STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285098	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Millard	12856 Deauville Drive Omaha, NE 68137

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)(iv)(5) and 12-006.09 Based on interview and record review the facility failed to monitor bowel movements and implement a bowel protocol for 1(Resident 2) of 1 resident sampled and failed to monitor blood glucose per physician's order for 1 (Resident 87) of 1 resident sampled. The facility census was 74. The findings are: A.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-14-2025 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 5. According to the MDS Manual, a score of 0 to 7 indicates severe cognitive impairment. -had a diagnosis of Alzheimer's Disease. -required limited assistance with hygiene, bed mobility and transfers -required extensive assistance with toileting, bathing and dressing. Record review of Resident 2's Bowel Movement (BM) log printed on 05-19-2026 revealed the following bowel movements in the last 30 days: -05-01-2026 no charting -05-02-2026 charted no BM -05-03-2026 charted no BM -05-04-2026 charted no BM -05-05-2026 no charting -05-06-2026 charted no BM -05-07-2026 charted a small BM -05-08-2026 charted no BM (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05-09-2026 charted no BM -05-10-2026 charted no BM -05-11-2026 charted no BM -05-12-2026 charted medium BM Record review of Resident 2's Medication Administration Record (MAR) for May 2026 revealed the following orders for bowels: -Miralax (a laxative) oral powder give one scoop by mouth in the morning for constipation. -Senna (a laxative) oral tablet 8.6 milligrams (mg) two times a day for constipation. -Bowel Protocol on day 2 of no BM give prune juice, day 3 of no BM give Milk of Magnesia 30 milliliters (ml), day 4 of no BM give biscodyl suppository, day 5 of no BM give fleet enema and notify the primary care provider as needed (prn) for constipation. Further review of Resident 2's MAR for May 2026 revealed Resident 2 did not receive the prn bowel protocol medications from 05-01-2026 to 05-13-2026. Record review of Resident 2's Progress Notes (PN) dated 05-13-2026 revealed Resident 2 had an episode of diarrhea and emesis. Record review of Resident 2's Comprehensive Care Plan (CCP) printed on 05-19-2026 revealed the lack of evidence that constipation was a potential problem for Resident 2 and provided no interventions for constipation. An interview conducted with the Director of Nursing (DON) on 05-20-2026 at 1:30 PM confirmed Resident 2 had not had a BM other than a small on 05-07-2026 and confirmed the prn bowel protocol medications were not given and should have been. B. Record review of facility policy entitled Blood Glucose Monitoring, Disinfecting and Cleaning R/S, LTC dated reviewed/revised 09/30/2025 showed facility staff would document the resident's blood glucose results in the Weights and Vitals tab in PCC. Record review of Resident 87's admission Record (AR) revealed the facility admitted the resident on 04/14/2025. Record review of Resident 87's admission MDS identified the resident had a diagnosis of diabetes mellitus. Record review of Resident 87's Medication Record (MR) dated May 2025 revealed the following: -An order for Tresiba insulin scheduled for the morning medication pass dated 04/15/2025. The order had an area to document the morning blood sugar reading. -An order for blood sugar reading twice daily for the morning and evening medication passes. There was no area available to document the blood sugar reading. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 87's Blood Sugar Summary revealed there was no record of blood sugar readings for the evening on 05/02/2025, 05/03/2025, and 05/04/2025. Record review of Resident 87's Progress Notes dated 05/01/2025 through 05/07/2025 revealed no information regarding the blood sugar levels for 05/02/2025, 05/03/2025, or 05/04/2025. An interview on 05/20/2026 at 12:58 PM with the Director of Nursing (DON) confirmed a lack of documentation of the blood sugar readings for the evening of 05/02/2025, 05/03/2025, and 05/04/2025. The DON further confirmed there was no place on the MR to document the reading.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview; the facility staff failed to implement interventions to promote pressure ulcer healing for 1 (Resident 26) of 4 sampled residents. The facility census was 74. Findings are:A.Record review of Resident 26's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-28-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had short-term and long-term memory problems.-required limited assistance with bed mobility and transfers.-required extensive assistance with toileting, bathing and upper body dressing-required total assistance with lower body dressing.-had a Traumatic Brain Injury (TBI) and hemiplegia (a medical condition that causes severe or complete paralysis on one vertical half of the body).-had limited Range of Motion (ROM) on one side of the body. -was at risk of developing a pressure ulcer.-had a stage 3 pressure ulcer Record review of Resident 26's Comprehensive Care Plan (CCP) revised on 03-19-2026 revealed Resident 26 had a potential or actual impairment to skin integrity related to localized edema and protein-calorie malnutrition. Resident 26 had a pressure ulcer to the right side of the right foot and the right heel. The goals listed was Resident 26 would not have complications related to pressure ulcers and would be free from skin injury through the review date. Interventions listed were:-monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, or maceration to the health care provider. -Restorative Nursing Referral. -provide pressure relieving/reducing device and/or skin protective device.The CCP did not indicate what pressure relieving device to use, for what area of the body or for how often. Record review of Resident 26's Wound Data Collection Sheet (WDCS) dated 01-13-2026 revealed Resident 26 had a new stage 3 pressure ulcer (According to the MDS Manual a stage 3 pressure ulcer is a wound with full thickness skin loss where the dermis is completely lost), to the right foot measuring 1.13 centimeters (cm) in length by 1.6 cm in width by 0.1 cm depth. Record review of Resident 26's Treatment Administration Record (TAR) for November 2025 revealed the absence of an order for pressure relieving boots. Record review of Resident 26's TAR for December 2025 revealed the absence of an order for pressure relieving boots. Record review of Resident 26's TAR for January 2026 revealed an order dated 01-14-2026 after the stage 3 pressure ulcer was identified for Prevalon boots to bilateral lower extremities, encourage to wear at all times in bed as resident allows. Record review of Resident 26's Progress Note dated 03-04-2026 revealed Resident 26 had developed a new pressure ulcer to the right foot near toe, staged as a Deep Tissue Injury (DTI: a purple or maroon area of discolored skin due to damage of underlying soft tissue) measuring 0.81 cm in length by 1.31cm in width by 0.2 cm in depth. Record review of Resident 26's Electronic Medical Record (EMR) under Tasks was a listing for Prevalon boot to right and left foot as resident allows revealed from 04-27-2026 to 05-26-2026 revealed no documentation of the use of Prevalon boots. Observation of Resident 26 in bed on 5/26/2026 at 8:15 AM revealed that resident is in bed. It was noted that resident was not wearing the Prevalon protective boots at time of observation. These boots were discovered in Resident 26's wheelchair.Interview with DON on 5/26/26 at 1:20 PM confirmed the facility had not initiated pressure relieving boots until after Resident 26 had developed a stage 3 pressure ulcer to the right foot.