

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E) Based on record reviews, observations, and interviews, the facility failed to follow the 2022 Food and Drug Administration (FDA) food code. This had the potential to affect all residents eating food out of the kitchen. The facility census was 52. Findings are: A record review of a policy titled, Date Marking- Food and Nutrition dated 4/3/24. The policy revealed:Policy:Time Temperature Control for Safety Foods (TCS) items are date-marked when received, when manufacturer package is opened and when removed from freezer into refrigeration. Dates are monitored to ensure food safety and quality for all foods at the location, including TCS snacks stored outside the preparation kitchen.Procedure:When TCS food is received, employees:Observe for vendors date of delivery and if not available, date mark the item with the delivery date.Observe for USE by date or USE or Freeze by date. This is an expiration date.As much as possible, food items should remain in their original containers/package if that package has a receiving date clearly marked.If the items are removed from the original container/package, individual items are labeled and dated with date of receiving.When TCS food has been opened but remains in storage, employees:Ensure that ready-to-eat TCS foods opened at the location are clearly date marked for:1. The date time the original container is opened2. The date or day by which the food shall be consumed on the premises, sold or discarded.3. Ready-to-eat foods TCS foods prepared at the location and held in refrigeration for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.4. A food item is discarded when:The container does not bear a date or day.The TCS item is beyond the USE by date. On 7/14/26 at 9:00 AM, the facility kitchen was observed. The following items were found to be present in the kitchen.Several stand-up refrigerator/freezers labeled 100, 400, and cook fridge contained prepared and opened food items with an open date, no use by date. All use by dates were found to be blank.In the walk-in refrigerator a tub of chicken salad was found with a posted open date of 7/3/26.In the walk-in freezer an uncovered dished-up bowl of ice cream was found with no date or label.The stove and ovens are found to be on caster wheels. When moved, food debris was found to be on the floor between the wall and stoves.A tall food warmer was currently in use with lunch holding warm food trays. In the crease between the door and the seal of the door food debris and dust was thick and coated. An observation on 7/14/26 at 2:05 PM revealed a Dietary Aide (DA)-L was preparing foods and drinks for dinner service. DA-L was found to have artificial fingernails nails. An interview on 7/14/26 at 4:00 PM with the Dietary Manager (DM) revealed not knowing that DA-L had artificial fingernails nails. An interview on 7/14/26 at 4:00 PM with the Registered Dietician (RD) confirmed that dietary employees may not wear artificial fingernails when working with exposed food.		

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
--	-------	-----------

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(A)(ii)Licensure Reference Number 175 NAC 12-006.18Licensure Reference Number 175 NAC 12-006.09 (H)(vi)(3)(g)Based on record review and interview the facility failed to ensure that pre-employment health screens were completed for 5 of 6 sampled staff to prevent the potential for communicable disease for all facility residents; failed to ensure that reusable medical care equipment was cleansed and/or changed at a frequency to ensure it was maintained in a sanitary and usable condition for 2 residents (Resident 6 and 15); failed to ensure that staff providing direct resident cares did not have artificial nails that prevented proper hand sanitization during care for 2 residents (Resident 6 and 15); failed to ensure that all reusable oxygen equipment was thoroughly cleaned after use; and failed to ensure that disposable oxygen equipment was properly labeled and discarded for the prevention of infection for 1 resident (Resident 67). The facility census was 52.Findings are: A. Record review of the facility policy titled Hiring and Screening dated [DATE] revealed that the facility complies with existing federal regulations. The section titled Health Assessment and Drug Screen revealed that a pre-employment health screen will be conducted on all job applicants who have accepted offers of employment. The health assessment is required prior to the first day of employment. Record review of the untitled and undated list of facility staff with hire dates revealed that Housekeeping Supervisor (HS) had a hire date of [DATE]. Record review of the employee file for HS revealed that it did not contain a Communicable Disease Screening form (a pre-employment health screen was not conducted). Record review of the untitled and undated list of facility staff with hire dates revealed that Nurse Aide-C (NA-C) had a hire date of [DATE]. Record review of the employee file for NA-C revealed a Communicable Disease Screening form dated 5/2004 for NA-C. The form was signed by NA-C on [DATE]. The section titled Completed by Location revealed boxes to document completion of Communicable Disease Review and Immunization Review. The boxes were not marked as completed. The line for the Form completed by and Date were not completed and contained no reviewer signature as required. Record review of the untitled and undated list of facility staff with hire dates revealed that Nurse Aide-D (NA-D) had a hire date of [DATE]. Record review of the employee file for NA-D revealed a Communicable Disease Screening form dated 5/2004 for NA-D. The form was signed by NA-D on [DATE]. The section titled Completed by Location revealed boxes to document completion of Communicable Disease Review and Immunization Review. The boxes were not marked as completed. The line for the Form completed by and Date were not completed and contained no reviewer signature as required. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	completed and contained no reviewer signature as required. Record review of the untitled and undated list of facility staff with hire dates revealed that Registered Nurse-E (RN-E) had a hire date of [DATE]. Record review of the employee file for RN-E revealed a Communicable Disease Screening form dated 5/2004 for RN-E. The form was signed by RN-E on [DATE]. The section titled Completed by Location revealed boxes to document completion of Communicable Disease Review and Immunization Review. The boxes were not marked as completed. The line for the Form completed by and Date were not completed and contained no reviewer signature as required. Record review of the untitled and undated list of facility staff with hire dates revealed that Dietary Aide-F (DA-F) had a hire date of [DATE]. Record review of the employee file for DA-F revealed a Communicable Disease Screening form dated 5/2004 for DA-F. The form was signed by DA-F on [DATE]. The section titled Completed by Location revealed boxes to document completion of Communicable Disease Review and Immunization Review. The boxes were not marked as completed. The line for the Form completed by and Date were not completed and contained no reviewer signature as required. Interview on [DATE] at 2:46 PM with the Facility Administrator (FA) confirmed that the facility did not complete the required Communicable Disease Screening for HS. The FA confirmed that the Communicable Disease Screening forms for NA-C, NA-D, RN-E, and DA-F were not reviewed as required and were incomplete. B. In an observation completed on [DATE] at 1:27 PM of Resident 6's bathroom it was observed that a bed pan was placed into a clear plastic bag hanging off a bar attached to the wall. There was visible brown particles debris in the bottom of the bed pan and an odor of vinegar and urine. In an observation completed on [DATE] at 9:45 AM Nurse Aide I (NA-I) and Nurse Aide N (NA-N) assisted Resident 6 to utilize the bed pan while lying in bed. When the resident had completed use of the bed pan NA-I took the bed pan into the resident's bathroom and then returned to the resident's bedside. In an observation completed on [DATE] at 9:55 AM of Resident 6's bathroom it was observed that the residents' bed pan was placed into a clear plastic bag hanging off a bar attached to the wall. There were visible brown and yellow particles to the inside of the residents' bed pan. In an interview completed on [DATE] at 10:00 AM with NA-I, NA-I stated that after a bed pan is utilized, they take it into the residents' bathroom and squirt a vinegar and water solution into it and then empty it into the toilet. They complete this a couple of times but sometime all the soiling does not come out. The NA stated that they are not sure how often the residents' bed pans are replaced. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview completed on [DATE] at 1:45 PM with the facility Director of Nursing (DON), the DON stated that they were unsure of the frequency that residents bed pans were changed and the method used by facility staff to cleanse them between uses. DON observed Resident 6's bed pan that is hanging in a clear plastic bag on a bar in the residents' restroom. The DON confirmed that the residents bed pan was unclear and should be thoroughly cleaned between uses until changed. The DON confirmed that the use of the vinegar and water solution for rinsing the bed pan did not properly cleanse the bed pan between uses. C. In an observation completed on [DATE] at 11:52 AM NA-I and NA-K assisted Resident 15 to utilize the bed pan while lying in bed. When the resident had completed using the bed pan NA-I took the bed pan into the resident's bathroom. The NA used a spray bottle to spray a solution into the bed pan and then swished it around and emptied the contents into the toilet. The NA then repeated the process and then placed the bed pan into a clear plastic bag hanging of a bar in the resident's bathroom. There is visible light brown thick substance present to the back edge and lip of the bed pan. In an interview completed on [DATE] at 1:45 PM with the facility Director of Nursing (DON), the DON stated that they were unsure of the frequency that residents bed pans were changed and the method used by facility staff to cleanse them between uses. DON observed Resident 6's bed pan that is hanging in a clear plastic bag on a bar in the residents' restroom. The DON confirmed that the residents bed pan was unclear and should be thoroughly cleaned between uses until changed. The DON confirmed that the use of the vinegar and water solution for rinsing the bed pan did not properly cleanse the bed pan between uses. D. In an observation completed on [DATE] at 9:45 AM Nurse Aide I (NA-I) assisted Resident 6 to utilize the bed pan while lying in bed. When the resident had completed use of the bed pan NA-I took the bed pan into the resident's bathroom and then returned to the resident's bedside. NA-I was observed to have long pointed bright pink fingernails to all fingers of both hands. In an observation completed on [DATE] at 11:52 AM NA-I assisted Resident 15 to utilize the bed pan while lying in bed. When the resident had completed using the bed pan NA-I took the bed pan into the resident's bathroom. When the NA returned to the resident bed side it was observed that the NA had long pointed bright pink fingernails to all fingers of both hands. In an interview completed on [DATE] at 1:35 PM with the facility Infection Preventionist (IP), the IP confirmed that the facility discouraged direct care staff from having long false fingernails. In an interview completed on [DATE] at 1:36 PM with NA-I, NA-I confirmed that they had long false fingernails and this was discouraged while working in the facility and providing care to residents. The NA confirmed that they should not have false nails on. E. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy dated [DATE] Oxygen Administration, Safety, Mask types &dash; R/S, LTC, Therapy and Rehab revealed that the purpose of the policy was to administer oxygen and store oxygen in a safe manner, to keep oxygen equipment clean and maintained in good condition, and to administer carious levels of oxygen concentration and/or humidity in a safe manner. Equipment included oxygen concentrators, oxygen cylinders, and oxygen tubing among others. Oxygen was to administered with a medical provider's orders. Continuing education would be provided annually of safety, handling and usage requirements for employees that handle oxygen. Guidelines revealed that 9.) all oxygen therapy equipment will be clean, sage and functional. 10.) All oxygen cylinders and concentrators will be stored in a clean, controlled area. 13.) Employees should be trained in proper cleaning and storage of all oxygen cylinders, concentrators and liquid oxygen. Record review of the Resident Clinical Census data from the electronic medical record (EMR) revealed Resident 67 was admitted on [DATE]. Record review of the Medical Diagnoses dated [DATE] revealed Resident 67 had the following diagnoses: malignant neoplasm (cancer) of the right bronchus or lung, secondary malignant neoplasm (cancer) of the brain, chronic obstructive pulmonary disease (COPD) (a progressive lung disease that makes it hard to breathe), chronic respiratory failure (a long-term condition where the respiratory system cannot adequately supply oxygen to the blood or remove carbon dioxide), shortness of breath, and generalized weakness among other diagnoses. Oxygen Concentrators were assigned to an individual resident and should not be shared without proper cleaning between residents. Best practice was to label each concentrator with the resident's name. Cleaning of the concentrator and filter and inspections revealed that disposable equipment should be changed weekly or according to the manufacturer's instructions and marked with a date and initials. Filters were to be changed between residents. Observation on [DATE] at 4:21 PM in the room of Resident 67 who has an oxygen concentrator at bedside revealed: The oxygen tubing is not labeled. Blue bag used for oxygen supplies when not in use was dated [DATE] and room [ROOM NUMBER] and had another resident's initials on the bag. There is also a portable oxygen cannister with oxygen tubing attached that is not labeled or dated. Observation on [DATE] at 9:25 AM revealed oxygen tubing was dated and labeled. Oxygen concentrator was at bedside and the blue bag for extra supplies or supply storage remained on the concentrator and was dated [DATE] with the wrong room number. Observation on [DATE] at 9:50 AM revealed the oxygen cylinder remained in the room but the tubing had been discarded. The blue bag on the oxygen concentrator remained on the concentrator dated [DATE], with the wrong room number and another resident's initials. The oxygen tubing was now dated and labeled. Interview on [DATE] at 1:20 PM with Medication Aide (MA) M revealed that the night shift staff are the ones that change the oxygen tubing. I am not sure how often it is done but I think it is completed once a week. The tubing is supposed to be dated and labeled. The blue bags were also supposed to be changed but wasn't sure how often. The bag on the oxygen concentrator does not belong to this resident. I think that the resident whose initials are on that blue bag passed away. (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on [DATE] at 1:23 PM with the Director of Nursing (DON) revealed the DON did not know how often the oxygen tubing was to be changed for each resident. I will need to check the facility policy. I will also need to check the policy for how often the blue bags that hold supplies are changed. I am not sure about how often they change out the oxygen concentrators or if we leave them here. DON confirmed that the blue bag on the oxygen concentrator for Resident 67 is labeled [DATE] and has the initials of another resident in room [ROOM NUMBER] on the label. That can't belong to Resident 67 because Resident 67 wasn't admitted until [DATE]. Interview on [DATE] at 1:26 PM with the Quality Assurance Coordinator (QAC) revealed that the oxygen concentrators come to the facility from a medical supply company. They are switched out every once in a while, by the company that supplies them for us, otherwise the facility keep them in house in storage. QAC further stated that the oxygen concentrators are cleaned and stored somewhere but wasn't sure where and stated that Infection Preventionist (IP) would know more about where the facility staff store them. Interview on [DATE] at 1:30 PM with the Infection Preventionist (IP) who revealed that oxygen tubing is supposed to be changed out weekly and labeled and dated. The little blue bags that are used for oxygen storage supplies is supposed to be changed every month. The IP confirmed that the blue bag in the room of Resident 67 was not supposed to be in that room and had not been changed from the last resident who must have used that oxygen concentrator. The IP confirmed that the last person who had that bag had expired and that the bag should have been thrown away. The IP stated that the concentrators are cleaned thoroughly, or supposed to be, then stored in the closet. Observation on [DATE] at 1:37 PM of the oxygen concentrators stored in a storage room where there were 4 concentrators not in use with the IP nurse revealed that 3 of the 4 stored concentrators that were cleaned had a used blue bag on them. The Infection Control Nurse immediately removed these and said (gender) had some work to do and some training to do with staff. The IP confirmed that the blue bags should have been removed from the concentrators if the concentrators were thoroughly cleaned.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. Licensure Reference Number 175 NAC 12-007.03(K). Based on observations and interviews, the facility failed to affix handrails securely to the walls in resident corridors, this had the potential to affect all residents residing in the facility. The facility census was 52. Findings are: An observation and walkthrough at 3:30 PM on 7/14/26 with the Maintenance Director (MD) and Housekeeping Supervisor (HS) revealed a several foot long rounded handrail in the front corridor area of the building entrance loose. The MD and HS observed drywall falling from around the edges of the handrails, screws and attachments that were affixed to the wall. An observation and walkthrough at 3:30 PM on 7/14/26 with MD and HS revealed loose handrailing beside the bathing room on 100 hall. MD revealed they were aware of this railing being loose. An observation and walkthrough at 3:30 PM on 7/14/26 with MD and HS revealed loose handrailing beside and across from the activity room in an open corridor area where people gather. MD revealed they were unaware of this railing being loose. An observation and walkthrough at 3:35 PM on 7/14/26 with MD and HS revealed loose handrailing across from the smaller dining room that is occupied by residents who reside in the 400 halls. MD revealed they were unaware of this railing being loose. An observation and walkthrough at 3:35 PM on 7/14/26 with MD and HS revealed loose handrailing outside of Resident 47's room. MD revealed they were unaware of this railing being loose. An observation and walkthrough at 3:35 PM on 7/14/26 with MD and HS revealed loose handrailing outside of Resident 50's room. MD revealed they were unaware of this railing being loose. A record review of documentation titled Logbook Documentation dated 7/1/26 revealed:1.Safety inspections shall be completed so that the entire operational location is inspected quarterly by the safe practices and inspections task group of the safety committee.2. The person assigned the responsibility for the safe practices and inspections task group, as outlined by the safety committee, should perform the safety inspections.3. The safety inspections shall be conducted on a scheduled basis.5. Immediately schedule and/or repair required repair.Instructions: Complete the inspection other interior areas checklist.Railings/grab bars in good condition: checkmark yes/no/non-applicable(NA)Lobby/Entrance - blankHallways - blankComments: No informationInspection summary for safety committee (include plan of correction): No informationPerform task for building: 100 handrail pulled out of wall again. An interview at 3:30 PM on 7/14/26 with MD revealed knowing the handrails in the front corridor area were loose and drywall was falling out of the wall. MD agreed this was considered a hazard and was aware of the concern. An interview at 3:30 PM on 7/14/26 with MD revealed knowing the handrails beside the bathing room on 100 hall were loose and not affixed to the wall securely. An interview at 3:30 PM on 7/14/26 with MD revealed not knowing the handrails beside and across from the activity room in an open corridor area were loose and not affixed to the wall securely. An interview at 3:35 PM on 7/14/26 with MD revealed not knowing the handrailing outside of Resident 47's room were loose and not affixed to the wall securely. An interview at 3:35 PM on 7/14/26 with MD revealed not knowing the handrailing outside of Resident 50's room were loose and not affixed to the wall securely.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Licensure Reference Number 175 NAC 12-006.12(D)(iii)Based on observation, record review, and interview the facility failed to ensure that medications and medical supplies were not expired. The facility census was 52.Findings are:Record review of the facility policy titled Medications: Acquisition, Receiving, Dispensing, and Storage dated 3/30/26 revealed that the location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations. Observation on 7/13/26 at 10:11 AM in the 100 medication storage room revealed that a box of Vacuette Drawing Needles expired on 5/19/26 (sterile, single-use stainless steel needles used by medical professionals to collect venous blood samples). An unopened box of Accucheck SafeT-Pro Plus lancets expired on 2/28/25 (a sterile single-use medical device with a blade that pricks the skin to draw small drops of blood for checking blood sugar). Alginate dressings with some expired on 9/1/24 and some on 7/1/25 (a natural wound dressing that covers and absorbs wound fluid). Tubes of Remedy Cream with some expired on 1/2025, some expired on 7/2025, and some on 11/2025 (an antifungal medication applied onto the skin). Observation on 7/14/26 at 2:56 PM in the 400 medication room revealed that an opened package of purple top specimen tubes expired on 3/1/25 (vacuum blood collection tubes containing an additive that prevents blood from clotting for laboratory blood tests) . A bag with two Bisacodyl suppositories in the refrigerator that expired on 1/2025 (a medication inserted into the rectum for stimulating a bowel movement to treat constipation). Observation on 7/14/26 in the 100 medication room with the facility Director of Nursing (DON) confirmed that the Vacuette drawing needles expired on 5/19/26. The DON confirmed that the unopened box of Accucheck Safe T-Pro Plus lancets expired on 2/28/25. The DON confirmed that the container of Alginate dressings had packages that expired on 9/1/24 and some on 7/1/25. The DON confirmed that the tubes of Remedy Cream were all expired. The DON confirmed that some tubes expired on 1/2025, some on 7/2025, and some on 11/2025. Observation on 7/14/26 at 3:47 PM in the 400 medication room with the DON confirmed that the opened package of purple specimen tubes expired on 3/1/25. The DON confirmed that the two Bisacodyl suppositories were expired with an expiration date of 1/2025. Interview on 7/14/26 at 3:47 PM with the DON confirmed that the facility is required to monitor medications and medical supplies to ensure that they are not outdated. The DON confirmed that the outdated medications and supplies should not be used and would be disposed of.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(H) Based on record reviews, interviews and observations, the facility failed to serve meals in a timely manner based on the facility's posted time for meals. This had the potential to affect all residents who ate meals in the dining rooms. The facility census was 52. Findings are: A record review of posted mealtimes and locations reveal: Breakfast-7:30 AM Lunch-11:30 AM Evening Meal-5:30 PM Dining room locations: 100 Avenue-Central Hub of Building 400 Avenue-Between 400 Nurse Station and room [ROOM NUMBER] An observation in 100 Avenue dining room on 7/13/26 at 11:57 AM, meal service had not yet started. An observation in 100 Avenue dining room on 7/13/26 at 12:45 PM, last person was served their meal for lunch. An observation in 100 Avenue dining room on 7/14/26 at 8:00 AM, meal service had not yet started. An observation in 400 Avenue dining room on 7/14/26 at 8:10 AM, meal service had not yet started. An observation in 400 Avenue dining room on 7/14/26 at 8:55 AM, last person was served their meal for breakfast. An interview with Medication Aide (MA)-J on 7/14/26 at 8:58 AM revealed they are responsible for delivering the meals but are unable to care for the residents and deliver meals, therefore kitchen staff typically do this and takes longer than anticipated. An observation in 400 Avenue dining room on 7/14/26 at 11:50 AM, meal service had not yet started. An observation in 400 Avenue dining room on 7/14/26 at 12:48 PM, last person was served their meal for lunch. An observation in 400 Avenue dining room on 7/15/26 at 8:35 AM, last person was served their meal for breakfast. An observation in 100 Avenue dining room on 7/15/26 at 8:37 AM, last person was served their meal for breakfast. The Dietary Manager (DM) was interviewed on 7/14/26 at 2:45 PM revealing that the dietary aides that serve the meal are also responsible for serving the residents and confirmed the above listed meals were late being served.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Licensure Reference Number 175 NAC 12-006.19 Based on record reviews and interviews, the facility failed to provide daily housekeeping per the Resident Agreement for 2 residents (Resident 18 and Resident 25) of 13 residents sampled. The facility census was 52. Findings are: A record review of a facility policy titled Housing with Services: Rehab/Skilled & Long-Term Care: Housekeeping Resource Packet dated 8/21/25 Standard or Light Cleaning-Rehabilitation/Skilled Care & Long Term Care: Purpose: To provide procedures for the proper, daily cleaning of resident rooms Background: Rehabilitation/skilled care setting provide care and services to residents who are often vulnerable to infections and the effects of infections due to weakened immune systems. As such, thorough, routine, and high quality cleaning procedures are necessary to minimize the prevalence of infection. Procedure: 1. Standard or light cleaning should occur on a daily basis in occupied rooms. If standard or light cleaning is not scheduled daily, the scheduled should be adjusted for daily cleaning in rooms where residents are under transmission precautions or other conditions that may require more frequent cleaning. A record review of a housekeeping calendar for July reveals that only Monday through Friday is scheduled for 1 housekeeper and 1 housekeeping supervisor both from 6:00 AM through 2:30 PM. The schedules states: 100-hall is scheduled for daily cleanings on Mondays, Wednesdays and Fridays. 400-hall is scheduled for daily cleanings on Tuesdays and Thursdays. Friday's state trash and toilets. A record review of a schedule outline for housekeeping titled, 100 rooms Monday, Wednesday, Friday 400 Tuesday and Thursday undated reveal: Dust all surfaces including vents, wipe high touch surfaces, clean bedrails, bedside tables top to bottom, call lights, bed remotes, clean mirrors, soap and sanitizer drip trays, sink, toilets inside and out, check/restock supplies, spray all fabric surfaces with airlift, take trash out, vacuum and mop. Monday through Friday-run floor machine Monday through Friday-clean bath house and shower house Monday through Friday-clean all public bathrooms and breakroom Monday through Friday-vacuum all carpet areas Monday and Friday-and as needed, clean all entryway windows (100) Tuesday and Thursday (400) Monday-high dusting in hallways and common areas (100) Thursdays (400) Wednesday-low dusting in hallways and common areas (100) Thursdays (400) Monday and Friday-Dust furniture in common areas Clean hopper rooms and carts on Wednesdays (100) Thursdays (400) Monday-(100) Tuesday (400) and as needed clean drip trays on sanitizer dispensers in hallways Monday through Friday-handrails at the end of the day Friday's-change out laundry carts A record review of a Resident Handbook, dated 6/21 revealed Housekeeping Services: Your room will be cleaned daily and replenished with paper supplies by the housekeeping staff. Wet Floor signs are placed in areas where the floors are wet. Please be careful when you see these signs in the halls. An interview with Housekeeping Supervisor (HS) and Housekeeper (HSK)-H on 7/14/26 at 9:55 AM revealed that no housekeeping services are done on weekends because there is no additional housekeepers hired at this time to fill the position. HS further revealed that it had been this way since coming to work at the facility. Additionally, HS revealed that an ad has been placed to hire someone to fill the position. A record review of an employee listing revealed a hire date for HS on 3/3/26. An interview on 7/12/26 at 3:47 PM with Resident 25 reveals soiling on the window makes it difficult to view nature outside, not sure if or when the window will be cleaned. An observation on 3/14/26 at 3:30 PM with HS and Maintenance Director (MD) revealed Resident 25's outdoor window contains buildup of soiling and scaling from outdoors. An interview with MD and HS on 3/14/26 at 3:30 PM reveals windows are cleaned outdoors in springtime. Windows were not scheduled to be cleaned however MD reveals a (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan will be set to get them cleaned in the future. An observation on 7/12/26 at 3:35 PM with Resident 18 revealed strong urine odors in room and bathroom. An interview on 3/14/26 at 3:35 PM with HS revealed some residents need additional cleaning in bathrooms as necessary to prevent lingering odors.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility failed to ensure that the Ombudsman was notified of transfers and discharges; and failed to ensure that a written copy of the reason for transfer to the hospital was given to the resident or the resident representative. This affected one of one sampled residents, Resident 14. Based on record review and interview, the facility failed to ensure that the State Ombudsman was notified of all transfers and discharges; and failed to ensure that a written copy of the reason for transfer to the hospital was given to the resident or the resident representative. This affected 1 of 1 sampled residents, Resident 14. The facility Census was 52. Findings were:Record review of the facility's Admission, Transfer and Discharge Team policy dated 9/8/2025 revealed the purpose was to discuss potential admissions, transfers, and discharges and implications for the operation of the entire facility and to make decisions on admissions, transfers, or discharges balancing the needs of the resident and the facility's ability to meet those needs. Furthermore the policy procedure stated that admissions, transfers, and discharges will be conducted according to state and federal guidelines. Record review of Resident 14's Clinical Census revealed Resident 14 transferred to the hospital on 7/5/26 and returned to the facility on 7/8/2026.Record review of the Ombudsman notifications for the past 6 months revealed that there were no notifications sent to the Ombudsman in the past 6 months.Interview with the Social Services Director (SSD) on 7/13/2026 at 1:37 PM confirmed that no information had been sent to the Ombudsman since SSD's hire date in May 2026. After searching through records, the SSD was unable to locate any other information sent to the State Ombudsman since the year 2022. The SSD also revealed not knowing this was a requirement of the facility as the SSD was not trained to send these notifications and would contact the specified State Ombudsman immediately to find out what was required from the facility. When asked if any notifications had been sent to residents or to the resident representatives, the SSD stated, I have not given any written notifications at the time of the transfers or discharges. I do call the families and let them know we are transferring, or that we transferred a resident. I did contact the family of Resident 14 prior at the time of the transfer to the hospital.Interview on 7/13/26 at 1:40 PM with the Facility Administrator (FA) revealed that SSD is new to the facility as of May 2026 and did not know that one needed to inform the Ombudsman about any transfers, or discharges of residents in the facility at any time. The FA joined the facility on 6/8/26 and will start an immediate review of those individuals that need to be reported to the State Ombudsman's office and assist the SSD with documents that have not been completed. The FA will discuss with the SSD what needs to be reported, to whom information needs to be reported, and what needs to be reported. Interview with the FA on 7/13/26 at 1:55 PM who is seated in the administration office with the SSD training the SSD about the interventions that must be taken when a resident leaves the facility. FA confirmed that no documentation related to Ombudsman notification was sent to the Ombudsman and that the Ombudsman is going to be contacted to find out how and when the Ombudsman wants to be notified about discharges and transfers. FA stated I did not know that we needed to send the resident or the representative a written copy of the reason for transfer. We will look into this too. FA confirmed that no written reason for transfer was given to either Resident 14 or the resident representative at the time of transfer and that the Ombudsman was not notified that Resident 14 transferred to the hospital on 7/5/2026.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)Based on record review and interview the facility failed to ensure that care conferences (meetings) (essential team conferences held quarterly at nursing homes with multiple medical professionals in one room to update the resident's care plan, address problems and answer resident/resident representative's questions) were provided to the resident/resident representative as required for 1 resident (Resident 5) of 3 sampled residents. The facility census was 52.Findings are:Record review of the facility policy titled Comprehensive Care Plan and Care Conferences dated 12/29/25 revealed that the purpose is to develop a person-centered care plan for each resident and to provide an ongoing method of assessing, implementing, evaluating, and updating the resident's care plan to help maintain the resident's highest practicable level of function. The social worker or designated employee will establish the time and place to hold the care conference. Invite residents and their representative at least two weeks in advance of the care conference. Invitations may be sent to the resident representative using the Care Plan Invitation Letter. If the resident and/or representative is not invited to the care conference, an explanation must be included in the medical record. Support the care conference by orienting residents and/or their representatives to the care planning process. Inform residents and representatives of the right to request meetings, request revisions to the care plan, and to be informed in advance of changes to the care plan. During the care conference, review the resident's advance directive orders to ensure the orders still reflect the resident's preferences and there are no changes needed. Document this discussion in the Progress Note-Care Conference Note. During or after the care conference, the Progress Note-Care Conference Note will be completed by a member of the interdisciplinary team. Include in this note that the resident was informed of their right to sign the care plan. Care plans are to be reviewed with each Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) completed. Interview on 7/12/26 at 11:39 AM with Resident 5 revealed that Resident 5 does not get care plan meetings every 3 months. Resident 5 revealed that they can't remember when their last care plan meeting was.Interview on 7/14/26 at 3:50 PM with the facility Social Services Director (SSD) revealed that residents are notified of upcoming care plan meetings and a notice is placed in the resident's room with the date, time, and location of the care plan meeting. The SSD revealed that the resident family/representative is notified of the upcoming care plan meeting by phone call. The SSD revealed that notes from the care plan meeting are documented in a progress note under care conference in the resident's medical record.Record review of the MDS resident assessment dated [DATE] for Resident 5 revealed that it was a quarterly assessment. The assessment revealed that Resident 5 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 15. (BIMS scoring: 13-15: Cognitively intact; 8-12: Moderately impaired; 0-7: Severely impaired). The assessment revealed that Resident 5 required moderate assistance with lower body dressing.Record review of the medical record for Resident 5 revealed no progress note for any care conference following the 10/14/25 MDS assessment. Record review of the MDS resident assessment dated [DATE] for Resident 5 revealed that it was an annual assessment. The assessment revealed that Resident 5 had a BIMS score of 14 (a change with a lower score than the score of 15 on 10/14/25). The assessment revealed that Resident 5 was now independent with lower body dressing. Record review of the medical record for Resident 5 revealed no progress note for any care conference following the 1/12/26 MDS assessment. Interview on 7/15/26 at 2:40 PM with the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSD confirmed that the facility had no documentation that a care conference was completed for Resident 5's MDS assessments on 10/14/25 and 1/12/26 as required. The SSD confirmed that the care conferences did not occur. The SSD confirmed that care conferences are required to be provided at least quarterly.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC. 12-006.09(H)(i)(2)Based on interviews, observations, and record reviews, the facility failed to provide the necessary care and services to assist in maintaining a resident's level of function for 1 resident (Resident 6) of 1 sampled resident, and complete routine bathing for 1 resident (Resident 6) of 2 sampled residents. The facility census was 52.Findings are:A.Record review of a Resident Handbook on 07/15/2026 revealed Restorative Nursing care focuses on restoring and or maintaining physical function. Restorative Nursing focuses on rehabilitation and restorative interventions to maintain the resident's abilities.In an interview completed on 07/13/2026 at 10:26 AM with Resident 6, Resident 6 stated that they felt that their level of function had declined since admission from the facility. The resident stated that they had received therapy services and were able to use the sit to stand lift for transfers at the end of therapy services. The resident stated that staff were able to utilize the sit to stand lift to assist the resident into the bathroom to use the toilet and they felt like they had less episodes of incontinence at that time. The resident stated that at this time staff had to use the full body lift to transfer the resident and due to this the resident now utilizes the bed pan for elimination vs being able to be transferred on to the toilet. The resident stated that they feel like they have more incontinence episodes due to this factor. The resident stated that once they completed therapy services the facility provided no exercises or programs to assist the resident in not having a decline in the ability to transfer or incontinence episodes.Record review Resident 6's comprehensive 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 12/15/2025 revealed Resident 6 voiced no symptoms or alterations in their mood during the mood interview. The resident required set up or clean up assistance with personal hygiene, was able to independently propel themselves in their wheelchair 150 feet, was occasionally incontinent of bladder and continent of bowel.Record review of Resident 6's Quarterly MDS dated [DATE] revealed the resident expressed mood symptoms of little interest or pleasure in doing things, and feeling down depressed or hopeless 2-6 or several days in the prior 7 days, required partial to moderate assistance with personal hygiene, partial to moderate assistance to wheel themselves in their wheel chair 150 feet, and was frequently incontinent of bladder and bowel.In an interview completed on 07/14/2026 at 9:58 AM with the Physical Therapy Assistant (PTA) the PTA confirmed that when Resident 6 was discharged from therapy services the resident was able to transfer using the sit to stand lift. The PTA stated that when a resident is discharged from therapy services the therapy department does not make recommendations for Restorative Nursing Services to maintain the residents level of function as long as possible due to the facility not having a Restorative Nursing program at this time.In an interview completed on 07/14/2026 at 10:18 AM with Nurse Aide I (NA-I), NA-I stated that the facility did not have a restorative nursing program at this time. The NA stated that Resident 6 was able to transfer using the sit to stand lift and use the toilet to void into but their legs got weak and they could not stand as long at this time so staff used the full body lift to transfer the resident and now the resident had to use the bed pan to toilet. The NA confirmed that this was a decline in the residents' abilities.In an interview completed on 07/14/2026 at 2:45 PM with the facility Director of Nursing, DON, the DON confirmed that the facility did not have a Restorative Nursing Program or any program to assist residents with health maintenance activities to assist in the prevention of the decline in function/abilities and should. The DON confirmed that Resident 6 had a decline in mood, ability to perform personal hygiene activities, ability to self-propel their wheelchair, (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and level in continence. The DON confirmed that a Restorative Nursing program could have helped in preventing the decline in Resident 6's condition.B.In an interview completed on 07/13/2026 at 10:26 AM with Resident 6, Resident 6 stated that they wished to have 2 baths a week but often only received 1 bath a week. The resident stated that some weeks they did not receive a bath all week.Record review of Resident 6's Progress Notes revealed documentation by the Social Services Director (SSD) on 06/11/2026 at 11:00 AM that the resident expressed during a care conference meeting that they were only getting one bath a week and were supposed to be scheduled for two baths a week. The note also documented that the resident's care plan was changed to better fit the residents needs and wants.Record review of Resident 6's Care Plan on 07/14/2026 revealed an intervention that the resident only wished to have one whirlpool bath a week during the day dated 01/03/2026 with a revision dated listed as 04/14/2026. There was not documentation present on the residents care plan reflecting the residents wishes for two baths a week voiced during the care conference held on 06/11/2026 as stated in the progress note.Record review of Resident 6's Point of Care documentation on 07/15/2026 revealed that Resident 6 received a whirlpool bath on 06/16, 06/23, 06/30, and 07/07. There was no documentation present that the resident received bathing twice weekly as preferred and no documentation present that the resident received a bath since 07/07.In an interview completed on 07/15/2026 at 1:20 PM with Nurse Aide K, (NA-K) stated that they were scheduled to give baths on this day. The NA stated that they got re-assigned to work the floor and there was not a bath aide assigned this day due to staffing issues.In an interview completed on 07/15/2026 at 3:45 PM with the facility DON, the DON stated that the afternoon shift would work to get the bathing done that was not completed this day due to the staffing issue.In an interview completed on 07/16/2026 at 9:20 AM with Resident 6, Resident 6 stated they did not get a bath yet this week. The resident stated they were not aware of a plan in place to ensure that the resident received a bath.In an interview completed on 07/16/2026 at 10:15 AM with NA-K, NA-K stated that they were scheduled to give baths this day. The NA stated that they were unaware if all of the residents from the previous day received a bath or not that they were just informed to complete their baths as scheduled for this day.In an interview completed on 07/16/2026 at 11:10 AM with the DON, the DON confirmed that Resident 6 had not had a bath since 07/07/2026, is scheduled to have a weekly bath, and had not been bathed in over a week.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2)Based on observations, record review, and interviews, the facility failed to provide care in a manner to promote healing of a pressure related skin injury for 1 resident, (Resident 15), of 1 sampled resident. The facility census was 52. Findings are:A.Record review of a document titled Top tips for Best Wound Cleansing Practices and dated 06/30/2017 revealed Potable drinkable tap water can be used if there is no other alternative.In an observation completed on 07/14/2026 at 2:19 PM of wound care being provided to Resident 15 by Licensed Practical Nurse-A (LPN-A). LPN-A entered the residents' bathroom and obtained a washcloth that was hanging on the bar of the residents bathroom wall under the faucet in the bathroom and moistened the washcloth with water from the tap. The LPN rang the excess water from the cloth and then with the resident placed on their left side placed the tap water moistened wash cloth to the resident's sacrum. The LPN then allowed the resident to roll back onto their back with the washcloth present over their sacrum. The LPN then awaited additional staff assistance with completing cares for Resident 15. Once the additional staff member was present the LPN then had the resident roll to their left side, removed the tap water moistened wash cloth from the resident's sacral area, and covered the resident's sacral area with a 4 inch by 4 inch foam bordered dressing. Both staff members completed cares for the resident and then exited the resident's room.In an interview completed on 07/14/2026 at 2:38 PM with LPN-A, LPN-A stated that the order for Resident 15's pressure-related skin injury stated to pat the area with water and then apply the 4 inch by 4 inch bordered foam dressing to the sacral area. The LPN stated that is what was written in the order for treatment of the area, so they were just following the orders when caring for the area.Record review of Resident 15's Order Summary Report on 07/14/2026 revealed the resident had an order stating Stage 1 pressure ulcer cleanse with water and pat dry with gauze cover with foam dressing every other day.In an interview completed on 07/14/2026 at 2:45 PM with the facility Director of Nursing (DON), the DON confirmed that wounds should be cleansed with a wound cleanser or soap and water. The DON confirmed that the directions for cleansing the wound should have been clarified with the residents provider ensuring that it was up to current clinical standards of practice.B.In an observation of Resident 15 completed on 07/13/2026 at 3:48 PM the resident was observed to be lying on their back in their bed with the head of their bed elevated greater than 35 degrees. The resident had a specialty mattress visible to their bed. The control box attached to the foot of the residents' bed had a white dial with weight setting written on it. The dial was set at the 275 mark.In an observation of Resident 15 completed on 07/14/2026 at 9:36 AM the resident was observed to be lying on their left side with the head of their bed elevated at approximately 35 degrees. The resident had a specialty mattress visible to their bed. The control box attached to the foot of the residents' bed had a white dial with weight setting written on it. The dial was set at the 225 mark.In an observation of Resident 15 completed on 07/14/2026 at 2:19 PM wound care was observed to be provided to the resident. The resident had a specialty mattress visible to their bed. The control box attached to the foot of the residents' bed had a white dial with weight setting written on it. The dial was set between the 225 and 275 mark.In an interview completed on 07/14/2026 at 2:38 PM with LPN-A, LPN-A confirmed that Resident 15 had an air exchange mattress present to their bed. The LPN stated that they were not sure of what the control box for the mattress was to be set at or how often it was checked to ensure that the setting was correct, and the mattress was functioning properly. The LPN stated that the resident should have an order for the mattress, and the order should state what the setting should be at and how often the mattress should be checked for the proper setting and function.Record review of (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 15's Electronic Medical Health Record (EMHR) on 07/14/2026 at 3:10 PM revealed no provider orders instructing what the specialty mattress was to be set at or the frequency the mattress was checked for the proper setting and function. In an interview completed on 07/14/2026 at 2:45 PM with the facility DON, the DON stated that they were unsure of the specifications for the specialty mattress on Resident 15's bed. The DON stated that they would contact the supplier and implement safety measures for the use of the mattress once obtained from the supplier. The DON confirmed that there should be directions in Resident 15's orders indicating what the mattress should be set on and frequency of checking the setting and the function of the mattress and there was not.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Licensure Reference Number 175 NAC 12-006.09(H)(iv)(1)Based on record review, observation, and interview, the facility failed to provide perineal care (the cleansing in the genital and anal areas to prevent infection and skin breakdown) per professional standards of practice for 2 residents (Resident 6 and Resident 15) of 2 sampled residents. The facility census was 52.Findings are:Record review of a document titled Nebraska ICAP UTI Perineal Care Procedure https://icap.nebraskamed.com/ and dated 0209/2017 revealed for female residents separate the labia and wash from front to back on each side of the labia and in the center over the urethra and vaginal opening, using a clean area of the washcloth for each stroke.Record review of a facility policy titled Perineal Care and dated 07/30/2025 revealed to separate the labia with one hand and using a disposable wipe, using downward strokes from the front to the back.A.In an observation completed on 07/14/2026 at 9:45 AM of perineal care being provided to Resident 6 by Nurse Aide N(NA-N) and Nurse Aide I(NA-I) the following was observed:-NA-I applied TENA cleansing cream to a moistened cloth wash cloth. The NA used the cloth to first wipe down the residents left front upper inner thigh, folded over a section of the moistened cloth then wiped down the right front upper inner thigh, folded over another section of the moistened cloth and wiped down the center of the residents' upper inner thighs. The NA did not separate the residents' legs, use one hand to separate the labia and cleanse the inner labia over the urethra and vaginal opening.In an interview completed on 07/14/2026 at 10:15 AM with NA-I, NA-I confirmed that they did not separate the residents' inner labia and cleanse the urethra and vaginal opening and should have.In an interview completed on 07/14/2026 at 3:45 PM with the facility Director of Nursing, the DON stated that it was the facility expectation to utilize disposable cloths for peri cares. The DON stated that each wipe was only to be used for one wipe then the cloth should be thrown away. The DON confirmed that NA-I should have separated the residents' inner labia and used a disposable cloth to wipe in a downward motion over the resident's meatus and vaginal opening during perineal cares.B.In an observation completed on 07/14/2026 at 11:52 AM of perineal care being provided to Resident 15 by NA-K the following was observed:-With Resident 15 lying on their right-side NA-K used a gloved hand to obtain a premoistened disposable wipe from its blue plastic rectangular container. The NA then used the wipe to wipe between the residents' legs going from front to back. The NA then folded the wipe and used the same wipe to repeat the motion wiping between the residents' legs going from front to back. The NA then threw the wipe in the trash can and placed the clean incontinence product under the residents' bottom and allowed the resident to roll back onto their back and then to their left side. The NA then pulled up the incontinence product between the residents' legs and fastened the closure of the product located over each hip. The NA did not cleanse the front of the resident's perineal area separating the labia and cleansing the meatus and over the vaginal opening.In an interview completed on 07/14/2026 at 12:10 PM with NA-K, NA-K confirmed that they did not cleanse the front of Resident 15's perineal area separating the labia and cleansing the meatus and over the vaginal opening and should have. The NA also confirmed that they should have used a clean wipe for each wipe and did not.In an interview completed on 07/14/2026 at 3:45 PM with the DON stated that each disposable wipe was only to be used for one wipe then the cloth should be thrown away. The DON confirmed that NA-I should have separated the residents' inner labia and used a disposable cloth to wipe in a downward motion over the resident's meatus and vaginal opening during perineal cares.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 (H)(vi)(3)(a)Licensure Reference Number 175 NAC 12-006.09 (J)(i)(1) The facility failed to ensure that admission weights were taken for all individuals in order to monitor and assess for adequate nutrition and hydration for those who receive assisted nutrition. This affected resident 67. Record review of the facility policy dated 6/2/26 admission Documentation revealed that the policy purpose was to obtain appropriate initial information regarding the resident and family and to provide the initial documentation needed on admission. The procedures included; Greet the resident and family and escort to resident's room, assist with transfer to bed or wheelchair if needed, introduce resident to roommate, explain the call light system and request return demonstration, and take the initial vital signs, weight and height and document in the weights and vitals tab in the electronic medical record. Record review of the Baseline Care Plan dated 7/8/2026 revealed that Resident 67 was at risk for altered fluid balance and skin turgor was to be evaluated, was at risk for ineffective tissue perfusion and needed to be observed for edema (excess fluid in the body tissues) and pulmonary embolism (a sudden blockage in a lung artery, typically caused by a blood clot), required enhanced barrier precautions (an infection control measure used in nursing homes and long-term care facilities) related to having a Peg Tube, (a flexible feeding tube placed directly into the stomach through the abdominal wall. It is used to deliver nutrition, fluids, and medications straight to the stomach, bypassing the mouth and esophagus) and was at risk for falls related to chronic obstructive pulmonary disease (a progressive lung disease that makes it hard to breathe), and malnutrition. Record review of the Medical Diagnoses dated 7/13/2026 revealed Resident 67 had the following diagnoses: Achalasia of the cardia (a rare swallowing disorder that affects the esophagus, making it difficult for food and liquid to move into the stomach which occurs when the lower esophageal sphincter (opening) fails to relax properly, leading to symptoms such as trouble swallowing, heartburn, and chest pain. The muscles of the esophagus do not contract effectively, which impairs the movement of food), malignant neoplasm (cancer) of the right bronchus or lung, secondary malignant neoplasm (cancer) of the brain, moderate protein calorie malnutrition, celiac disease (a chronic autoimmune disorder where eating gluten-a protein found in wheat, barley, and rye-causes your immune system to mistakenly attack your small intestine), iron deficiency anemia (lack of sufficient amount of iron in the blood stream), nausea, vomiting, and generalized weakness among other diagnoses. Record review of the Resident Clinical Census data from the electronic medical record (EMR) revealed Resident 67 was admitted on [DATE]. Record review of the weights and vitals signs for the resident on 7/12/2026 revealed that there was no weight taken at the time of admission for Resident 67 and that there were no recorded weights for Resident 67 in the electronic medical record. Record review of the Resident Vitals and Weights data revealed that the first recorded weight for Resident 67 was taken on 07/13/2026 at 11:21 AM by the Director of Nursing (DON). Interview with the Director of Nursing (DON) on 07/13/2026 at 3:40 PM revealed that when new residents are admitted to the facility, that the procedure includes doing vital signs, getting height and weight, doing an initial assessment, etc. We did have a night admission, and this was my first night shift admission while working at the facility and it was also the first night shift admission for the charge nurse that was working that night. We did obtain the vital signs and got the first assessments completed for Resident 67. Unfortunately, the first weight was completed today. The resident was admitted on [DATE] and no weight was taken until today on 7/13/26 when the registered dietitian found that there was no weight in Resident 67's chart. I will confirm that there as (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	no weight taken prior to today. It was a concern for me too, as Resident 67 has a PEG tube for nutritional intake as well as a history of cancer. So, I know that having the admission weight is very important. I agree that this would make it very hard to follow whether this resident is having any weight loss or weight gain since Resident 67 was just admitted .Interview with the Facility Administrator (FA) on 7/13/2026 at 3:45 confirmed that residents are to have an admission weight when they admit to the facility. We will be working on this to fix this process too.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interview the facility failed to maintain a medication administration error rate of less than 5%. The facility error rate was 7.61% (27 medication administrations and 2 errors). This affected 2 of 6 residents (Residents 62 and 12). The facility census was 52.Findings are:A.Record review of the facility policy titled Insulin Administration, Insulin Pens, Insulin Pumps dated 10/31/25 revealed that the purpose of the policy is to administer insulin injections correctly and allow for safe use of insulin pens. (Insulin is a medication used to regulate blood sugar levels). The section titled Insulin Pen (a device resembling an oversized ink pen that is prefilled with insulin and used with disposable pen needles for more accurate dosing) revealed that insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. Verify the provider order, the expiration date, and the number of days the pen has been open. Follow manufacturer's instructions. Wipe the top of the pen where the needle will attach with an alcohol swab. Remove the protective pull tab from the needle and screw it onto the pen. Turn the dosage knob to 2 units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. Dial in the ordered dose of units. Inject the dose into the chosen site. Be sure to wait about 10 seconds to ensure that the full dose has been delivered. Record review of the manufacturer product information insert titled Novolog Injection FlexPen dated 3/2023 revealed that before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing turn the dose selector to select 2 units. Hold the Novolog Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards and press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog flex pen. Turn the dose selector to the number of units you need to inject. Insert the needle into the skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. Keep the needle in the skin for at least 6 seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. Inject Novolog insulin subcutaneously within 5-10 minutes before a meal to prevent hypoglycemia (low blood sugar that may be life-threatening).Record review of the admission Record dated 7/15/26 for Resident 62 revealed that Resident 62 admitted into the facility on 7/8/26. Diagnoses included Diabetes and Long Term Insulin Use.Record review of the Order Summary (a listing of all physician's orders for a resident) dated 7/15/26 for Resident 62 revealed an order for 3 units of rapid acting insulin to be administered subcutaneously (injected just below the skin) 3 times daily with meals. Observation on 7/14/26 at 12:06 PM at the medication cart near the 100 hall medication room revealed that Licensed Practical Nurse-A (LPN-A) reviewed the insulin order for Resident 62. LPN-A removed the cap from the Novolog Flex insulin pen and wiped the top of the pen with an alcohol prep pad. LPN-A placed a needle on the pen and dialed 2 units and pressed the plunger with the pen held horizontal (LPN-A did not hold the pen with the needle pointing upward and observe for a drop of insulin while priming as required to ensure accurate dose of insulin). LPN-A dialed the ordered insulin dose of 3 units on the insulin pen. LPN-A carried the pen into the room of Resident 62. Observation on 7/14/26 at 12:14 PM in the room of Resident 62 revealed that LPN-A wiped an area on the left upper abdomen of Resident 62 with an alcohol prep pad. LPN-A placed the needle of the insulin pen into the resident's abdomen and injected the insulin by pushing (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the plunger on the insulin pen. LPN-A removed the needle immediately. (LPN-A did not hold the needle in place for at least 10 seconds to ensure the full insulin dose was delivered). LPN-A transported Resident 62 from the resident's room to the 100 dining room per wheelchair and positioned Resident 62 at a table. LPN-A exited the dining room without directing Resident 62 to drink or eat anything. Resident 62 began to visit with a tablemate. Observation of Resident 62 from 12:14 PM to 12:30 PM revealed that Resident 62 did not eat or drink anything after the administration of the insulin. Observation on 7/14/26 at 12:30 PM in the 100 dining room revealed that the Activity Director delivered a plate with mashed potatoes and gravy and minced up meat to Resident 62. Resident 62 used the fork to move some meat into gravy and took a first bite followed by a second bite of mashed potatoes with meat at 12:32 PM. (18 minutes after the rapid acting insulin was administered). Interview on 7/14/26 at 3:37 PM with LPN-A confirmed that when preparing the Novolog insulin for administration to Resident 62 the insulin pen was not held with the needle pointed upward while priming the insulin pen. LPN-A confirmed that the needle was not held into place for at least 10 seconds during administration. LPN-A confirmed that residents should eat something within 15 minutes of receiving fast acting insulin. LPN-A revealed that insulin is given before taking residents into the dining room. LPN-A revealed that the LPN does not request the resident to take a drink or eat upon getting them into the dining room. Interview on 7/15/26 at 1:53 PM with the facility Director of Nursing (DON) confirmed that an insulin pen is to be primed with 2 units before setting the physician ordered dose of insulin. The DON confirmed that the rapid acting insulins Novolog and Lispro require them to be administered within 15 minutes or less of a meal. The DON confirmed that the pen is to be held into place for 10 seconds during injection/administration. The DON confirmed that failure to prime the insulin pen correctly and failure to hold the insulin pen in place for 10 seconds during administration to ensure the correct dose of insulin is administered is a medication error. B. Record review of the manufacturer Instructions for Use Insulin Lispro Kwikpen dated July 2023 revealed that priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to 2 units to prime the pen. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with the needle pointing up and push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin at the tip of the needle repeat priming no more than 4 times. If you still do not see insulin, change the needle and repeat the priming steps. Turn the dose knob to select the number of units ordered for injection after priming. Insert the needle into the skin to inject the insulin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. Record review of the manufacturer product insert titled Humalog (insulin lispro) injection dated 1/2026 revealed that lispro is a rapid acting insulin. Inject within 15 minutes before a meal or immediately after a meal. Record review of the admission Record dated 7/15/26 for Resident 12 revealed that Resident 12 admitted into the facility on 6/24/26. Diagnoses included Diabetes. Record review of the Order Summary dated 7/15/26 for Resident 12 revealed an order for insulin lispro 5 units subcutaneously before lunch. Observation on 7/15/26 at 11:53 AM at the medication cart on the facility 400 hall revealed that Registered Nurse-B (RN-B) reviewed the insulin order for Resident 12. RN-B removed the cap from the Lispro insulin kwikpen and disinfected the top of the pen with an alcohol prep pad. RN-B placed a needle on the pen. RN-B dialed 2 units and pressed the dose knob in with the needle held horizontally (the needle was not held pointed upward while priming as required to ensure correct dose of insulin). RN-B turned the dose (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	knob to 5 units. RN-B carried the pen into the room of Resident 12. RN-B cleansed an area on Resident 12's left lower abdomen and injected the insulin. RN-B held the needle in place for 3 seconds before removing the needle (RN-B did not hold the needle in place for at least 10 seconds to ensure all of the insulin was administered). The time of the administration of the insulin was 11:55 AM. RN-B assisted Resident 12 from the resident room into the 400 dining room. Resident 12 was assisted into a chair at a table with a tablemate. Observation of Resident 12 from 11:55 AM to 12:09 PM revealed that Resident 12 did not eat or drink anything after the administration of the insulin. Observation on 7/15/26 at 12:09 PM revealed that Dietary Aide-G (DA-G) delivered a plate with an egg salad sandwich to Resident 12. Resident 12 used the knife to cut the sandwich in half. Resident 12 removed the lid from cup of tea and removed the teabag. Resident 12 opened a packet of artificial sweetener and poured it into the cup of tea. Resident 12 used the spoon to stir the tea and took a sip of tea at 12:13 PM. Resident 12 then took a bite of the sandwich. (18 minutes after the rapid acting insulin was injected). Interview on 7/15/26 at 2:17 PM with RN-B confirmed that the insulin pen was not held with the needle pointed upward when priming. RN-B revealed that the needle is to be held in place during injection for 5 seconds. RN-B confirmed that the insulin lispro is a rapid acting insulin and that the resident should be provided some nourishment within 15 minutes of insulin administration to prevent low blood sugar. Interview on 7/15/26 at 1:53 PM with the facility Director of Nursing (DON) confirmed that an insulin pen is to be primed with 2 units before setting the physician ordered dose of insulin. The DON confirmed that the rapid acting insulins Novolog and Lispro require them to be administered within 15 minutes or less of a meal. The DON confirmed that the pen is to be held into place for 10 seconds during injection/administration. The DON confirmed that failure to prime the insulin pen correctly and failure to hold the insulin pen in place for 10 seconds during administration to ensure the correct dose of insulin is administered is a medication error.		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interview the facility failed to ensure that staff administered resident insulin (a medication used to regulate blood sugar levels) in a manner to prevent significant medication administration errors (errors that jeopardize the residents health or safety) for 2 of 2 residents observed (Residents 62 and 12). The facility census was 52.Findings are:A.Record review of the facility policy titled Insulin Administration, Insulin Pens, Insulin Pumps dated 10/31/25 revealed that the purpose of the policy is to administer insulin injections correctly and allow for safe use of insulin pens. (Insulin is a medication used to regulate blood sugar levels). The section titled Insulin Pen (a device resembling an oversized ink pen that is prefilled with insulin and used with disposable pen needles for more accurate dosing) revealed that insulin pens must be clearly labeled with the name or other identifiers to verify that the correct pen is used on the correct person. Verify the provider order, the expiration date, and the number of days the pen has been open. Follow manufacturer's instructions. Wipe the top of the pen where the needle will attach with an alcohol swab. Remove the protective pull tab from the needle and screw it onto the pen. Turn the dosage knob to 2 units to prime the pen. Holding the pen with the needle pointing upwards, press the button until at least a drop of insulin appears. Dial in the ordered dose of units. Inject the dose into the chosen site. Be sure to wait about 10 seconds to ensure that the full dose has been delivered. Record review of the manufacturer product information insert titled Novolog Injection FlexPen dated 3/2023 revealed that before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing turn the dose selector to select 2 units. Hold the Novolog Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards and press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog flex pen. Turn the dose selector to the number of units you need to inject. Insert the needle into the skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. Keep the needle in the skin for at least 6 seconds and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. Inject Novolog insulin subcutaneously within 5-10 minutes before a meal to prevent hypoglycemia (low blood sugar that may be life-threatening).Record review of the admission Record dated 7/15/26 for Resident 62 revealed that Resident 62 admitted into the facility on 7/8/26. Diagnoses included Diabetes and Long Term Insulin Use.Record review of the Order Summary (a listing of all physician's orders for a resident) dated 7/15/26 for Resident 62 revealed an order for 3 units of rapid acting insulin to be administered subcutaneously (injected just below the skin) 3 times daily with meals. Record review of the Blood Sugar Summary dated 7/15/26 for Resident 62 blood sugars from 7/9/26 through 7/15/26 revealed that the resident's blood sugar was documented as a high of 196 on 7/11/26 at 12:13 PM. Resident 62 had a blood sugar of 94 on 7/15/26 at 7:55 AM. Observation on 7/14/26 at 12:06 PM at the medication cart near the 100 hall medication room revealed that Licensed Practical Nurse-A (LPN-A) reviewed the insulin order for Resident 62. LPN-A removed the cap from the Novolog Flex insulin pen and wiped the top of the pen with an alcohol prep pad. LPN-A placed a needle on the pen and dialed 2 units and pressed the plunger with the pen held horizontal (LPN-A did not hold the pen with the needle pointing upward and observe for a drop of insulin while priming as required to ensure accurate dose of insulin). LPN-A dialed the ordered insulin (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dose of 3 units on the insulin pen. LPN-A carried the pen into the room of Resident 62. Interview on 7/14/26 with Resident 62 revealed that their blood sugar levels were up and down. Observation on 7/14/26 at 12:14 PM in the room of Resident 62 revealed that LPN-A wiped an area on the left upper abdomen of Resident 62 with an alcohol prep pad. LPN-A placed the needle of the insulin pen into the resident's abdomen and injected the insulin by pushing the plunger on the insulin pen. LPN-A removed the needle immediately. (LPN-A did not hold the needle in place for at least 10 seconds to ensure the full insulin dose was delivered). LPN-A transported Resident 62 from the resident's room to the 100 dining room per wheelchair and positioned Resident 62 at a table. LPN-A exited the dining room without directing Resident 62 to drink or eat anything. Resident 62 began to visit with a tablemate. Observation of Resident 62 from 12:14 PM to 12:30 PM revealed that Resident 62 did not eat or drink anything after the administration of the insulin. Observation on 7/14/26 at 12:30 PM in the 100 dining room revealed that the Activity Director delivered a plate with mashed potatoes and gravy and minced up meat to Resident 62. Resident 62 used the fork to move some meat into gravy and took a first bite followed by a second bite of mashed potatoes with meat at 12:32 PM. (18 minutes after the rapid acting insulin was administered). Interview on 7/14/26 at 3:37 PM with LPN-A confirmed that when preparing the Novolog insulin for administration to Resident 62 the insulin pen was not held with the needle pointed upward while priming the insulin pen. LPN-A confirmed that the needle was not held into place for at least 10 seconds during administration. LPN-A confirmed that residents should eat something within 15 minutes of receiving fast acting insulin. LPN-A revealed that insulin is given before taking residents into the dining room. LPN-A revealed that the LPN does not request the resident to take a drink or eat upon getting them into the dining room. Interview on 7/15/26 at 1:53 PM with the facility Director of Nursing (DON) confirmed that an insulin pen is to be primed with 2 units before setting the physician ordered dose of insulin. The DON confirmed that the rapid acting insulins Novolog and Lispro require them to be administered within 15 minutes or less of a meal. The DON confirmed that the pen is to be held into place for 10 seconds during injection/administration. The DON confirmed that failure to prime the insulin pen correctly and failure to hold the insulin pen in place for 10 seconds during administration to ensure the correct dose of insulin is administered is a medication error. B. Record review of the manufacturer Instructions for Use Insulin Lispro Kwikpen dated July 2023 revealed that priming the pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Turn the dose knob to 2 units to prime the pen. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with the needle pointing up and push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin at the tip of the needle repeat priming no more than 4 times. If you still do not see insulin, change the needle and repeat the priming steps. Turn the dose knob to select the number of units ordered for injection after priming. Insert the needle into the skin to inject the insulin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. Record review of the manufacturer product insert titled Humalog (insulin lispro) injection dated 1/2026 revealed that lispro is a rapid acting insulin. Inject within 15 minutes before a meal or immediately after a meal. Record review of the admission Record dated 7/15/26 for Resident 12 revealed that Resident 12 admitted into the facility on 6/24/26. Diagnoses included Diabetes. Record review of the Order Summary dated 7/15/26 for Resident 12 revealed an order for insulin lispro 5 units subcutaneously before lunch. Observation on 7/15/26 at 11:53 AM at the medication cart on the facility 400 hall revealed that Registered Nurse-B (RN-B) (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Hastings Village		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S 1st Avenue 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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed the insulin order for Resident 12. RN-B removed the cap from the Lispro insulin kwikpen and disinfected the top of the pen with an alcohol prep pad. RN-B placed a needle on the pen. RN-B dialed 2 units and pressed the dose knob in with the needle held horizontally (the needle was not held pointed upward while priming as required to ensure correct dose of insulin). RN-B turned the dose knob to 5 units. RN-B carried the pen into the room of Resident 12. RN-B cleansed an area on Resident 12's left lower abdomen and injected the insulin. RN-B held the needle in place for 3 seconds before removing the needle (RN-B did not hold the needle in place for at least 10 seconds to ensure all of the insulin was administered). The time of the administration of the insulin was 11:55 AM. RN-B assisted Resident 12 from the resident room into the 400 dining room. Resident 12 was assisted into a chair at a table with a tablemate. Observation of Resident 12 from 11:55 AM to 12:09 PM revealed that Resident 12 did not eat or drink anything after the administration of the insulin. Observation on 7/15/26 at 12:09 PM revealed that Dietary Aide-G (DA-G) delivered a plate with an egg salad sandwich to Resident 12. Resident 12 used the knife to cut the sandwich in half. Resident 12 removed the lid from cup of tea and removed the teabag. Resident 12 opened a packet of artificial sweetener and poured it into the cup of tea. Resident 12 used the spoon to stir the tea and took a sip of tea at 12:13 PM. Resident 12 then took a bite of the sandwich. (18 minutes after the rapid acting insulin was injected). Interview on 7/15/26 at 2:17 PM with RN-B confirmed that the insulin pen was not held with the needle pointed upward when priming. RN-B revealed that the needle is to be held in place during injection for 5 seconds. RN-B confirmed that the insulin lispro is a rapid acting insulin and that the resident should be provided some nourishment within 15 minutes of insulin administration to prevent low blood sugar. Interview on 7/15/26 at 1:53 PM with the facility Director of Nursing (DON) confirmed that an insulin pen is to be primed with 2 units before setting the physician ordered dose of insulin. The DON confirmed that the rapid acting insulins Novolog and Lispro require them to be administered within 15 minutes or less of a meal. The DON confirmed that the pen is to be held into place for 10 seconds during injection/administration. The DON confirmed that failure to prime the insulin pen correctly and failure to hold the insulin pen in place for 10 seconds during administration to ensure the correct dose of insulin is administered is a medication error.		