 15-minute checks. A policy titled “Call Light-R/S, LTC, Therapy & Rehab” revised 07/08/2025 indicated the purpose of the policy was: a. To ensure residents always have a method of calling for assistance b. To promptly answer resident’s call light It also indicated the procedure as: 1. New admission - explain and demonstrate the use of call light system. 2. When resident’s call light is observed/heard, go to resident’s room promptly. 3. Respond to request as soon as possible. Turn call light off and inquire about resident’s request. 4. When leaving the room, place call light within easy reach of resident. 5. For residents unable to use call light, care plan appropriate interventions and provide an adaptive call light if applicable. 6. Each facility is responsible for having an alternate method of communication during a loss of power or call light system failure. On 7/29/25 at 3:30 PM, the Administrator stated staff should walkie-talkie for staff assistance with call lights and/or transfers. On 7/29/25 at 1:31 PM, the Director of Nursing (DON) stated the 15-minute checks form is the only place staff should document checking on the resident.	F0725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0725 SS = E SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interviews and policy review, the facility failed to secure prescribed medications from the possibility of unauthorized access. The facility reported a census of 88 residents. Findings included: On 7/29/25 at 9:44 AM, Staff D, Certified Medication Aide (CMA) was observed administering resident's medications. She locked the medication cart and walked into the resident's room. An opaque medication cup was observed on the medication cart with an orange, round pill. A resident who self-propelled in his wheel-chair was observed 3 doors away. At 9:46 AM, Staff D returned to the medication cart, poured water into a cup and returned to the resident's room. The orange, round pill was observed still in the opaque medication cup on the medication cart.	F0725 F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0761 SS = D	Continued from page 11 At 9:47 AM, Staff D returned to the medication cart. She stated the facility's medication handling and storage process was narcotics were locked in the lock box in the medication cart and all other medications were to be secured in the medication cart and not left accessible when staff leaves the cart unattended. At 9:49 AM, Staff D identified the orange, round pill as Senna (stool softener) and confirmed it should have been disposed of and not left unattended on the medication cart. A policy titled "Medications: Acquisition Receiving Dispensing and Storage – R/S, LTC" revised 03/04/2025 indicated: 3. an employee will be responsible for signing for receipt of medication and obtaining the signature of the delivery person. It is preferred that a licensed nurse receive and verify the medications. Once medications are received, they will be secured in the appropriate storage area (i.e., medication cart or medication room). Licensed nurses and medication aides (when allowed by state law) are responsible for reconciling medications received. 5. Medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services and/or designee will be permitted to have access to the keys to the medication storage areas. On 7/29/25 at 4:19 PM, the Director of Nursing (DON) stated medications should be secured in the medication cart of appropriately disposed of not left unattended.	F0761		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum,	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0880 SS = D	Continued from page 12 the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0880 SS = D	Continued from page 13 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff interview, and policy review the facility failed to implement the infection control policy as staff failed to disinfect a mechanical lift between two residents' use (#4, #11). The facility reported a census of 88 residents. Findings include: On 7/29/25 at 9:16 AM, Staff A, Certified Nurse Aide (CNA) and Staff B, CNA transferred Resident #4 from her wheelchair to her bed. Staff A brought the mechanical lift out of Resident #4's room and placed it against the wall outside, beside Resident #4's door. The mechanical lift was not disinfected. At 9:41 AM, Staff B, CNA and Staff C, CNA took the mechanical lift into Resident #11's room to get Resident #11 out of bed. The mechanical lift was not disinfected prior to use. At 9:49 AM, Staff B, CNA brought the mechanical lift out of Resident #11's room and placed it against the wall between rooms 212 & 214. It was not disinfected. At 9:51 AM, Staff D, Certified Medication Aide (CMA) and Resident #11 stated there was no disinfectants (Saniwipes) kept in the resident's room. Staff D also stated disinfectants were not stored in any residents' rooms but were located at the nurses' station. At 9:57 AM, Staff C, CNA stated the Saniwipes were in the storage pouches on the back of the reusable equipment. At 9:58 AM, there was no Saniwipes observed in the storage pouch on the back of the mechanical lift.	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INDIANOLA	708 SOUTH JEFFERSON PO BOX 319, INDIANOLA, Iowa, 50125

(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
F0880 SS = D	Continued from page 14 At 9:59 AM, Staff C, CNA stated staff wipes down the reusable equipment in the hallway after each use and during the night. She added that reusable equipment is not wiped down before being used. She stated the mechanical lift should have been wiped down after being used in Resident #4's room. On 7/29/25 at 3:30 PM, the Director of Nursing (DON) stated staff should have found the Saniwipes and disinfected the equipment. At 5:43 PM, the Administrator provided an email that the facility did not have a policy specific to disinfecting reusable equipment but indicated staff was expected to wipe down the lifts between use.	F0880		

Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in 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.

Compliance Date: 8/16/25

F0550 Resident Rights/Exercise of Rights

After state exit on 7/29/25 staff member in question was educated regarding changing the resident's shirt and was instructed to go and change the shirt. Management verified that this was then completed. Staff member A was also educated that the expectation was to take residents to a private place to have conversation in a dignified manner. Education was also provided to CNAs, covering this and providing meals to residents in a timely manner. Coaching provided to the CNA in question.

This has the potential to affect all residents who may require assistance with dressing

8/12/25 Education provided across the board regarding speaking to residents in a dignified manner and regarding approach. Resident Rights Policy provided with education. Quizzes provided regarding competency.

Audits will be completed by Social Services or designed biweekly x 2 and then weekly x 5 on random residents to ensure clothing is clean and that assistance is provided at meal times. Residents x 3 will be interviewed biweekly x 2 then weekly x 4 regarding staff interactions and communications to aid in ensuring dignity. Results of all audits will be brought to the monthly QAPI meeting for further review and recommendations.

F0725 Sufficient Nursing Staff

Call lights are monitored daily to ensure timely responses. Education regarding Call lights provided 8/12/25 including the policy. Continued follow-up and monitoring to occur for residents #1,4,7,8,9,12,13. Resident #12 care plan updated 8/12/25 per IDT team removing 15-minute checks.

This has the potential to affect all residents.

All staff reminded 8/12/25 regarding responding promptly to call lights. This was also communicated on the communication board 8/11/25.

Call lights will be audited daily by Administrator or designee daily x 5 and then weekly x 4 weeks. Education and follow-up as needed will be completed immediately. All results of audits will be brought to monthly QAPI meeting for further review and recommendations

F761 Storage of Drugs and Biologicals

Education to the CMA Staff Member D was provided immediately on 7/29/25. Education was provided to all staff to give the medication directly to the nurse or CMA if found on the floor and for the medication to be destroyed right away.

This has the potential to affect all residents.

Audit regarding medication storage will be conducted weekly x 4 to ensure understanding of proper storage and handling of medications. Audits will be brought to monthly QAPI for further review and recommendations.

F880 Infection Prevention & Control

Resident #11 and #4 were reviewed for infections that could have been spread from resident to resident. No noted reportable infections during the timeframe.

This has the potential to affect any residents that use mechanical devices to transfer.

Nursing staff were educated on 8/12/25 to ensure that they are sanitizing mechanical devices between resident transfers.

Audit will be completed by Clinical Care Lead or designee weekly x 4 to ensure proper sanitizing of lift after use. All results of audits will be brought to monthly QAPI meeting for further review and recommendations.