

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 926 East E Street Hastings, NE 68901	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>50105</p> <p>Title 175 NAC Chapter 12-006.05 (E)</p> <p>Based on interviews and record reviews, the facility failed to provide bathing as required for 1 resident (Resident 5). The facility census was 37.</p> <p>Findings are:</p> <p>An interview on 03/03/2025 at 10:24 AM with Resident 5 revealed that they are scheduled for weekly baths and did not get a bath last week. According to Resident 5, they were told the bath chair was not working, however told the bath aide they would like a shower and need at least one a week.</p> <p>Record review of Resident 5's Admission Record dated 03/03/2025 reveals an admitted on 05/18/2023.</p> <p>Record review of Resident 5's Care Plan Report with an initiation date of 05/18/2023, reveals:</p> <p>-RESIDENT ADL PREFERENCES: Resident prefers a whirlpool bath one time per week during the day.</p> <p>-BATHING: Prefers whirlpool.</p> <p>-BATHING: Resident requires bed bath 1 staff assist.</p> <p>Record review of Resident 5's Plan of Care (POC) Response History dated 03/04/2025 reveals 30 day look back for questions: Type of Bath reveals on 02/07/2025, 02/12/2025, 02/19/2025 a whirlpool bath was provided, and on 02/26/2025 response states not applicable. Bathing: Self Performance reveals on 02/07/2025, 02/12/2025, 02/19/2025 physical help in part of bathing activity was provided and on 02/26/2025 activities of daily living (ADL) activity itself did not occur. Bathing: Support Provided reveals on 02/07/2025, 02/12/2025, 02/19/2025 one-person physical assist was provided and on 02/26/2025, ADL activity itself did not occur.</p> <p>Record review of Resident 5's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems), dated 12/30/2024 reveals Section C Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14/15 which concludes the resident is cognitively intact.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 03/04/2025 at 1:50 PM reveals that Medication Aide-A (MA-A) was present last week on 02/26/2025 however was not the bath aide that day. MA-A reveals that they do not know who was the bath aide that day however was aware the bath chair was not working that day. MA-A was asked what non-applicable means on the charting for type of bath given, MA-A states they do not know.</p> <p>An interview on 03/06/2025 at 10:19 AM with Registered Nurse-C (RN-C) reveals that scheduling floor staff on who is responsible for resident care, baths, and medication aide on the cart is determined in morning huddle and not written down. When asked what happens when a bath is missed, RN-C reveals that evening shift will assist and/or will be offered on another date.</p> <p>An interview on 03/06/2025 at 11:15 AM with Resident 5 reveals that the bath aide on 02/26/2025 came into the room last week stated the bath chair was broken, then stated that they did not have time to provide a shower.</p> <p>An interview on 03/06/2025 at 11:28 AM with Nurse Aide-B (NA-B), revealed they worked on 02/26/2025 and recalls MA-A as the bath aide that day. When asked what non-applicable means on charting for type of bath given, NA-B states they do not know.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253</p> <p>Licensure Reference Number 175NAC 12-006.11(E)</p> <p>Based on observation, interview, and record review the facility failed to ensure sanitary conditions in the kitchen and failed to label and date leftover foods in order to prevent the potential for food borne illnesses for all residents who consumed meals prepared in the kitchen. This had to potential to affect all residents that consumed meals prepared by the facility kitchen; and the facility failed to ensure that resident room meals were served and removed in a manner to prevent the potential for foodborne illness for 2 residents (Residents 34 and 16) of 2 residents observed. The facility census was 37.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the undated Resident Handbook states under Food and Nutrition Services the facility serves nutritious, well-balanced meals and the registered dietician routinely reviews menus, food preparation, sanitation, and dining services.</p> <p>Record review of the undated policy Date Marking; Food and Nutrition revealed the purpose of the policy is to provide a guideline for proper date-marking to ensure that food is handled and stored safely. Furthermore, leftovers were defined and food items prepared for service that were not served and subsequently stored for use within 7 days per the food code. Check state regulations for more details. The definition of the best if used by dates stated that after that date the food may not taste or perform as expected but is still safe to use or consume. These, best if used by dates are not expiration dates. Staff are directed to look for the use by date, which by policy definition, is the expiration date.</p> <p>Observations on 03/03/2025 at 08:20 AM during the initial observation the kitchen area, the following items were found in the dietary department:</p> <ul style="list-style-type: none"> -a plastic container labeled tomato soup that had a preparation date of 02/28/2025 and a use by date of 03/02/2025 in the stand-up refrigerator -3 metal unmarked containers without identification of contents, dates of preparation, or use by dates in the stand-up refrigerator. -a container labeled coleslaw with a date of preparation of 02/26/2025 and a label that revealed a use by date of 02/28/2025 in the walk-in refrigerator. -a container of potato salad with a date of preparation of 02/28/2025 and a label that revealed a use by date of 03/02/2025 in the walk-in refrigerator -a boxed cherry pie lying on the floor the of the walk-in freezer <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Record review of the facility policy titled Room Tray Service dated 3/12/24 revealed that the purpose is to serve meals in a timely manner to ensure safe and acceptable food temperatures. The procedure revealed that the room tray is to be delivered in a sanitary manner and plated at the proper serving temperature. Trays will be transported and delivered by employees. Remove dinnerware and utensils from the resident's room and return promptly to the kitchen. Periodically monitor room/tray service to ensure quality and timeliness of service and compliance with food temperature standards. Have the resident ready for his or her meal before room service is delivered. Monitor residents eating in their rooms as per care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) or individual needs and for problems such as choking. Record meal intakes of residents who eat in their rooms.</p> <p>Record review of the Nebraska Food Code dated 7/21/16 revealed that 81-2,282(2)(c) Food shall be deemed to be adulterated (unsafe) if it has been manufactured, processed, packaged, stored, or held under unsanitary conditions where it may have become unsafe for use as food. Time/temperature control for safety food means a food that requires time/temperature control for safety (TCS) to limit pathogenic microorganism growth (the ability of disease-causing germs to multiply) or toxin formation (a poisonous substance produced by germs). TCS includes meats and dairy products. Time/Temperature Control for Safety- Food that is cooked to a temperature and for a time specified under SS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 135 degrees Fahrenheit (F) or above. 81-2,272.01 Time/Temperature Control for Safety Food, Hot and Cold Holding. (Replaces 2013 Food Code 3-501.16). (1) Except during preparation, cooking, or cooling or when time is used as the public health control as specified under Nebraska Pure Food Act, and except as specified under subsection (2) of this section, time/temperature control for food safety shall be maintained: (a) At one hundred thirty-five degrees Fahrenheit or above or at Forty-one degrees Fahrenheit or less.</p> <p>Observation on 3/3/25 at 8:56 AM in the room of Resident 34 revealed that Resident 34 was flat in bed. The breakfast meal tray sat on the over bed table beside the bed. A plate with a brown cover over it, an unopened container of fruit, and a bowl with unopened aluminum foil over it sat on the tray. A full glass of milk with plastic wrap in place over the top of the glass sat on the tray. The silverware remained wrapped inside a red cloth napkin on the tray.</p> <p>Observation on 3/3/25 at 10:13 AM in the room of Resident 34 revealed that the resident remained flat in the bed. The breakfast meal tray remained on the over bed table beside the bed. A plate with a brown cover over it, an unopened container of fruit, and a bowl with unopened aluminum foil over it sat on the tray. A full glass of milk with plastic wrap in place over the top of the glass sat on the tray. The silverware remained wrapped inside a red cloth napkin on the tray.</p> <p>Observation on 3/3/25 at 11:21 AM in the room of Resident 34 revealed that the resident continued to lay flat in the bed. The breakfast meal tray remained on the over bed table beside the bed. A plate with a brown cover over it, an unopened container of fruit, and a bowl with unopened aluminum foil over it sat on the tray. A full glass of milk with plastic wrap in place over the top of the glass sat on the tray. The silverware remained wrapped inside a red cloth napkin on the tray.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 3/3/25 at 11:55 AM in the room of Resident 34 revealed that the resident continued to lay flat in the bed. The breakfast meal tray remained on the over bed table beside the bed. A plate with a brown cover over it, an unopened container of fruit, and a bowl with unopened aluminum foil over it sat on the tray. A full glass of milk with plastic wrap in place over the top of the glass sat on the tray. The silverware remained wrapped inside a red cloth napkin on the tray.</p> <p>Observation on 3/3/25 at 12:29 PM outside the room of Resident 34 revealed that Nurse Aide-B (NA-B) removed a meal tray from inside the enclosed tray cart and carried it into the room of Resident 34. NA-B exited the room with the resident breakfast meal tray and placed it inside the meal tray cart. NA-B re-entered the room of Resident 34.</p> <p>Interview on 3/3/25 at 12:34 PM with NA-B revealed that Resident 34 had not eaten any of the breakfast meal that was in the resident room all morning. NA-B revealed that staff leave the breakfast tray in the room in case the resident might want to eat something. NA-B revealed that Resident 34 is able to feed themselves.</p> <p>Observation on 3/3/25 at 12:43 PM in the room of Resident 34 revealed that Resident 34 sat on the edge of the bed with the meal tray on the over bed table in front of the resident. Resident 34 had eaten 3/4 of the slice of pie. The mashed potatoes and barbecue pork on the plate were untouched.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 34 dated 1/22/25 revealed that Resident 34 admitted into the facility on [DATE]. Resident 34 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 10 (a score of 10 indicates moderately impaired cognition). The MDS revealed that Resident 34 was independent with eating and able to move from lying on the back to sitting on the side of the bed with partial assistance.</p> <p>Record review of the care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for Resident 34 dated 3/3/25 revealed that Resident 34 is able to feed themselves independently.</p> <p>C.</p> <p>Record review of the MDS dated [DATE] for Resident 16 revealed that Resident 16 admitted into the facility on [DATE]. Resident 16 had a Brief Interview for Mental Status (BIMS) score of 6 (a score of 6 indicates severely impaired cognition). The MDS revealed that Resident 16 requires verbal cues for eating and is able to move from lying on the back to sitting on the side of the bed with partial assistance.</p> <p>Record review of the care plan for Resident 16 dated 3/3/25 revealed that Resident 16 is able to feed themselves independently with supervision.</p> <p>Interview on 3/4/25 at 10:07 AM with Nurse Aide-B (NA-B) revealed that Resident 16 will sometimes go to the dining room for lunch, but usually won't go to the dining room for lunch and sits on the edge of the bed to eat lunch in the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 3/4/25 at 12:40 PM in the room of Resident 16 revealed that Resident 16 laid on their left side in the bed facing the wall. Nurse Aide-D (NA-D) carried the noon meal tray into the resident's room and sat it on the over bed table next to the bed. NA-D removed the cover from the plate and exited the resident room. The plate contained 3 pureed food items (cooked food that has been blended, ground, or pressed into a smooth, creamy, or liquid consistency for residents with chewing or swallowing difficulties) on it. A sealed container of applesauce, a cup of reddish liquid drink with a lid on it, and a cup of water with a lid on it sat on the meal tray. The silverware was wrapped in a dark red cloth napkin on the tray next to the drinks.</p> <p>Observation on 3/4/25 at 3:08 PM in the room of Resident 16 revealed that the noon meal tray remained on the over bed table. Resident 16 was flat in the bed. The food on the plate, the container of applesauce, and the drinks remained untouched. The silverware remained wrapped in the napkin.</p> <p>Interview on 3/4/25 at 3:16 PM with NA-D revealed that nursing staff pass the room meal trays to residents in the resident rooms. NA-D revealed that nursing staff pick up the room trays but they don't always get picked up due to staff being busy with call lights.</p> <p>Interview on 3/4/25 at 3:23 PM with the Dietary Manager (DM) confirmed that safe food temperatures are to be at 135 Fahrenheit (F) or above for hot foods in the steam table. The DM confirmed that cold drinks and foods are to be below 41 F for food safety.</p> <p>Observation on 3/4/25 at 3:25 PM in the room of Resident 16 with the Dietary Manger (DM) confirmed that the noon meal tray was still in the resident room and that no items had been consumed by Resident 16. The plate contained 3 pureed food items on it. A sealed container of applesauce, a cup of reddish liquid drink with a lid on it, and a cup of water with a lid on it sat on the meal tray. The silverware was wrapped in a dark red cloth napkin on the tray next to the drinks. The DM confirmed that the food items were accessible to the resident.</p> <p>Interview on 3/4/25 at 3:25 PM with the DM confirmed that the food on the meal tray still in the room of Resident 16 would not be safe to eat due to the potential for food borne illness since it was still sitting out. DM revealed that when the room trays are delivered the staff should return the tray to the kitchen if the resident is not up to eat the meal. DM revealed that the kitchen should hold the meal tray and reheat it if it will not be eaten when delivered. The DM confirmed that the facility is required to be in compliance with the food code.</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>50105</p> <p>Based on interviews and record reviews, the facility failed to employ a qualified social worker on a full-time basis. The facility census was 37.</p> <p>Findings are:</p> <p>A review of the Long Term Care Bed Count Record provided by the facility dated 03/03/2025 revealed the facility had a census of 37 and a licensed bed count of 175.</p> <p>An interview on 03/03/2025 at 12:43 PM with Resident 32's Power of Attorney (POA; a legal document that allows someone else to act on your behalf) revealed that the Social Services Department does not always provide updates on Resident 32. The POA further states the social services director is not always available when needed.</p> <p>An interview on 03/04/2025 at 3:28 PM with the Social Services Director (SSD) revealed that they are responsible for all duties within the department and works on a full-time basis. SSD was asked about qualifications for obtaining the role, the SSD revealed they moved into the position from the kitchen and activities department, then obtained an online certification as a social services designee in long term care.</p> <p>A record review of the SSD certification dated 07/11/2022 revealed a 10-hour program certificate by Career Smart Learning, modeled on the 36-hour program designed for a 120 bed and under facility.</p> <p>A record review of a facility job description for Social Worker, Long Term Care dated 03/05/2025 revealed that a bachelor's degree in social work is required, however, healthcare and/or mental health hospital experience is preferred.</p> <p>An interview on 03/05/2025 at 10:45 AM with the Facility Administrator revealed that the SSD does not have the required qualifications to hold the position for a greater than 120 bed facility and that the facility is licensed for 175 beds.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938</p> <p>Licensure Reference Number 175NAC 12-006.18(B)</p> <p>Licensure Reference Number 175NAC 1-005.06(E)</p> <p>Based on observation, interview, and record review the facility failed to ensure that staff wore gown and gloves as required during high contact resident care (activities with the highest risk for transfer of germs to hands and clothing) for 1 resident (Resident 33) of 2 residents observed to prevent the potential for cross contamination and infection. The facility census was 37.</p> <p>Findings are:</p> <p>Record review of the facility policy titled Standard and Transmission Based Precautions dated 4/2/24 revealed that the purpose of the policy is to prevent the spread of infection and to provide appropriate personnel with protective equipment when necessary. The section titled Enhanced Barrier Precautions (EBP) revealed that it refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs (Multi-Drug Resistant organisms -microorganisms (primarily bacteria) that have become resistant to one or more classes of antibiotics, making infections difficult to treat) to staff hands and clothing. Enhanced Barrier Precautions are needed for residents with chronic wounds and Residents with Indwelling Medical devices including indwelling urinary catheters. High contact resident care activities include: transfers, dressing, assisting with transfers and mobility, device care or use of urinary catheter. The facility is to incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 2/12/25 for Resident 33 revealed that Resident 33 admitted into the facility on [DATE]. The MDS revealed that Resident 33 has an indwelling urinary catheter. Resident 33 is dependent for transfer to and from a chair to bed. Resident 33 is dependent for toileting, dressing, and personal hygiene.</p> <p>Record review of the care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 3/3/25 for Resident 33 revealed that Resident 33 requires a mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) with the assistance of two staff for transfers between surfaces. The care plan revealed that Resident 33 requires Enhanced Barrier Precautions due to the indwelling urinary catheter. The care plan revealed that staff must put on gown and gloves when performing high contact care activities including dressing, bathing, transferring, providing hygiene, changing linens, repositioning, and device care.</p> <p>Observation on 3/4/25 at 9:07 AM outside the room of Resident 33 revealed that a sign on the doorframe revealed Enhanced Barrier Precautions. The sign revealed that providers and staff must wear gloves and a gown for the following high contact resident care activities: transferring, device care or use (urinary catheter).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 3/4/25 at 9:08 AM at the room of Resident 33 revealed that Nurse Aide-E (NA-E) and Nurse Aide-B (NA-B) entered the resident's room. NA-E and NA-B did not put on a gown or gloves. NA-E removed the call light from the resident's right hand using the bare hands. NA-E removed the blanket from the resident's lap/legs using the bare hands. The blanket was against the uniform of NA-E as NA-E placed the blanket on the resident's bed. NA-B placed a soaker pad on the seat of the recliner with the bare hands. NA-E used the bare hands to remove the urinary catheter bag from the privacy cover and handed the catheter bag to NA-B. NA-B held the catheter bag against the control bar of the mechanical total body lift using the bare hands. NA-E performed hand sanitization with Alcohol Based Hand Rub (ABHR). NA-E used the bare hands to attach the lift sling (a fabric device with straps that is placed underneath a resident when a mechanical assistive device is used to transfer a resident with difficulty or the inability to stand up on their own from a seated or lying position) to the mechanical total body lift. NA-E repositioned Resident 33's bare hands on the resident's upper abdomen using the bare hands. The urinary catheter tubing contained visible urine that was a pale tan color that was milky or cloudy in appearance. NA-B operated the mechanical total body lift and transferred Resident 33 to the recliner. NA-B held the catheter bag with the bare hands as NA-E reached over the back of the recliner. NA-E used the bare hands and repositioned the sling with the resident from behind the back of the recliner. NA-B handed the catheter bag to NA-E. NA-B picked up a pillow from the bed with the bare hands. NA-E handed the catheter bag back to NA-B. NA-B and NA-E positioned the pillow behind Resident 33 using the bare hands. NA-B and NA-E repositioned Resident 33 in the recliner using the bare hands. NA-B hung the catheter bag under the right footrest of the recliner. NA-E removed the catheter bag with the bare hands and moved it to underneath the left footrest of the recliner. NA-E picked up the blanket from the bed and placed the blanket on Resident 33. NA-E exited the room. NA-B removed the mechanical total body lift from the resident room.</p> <p>Interview on 3/4/25 at 9:10 AM with NA-E revealed that Resident 33 has had a urinary catheter since admission. NA-E revealed that Resident 33's urine had been cloudier recently and that the nurse was requesting a urinalysis to check for infection.</p> <p>Interview on 3/04/25 at 2:16 PM with NA-B revealed that the yellow carts on the halls contain Personal Protective Equipment (PPE) (protective clothing such as disposable gloves, gowns, face masks, and face shields worn to help prevent the spread of germs) for residents on Enhanced Barrier Precautions. NA-B revealed that residents with urinary catheters are on EBP. NA-B revealed that the PPE for EBP is gown and gloves. NA-B revealed that EBP for residents with catheters is for the protection of the staff and the resident. NA-B confirmed that staff are required to wear gown and gloves for residents on EBP when providing any cares to the resident on EBP. NA-B confirmed that this includes transferring residents on EBP.</p> <p>Interview 3/6/25 at 9:22 AM with NA-E revealed that EBP means that when staff go into a room of a resident on EBP they wear a gown and gloves. NA-E revealed that EBP is for residents with urinary catheter or open wounds. NA-E confirmed that wearing a gown and gloves are required anytime staff are going to touch a resident on EBP. NA-E revealed that the facility provided training on EBP. NA-E confirmed that NA-E did not wear gown and gloves as required with the transfer of Resident 33 on 3/4/25 observed by this surveyor. NA-E revealed that the staff were rushed that day and did not wear the gown and gloves. NA-E revealed that normally NA-E wears the gown and gloves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 926 East E Street Hastings, NE 68901	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/6/25 at 10:09 AM with the facility Infection Preventionist (IP) confirmed that staff are required to wear gown and gloves during high contact resident care including resident transfers and manipulating or moving resident indwelling catheters. The IP revealed that the IP does on the spot training with staff when they do not follow EBP. The IP confirmed that the nurse aides were required to wear gown and gloves during the transfer of Resident 33 observed by this surveyor.</p>