

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Syracuse		STREET ADDRESS, CITY, STATE, ZIP CODE 1622 Walnut Street Syracuse, NE 68446	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47733</p> <p>Licensure Reference Number NAC 175 12-006.04(F)(i)5</p> <p>Based on record review and interview the facility staff failed to notify the physician and responsible party regarding missed/unavailable doses of medication for 1 (Resident 18) of 8 resident's reviewed. The facility staff identified a census of 42.</p> <p>Findings are:</p> <p>Record review of Resident 18's Face Sheet dated 01/15/2025 revealed Resident 18 was admitted to the facility on [DATE].</p> <p>Record review of Resident 18's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) signed as completed on 11/04/2024 revealed the facility staff assessed the resident's use of anticonvulsant medication. This MDS also assessed Resident's mental status and documented severe impairment.</p> <p>Record review of Resident 18's Medication Administration Record (MAR, a record of how the Resident's medications are administered) for Phenytoin (an anticonvulsant medication) Oral Suspension 125 MG/ML (Milligram/Milliliter), give 8 ML by mouth two times a day revealed 19 missed doses total for November and December 2024. The missed doses for November 2024 revealed the medication was unavailable for a total of 16 doses, and December 2024 revealed 3 doses were unavailable.</p> <p>1/15/24 @ 1:15 PM Interview with Clinical Care Leader (CCL, A nurse that supervises the day-to-day cares in the facility) confirmed that the staff had not alerted the pharmacy that the medication was unavailable. The CCL revealed the staff had not notified the physician or POA of the missed doses of Phenytoin.</p> <p>Record review of the facility policy dated 12/23/2024 revealed the facility must immediately inform the resident, consult, the resident's physician and notify, consistent with his or her authority, the resident representative.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285</p> <p>Licensure Reference Number 175 NAC 12-006.09D</p> <p>Based on observation, record review and interview; the facility failed to ensure the MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) was coded to reflect the resident used a wander guard system (a medical alert device used to send an alert to staff or sound an alarm to prevent elopement for wandering residents)for 1 (Resident 6) of 11 residents that utilized a wander guard system. The facility census was 42.</p> <p>Findings are:</p> <p>Observation on 01/16/25 at 8:34 AM revealed Resident 6 seated in a recliner in their room. Resident 6 had a wander guard system bracelet present on the right wrist.</p> <p>Interview on 01/15/25 at 3:18 PM with the facility Social Worker confirmed that the wander guard was placed on Resident 6 on 12/19/24. The Social Worker further confirmed that Resident 6 was at risk for elopement.</p> <p>Record review of Resident 6's CCP (Comprehensive Care Plan, a individualized plan of care which identifies care needs for the resident) dated revised 12/19/24 revealed that Resident 6 had the potential for elopement related to exit-seeking due to Dementia. Interventions included: Wander guard used to alert staff to resident near exits. This was initiated on 12/19/2024.</p> <p>Record review of Resident 6's annual MDS annual 12/26/24, with a review period between 12/20/24 and 12/26/24, revealed an admitted [DATE] and diagnoses that included Unspecified Dementia, Depression and Generalized anxiety Disorder. Resident 6's MDS identified a BIMS (Brief Interview for Mental Status, aides in detecting cognitive impairment) score of 05 which indicated severely impaired cognitive ability, wandering occurred 1-3 days during the assessment review dates, no impairment with range of motion, walker and wheelchair use, independent while in a manual wheelchair with wheeling 50 feet - 150 feet, and no wander guard used.</p> <p>Interview on 01/16/25 at 9:40 AM with the MDS Coordinator confirmed the information in the CCP and that a wander guard was placed on Resident 6 on 12/19/24. The MDS Coordinator confirmed that there was an error in the MDS and that the wander guard system was not coded correctly in Section P0200 E of the MDS to identify the use of a wander guard system for Resident 6.</p> <p>Record review of facility Order Listing Report dated 1/16/25 revealed a total of 11 residents with orders for a wander guard system.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on observation, interview and record review; the facility failed to re-evaluate elopement risk and monitor the functioning of the wander guard system (a medical alert device used to send an alert to staff or sound an alarm to prevent elopement for wandering residents) for 1 (Resident 6) of 11 residents that utilized a wander guard system. The facility census was 42.</p> <p>Findings are:</p> <p>Record review of a facility policy entitled Elopement- Rehab/Skilled & Adult Day Services, dated 8/16/24 revealed the following:</p> <p>- During the stay:</p> <p>1. Residents will be assessed and monitored in the following ways:</p> <p>a. The Elopement Risk UDA (assessment) will be completed for all residents with the quarterly, annual and significant change MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) assessments. The Elopement Risk UDA can also be triggered PRN (as needed) when elopement risk is identified (i.e. change in resident's medical condition and/or cognitive status, resident who is exhibiting a new mood or behavior or a new attempt to elope).</p> <p>Record review of Resident 6's annual MDS dated [DATE], with a review period between 12/20/24 and 12/26/24, revealed an admitted [DATE] and diagnoses that included Unspecified Dementia, Depression and Generalized anxiety Disorder. Resident 6's MDS identified a BIMS (Brief Interview for Mental Status, aides in detecting cognitive impairment) score of 05 which indicated severely impaired cognitive ability, wandering occurred 1-3 days during the assessment review dates, no impairment with range of motion, walker and wheelchair use, independent while in a manual wheelchair with wheeling 50 feet - 150 feet, and no wander guard used.</p> <p>Record review of Resident 6's CCP (Comprehensive Care Plan, an individualized plan of care which identifies care needs for the resident) dated revised 12/19/24 revealed that Resident 6 had the potential for elopement related to exit-seeking due to Dementia. Interventions included: Wander guard used to alert staff to resident near exits. This was initiated on 12/19/2024.</p> <p>Record review of an Elopement Risk Assessment for Resident 6, completed on 6/14/24, revealed that Resident 6 was identified not at risk for elopement.</p> <p>Record review of Resident 6's Electronic Medical Record, including elopement assessments, revealed that no elopement assessments had been completed after 6/14/24 for Resident 6.</p> <p>Record review of Physician Orders revealed the following orders for Resident 6:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 12/16/2024: Wander guard for increase confusion and exit seeking.</p> <p>- 12/19/24: Check function of wander guard bracelet Q (every) shift two times a day for wander guard integrity.</p> <p>Record review of Resident 6's Progress Notes revealed the following:</p> <p>- 12/13/2024: Resident presenting with higher confusion and asking when [gender] can leave. Resident restless but was able to be redirected. Wander guard was placed for safety. Family notified, fax sent to MD (Medical Doctor).</p> <p>- 12/16/24 14:31: Dr. noted fax regarding wander guard bracelet.</p> <p>- 12/16/24 15:00: Dr. ok to wander guard. Placed in orders [sp].</p> <p>- 12/27/24 12:38: Resident wandered the facility lost several times. This MSW [master Social Work] observed and redirected resident several times. Resident requires redirection, cues, and reminders. Memory loss and low recollection on what is said.</p> <p>Observation on 01/16/25 at 8:34 AM revealed Resident 6 seated in a recliner in their room. Resident 6 had a wander guard system bracelet present on the right wrist.</p> <p>Interview on 01/16/25 at 8:40 AM with LPN (Licensed Practical Nurse) A revealed the wander guards are checked by the medication aides and documented on the Electronic MAR / TAR (Medication Administration Record / Treatment Administration Record) in the resident's record.</p> <p>Observation on 01/16/25 at 8:41 AM with MA (Medication Aide) B revealed that MA B entered Resident 6's room and checked the wander guard system with the testing device. The light on the wander guard bracelet, on Resident 6's right arm, turned green which indicated that it functioned properly.</p> <p>Interview on 01/16/25 at 8:43 AM with MA B revealed the order for the wander guard had not populated onto Resident 6's Electronic MAR /TAR and was not available to be documented as completed and checked.</p> <p>Interview on 01/16/25 at 8:45 AM LPN A confirmed the wander guard checks had not populated onto the Electronic MAR/TAR dated December 2024 and January 2025 so those checks could not be documented as completed. LPN A confirmed that wander guard system checks were to be done BID (twice a day) and should have started on 12/19/24. LPN A reviewed Resident 6's Electronic MAR / TAR dated December 2024 and January 2025 and confirmed those checks were not completed or documented.</p> <p>Interview on 01/16/25 at 01:26 PM with CCLC (Clinical Care Lead Coordinator) confirmed that an elopement assessment for Resident 6 had not been completed when the wander guard was initiated on 12/19/24 and should have been. The CCLC confirmed that the monitoring of the function of the wander guard for Resident 6 had not been completed or documented and should have been.</p> <p>Record review of facility Order Listing Report dated 1/16/25 revealed a total of 11 residents with orders for a wander guard system.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47733</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on record review and interview; the facility failed to ensure 1 Resident (#18) of 9 Resident's reviewed were free from significant medication errors. The facility staff identified a census of 42.</p> <p>Findings are:</p> <p>Record review of Resident 18's Face Sheet dated 01/15/2025 revealed a diagnosis of Epilepsy and an admitted [DATE].</p> <p>Record review of Resident 18's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) signed as completed on 11/04/2024 revealed the facility staff assessed the resident's use of anticonvulsant medication, used to treat Epilepsy. This MDS also assessed Resident's mental status and documented severe impairment.</p> <p>Record review of Resident 18's MAR (Medication Administration Record) revealed Phenytoin Oral Suspension 125 MG/ML (Milligram/Milliliter), give 8 ML by mouth two times a day, related to Epilepsy. Record review of the MAR revealed in November 2024, the medication was unavailable for a total of 16 doses. Further review revealed 3 doses were unavailable in December 2024 for a total of 19 unavailable doses.</p> <p>Record review of Resident 18's (CCP) Comprehensive Care Plan, a written plan to meet the needs of the resident, dated 08/22/2024 revealed the following,</p> <p>-Focus: Resident 18 has a seizure disorder.</p> <p>-Goal: Resident 18 will remain free from injury related to seizure activity through review date.</p> <p>-Interventions: Seizure Precautions: Do not leave resident alone during a seizure; protect from injury; if resident is out of bed, help to the floor to prevent injury; remove or loosen tight clothing don't attempt to restrain resident during a seizure as this could make the convulsions more severe; protect from onlookers, draw curtain etc.</p> <p>-Post seizure treatment: Turn on side with head back, hyper-extended to prevent aspiration; keep airway open; after seizure take vital signs and neuro check; monitor for aphasia, headache, altered LOC, paralysis, weakness, pupillary changes.</p> <p>-Notify nurse ASAP if seizure activity occurs.</p> <p>An interview on 1/13/2025 at 7:38 AM with Resident 18's POA (Power of Attorney-An appointed individual to make decisions for the Resident, when the Resident cannot make decisions for themselves) revealed a significant medication was unavailable for Resident 18 several times in October and November. The POA was unable to give a date that they received this information.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 01/15/2025 at 1:15 PM with the CCL (Clinical Care Leader) revealed the staff had not notified the pharmacy that Resident 18 was out of Phenytoin Oral Suspension, and this was a significant medication error .</p> <p>Record review of the facility policy titled Medication; Acquisition receiving dispensing and storage dated 3/29/24. The Policy/Procedure revealed the licensed nursing employees are responsible for ordering from the pharmacy and checking all new orders of medications. Discrepancies and omissions are to be reported promptly to the issuing pharmacy and the charge nurse.</p> <p>Record review of the Facility policy titled Local pharmacy medications ordering dated 9/03/24 revealed, If the medication has been reordered and not received on the next delivery, the staff are to call the pharmacy are determine why the medication was not delivered.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614</p> <p>Licensure Reference Number 175 NAC 12-006.18</p> <p>Based on observation, interview and record review the facility staff failed to ensure hand hygiene and gloving techniques were followed during wound care for 1(Resident 34) and tube feeding for 1(Resident 17), failed to ensure wound care supplies were not contaminated for 1 (Resident 34), failed to implement interventions to prevent the spread of Covid-19 and failed to ensure the facility had a Legionella water management plan. The facility failure had the potential to effect all residents in the facility. The facility had a census of 42.</p> <p>Findings are:</p> <p>A. A record review of Resident 34's hospice wound care order dated 12/16/2024 revealed the following instructions:</p> <p>-Wash left heel with wound wash, dry with gauze, apply layer of Vaseline gauze to wound and cover with dry gauze dressing and secure with Medi pore tape. Hospice nurse to complete twice a week. If dressing becomes soiled or is removed, apply dry dressing and secure as needed (PRN).</p> <p>An observation on 01/15/2025 at 10:47 AM of wound care performed by the Clinical Care Lead (CLL) for Resident 34 revealed the following:</p> <p>- The CCL entered the resident room wearing a gown and face mask. They washed their hands and donned gloves. The CLL placed a pair of scissors, a pack of Kerlix (a brand of gauze bandage), a roll of tape, a foam dressing 4 x 4 (a wound care product that absorbs drainage), an open package of Vaseline gauze (a sterile non-adhesive wound dressing that's made of fine mesh gauze and white petrolatum) and a bottle of wound cleanser directly on the residents' bed. The resident raised their left leg and the CLL removed the soiled bandage from the residents' foot by cutting the kerlix with the scissors and discarded the dressing in the trash. The CCL removed their gloves and donned clean gloves. The CCL did not use hand sanitizer or wash their hands between taking gloves off and replacing them. The CLL opened the roll of kerlix and cut a portion of it off with the scissors. The scissors were placed directly on the residents' bed. The CCL soaked a piece of kerlix with wound cleaner and wiped the residents left heel wound and discarded the wet kerlix. The CCL used the scissors, which had not been cleaned, to cut a piece of Vaseline gauze. The scissors were placed directly on the bed. The Vaseline gauze was placed on the open area of the wound. The CCL opened a foam dressing package, placed the dressing over the wound and secured it in place by wrapping the remaining kerlix over it. The CCL cut a piece of tape and used it to secure the dressing in place. The CLL secured the wound care dressings in a plastic container and washed their hands, removed their gown and face mask and exited the room.</p> <p>An interview on 01/15/2025 at 11:05 AM with the CLL confirmed they had not washed their hands or used hand sanitizer between glove changes and they should have done so. The CLL confirmed the scissors should have been cleaned in between cutting the dirty dressing and the clean kerlix and the wound care supplies should have been placed on a barrier sheet, not directly on the residents' bed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A record review of the facility Hand Hygiene (hygiene - the practice of keeping clean to prevent disease and maintain good health) policy dated 3/29/2022 revealed the following information:</p> <p>-Policy</p> <p>All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene.</p> <ol style="list-style-type: none"> 1. Entering Room. 2. Before Clean Task 3. After Bodily Fluid/Glove removal 4. Exiting Room 5. Zones: Patient zone and Health care zone. <p>The preferred method of hand hygiene for most patient care settings is the use of waterless alcohol-based hand sanitizer.</p> <p>-Gloves are a protective barrier for the Health Care Worker (HCW) according to standard precautions.</p> <ol style="list-style-type: none"> 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal. <p>-Procedure.</p> <p>HCW will use waterless alcohol-based hand sanitizer or soap and water to clean their hands:</p> <p>-When entering patient room. If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves.</p> <p>After removing gloves regardless of task completed.</p> <p>After contact with a patients' non-intact skin, wound dressings, secretions, excretions, mucous membranes, as long as hands are not soiled.</p> <p>B. A record review of the Infection Control Assessment and Promotion Program (ICAP) Summary of Recommendations for Covid-19 in a long-term care facility, revised on 05/11/2013 under the heading Isolation of Resident Identified to have Covid-19 (Red Zone) states that Resident door should be kept closed.</p> <p>On 1/13/2025 the facility provided a list of residents who were positive for Covid-19. These residents were in the following rooms.:100, 102,103, 104, 106, 107, 109, 112, 201, 205, 207, 213, 210, 301, 311, 312, 313, 316, 402. 405, 411 and 500.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 1/13/2025 at 9:56 AM revealed the doors to rooms 201, 205, 207, 213, and 312 were open.</p> <p>An observation on 1/14/25 at 7:50 AM revealed the doors to rooms 312, 402, 210, 205, and 109 were open.</p> <p>An observation on 1/15/2024 at 9:15 AM revealed the doors to rooms 112, 109, 106, 102, 201, 207, 210, 213, and 500 were open.</p> <p>An interview on 1/15/2025 at 9:15 AM with the Clinical Care Lead (CCL) confirmed having the doors open in a Covid-19 positive room was an infection control breach. The CCL confirmed the Airborne Precautions from the Centers for Disease Control and Prevention (CDC) sign on each door stated the doors were to be kept closed at all times. The CCL confirmed the facility is following the Infection Control Assessment and Promotion Program (ICAP) Summary of Recommendations for Covid-19 in a long-term care facility, revised 5/11/23.</p> <p>The CCL confirmed the ICAP summary stated the Resident door should be kept closed.</p> <p>C. An interview on 1/16/2024 at 9:40 AM with the Maintenance Director (MD) confirmed the facility uses The Equipment Lifecycle System (TELS system - a system which helps with life safety, asset management, maintenance and repairs and is used to track and document repairs and maintenance in a facility). The MD was unable to produce a text and flow diagram (a visual representation of a process or workflow where each step is described with text and connected by arrows to show the sequence of actions) to show the areas where Legionella and other waterborne pathogens could grow and spread in the facility's water system.</p> <p>An interview on 01/16/2024 at 9:45 AM with the Facility Administrator confirmed they did not know if there was a Legionella Water Management program team and did not know if there was a water flow diagram for the facility.</p> <p>An interview on 1/16/2024 at 10:12 AM with the facility Maintenance Director confirmed there was not a water management program team in the facility, The facility did not have a water system flow diagram and there were no confirmatory procedures to show that the program is being followed as written and to validate that the program is effective. The MD confirmed the facility did not have the measures required by the facility policy to prevent the growth of Legionella.</p> <p>A record review of the Company's Plumbing Systems, Resource packet Policy, containing the Legionnaires disease and water management program Policy revised on 1/17/2024 revealed the following information:</p> <p>-Policy</p> <p>-All Good Samaritan Society rehab/skilled locations will identify a water management team at their location that will annually and with any major maintenance and water service change, identify where Legionella could grow. This team will determine the water management program for the location. Revisions will be made as needed to the water management plan. Documentation of control measures will occur in the Society's approved environmental services management software system.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Water Management Program</p> <p>The written program should include at least the following:</p> <p>Program team including names, titles, contact information and roles on the team. At a minimum the team should include:</p> <p>Someone who understands accreditation standards and licensing requirements,</p> <p>Someone with expertise in infection prevention,</p> <p>A clinician with expertise in infectious diseases</p> <p>and Risk and Quality management staff.</p> <p>Describe your building water system using a flow diagram; this should be a simple diagram that is easily understood by all team members.</p> <p>Identify areas where Legionella could grow and spread:</p> <p>Using the water system flow diagram, identify where potentially hazardous conditions could occur in your building water system,</p> <p>-Apply control measures:</p> <p>Control measures and limits should be established for each control point.</p> <p>Include confirmatory procedures to show that the program is being followed as written and to validate that the program is effective.</p> <p>17285</p> <p>D. Record review of Resident 17's Quarterly MDS (Minimum Data Set - a comprehensive standardized assessment of resident's functional capabilities and health needs) dated 11/8/24 revealed an admitted [DATE] and diagnoses that included Malignant Neoplasm of Oropharynx; Dysphagia (difficulty swallowing); and Gastrostomy Status (presence of a feeding tube in the stomach for nutrition and hydration support). The MDS identified BIMS (Brief Interview for Mental Status, aids in detecting cognitive impairment) score of 14 which indicated the resident was cognitively intact. The MDS identified Resident 17 did not eat due to a medical condition and had a feeding tube while a resident with 51% or more calories by feeding tube and 501 cc or more for fluids.</p> <p>Record review of Resident 17's Physician Orders revealed the following orders:</p> <p>- 12/01/2023 NPO (nothing by mouth) diet,</p> <p>- 11/08/2024 Nutren 2.0 Oral Liquid (Nutritional Supplements) Give 250 ml via G-Tube three times a day with minimum of 100 ml water before and after each feeding - By Gravity.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Syracuse		STREET ADDRESS, CITY, STATE, ZIP CODE 1622 Walnut Street Syracuse, NE 68446	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 01/15/25 at 08:20 AM revealed Resident 17 was in isolation due to use of the feeding tube. A sign on the door indicated that personal protective equipment, including gowns, gloves, N-95 mask, and eye protection were required during cares.</p> <p>Observation on 01/15/25 at 08:20 AM revealed LPN (Licensed Practical Nurse) C knocked on the door, entered the room in goggles, an N 95 Mask, a gown and gloves. LPN C explained the procedure to Resident 17, cleaned the bedside table with a disinfectant cloth and placed a tissue barrier. With the same gloves and no hand hygiene performed, LPN C reached into the pocket of their uniform pants, retrieved a set of keys, unlocked the supply cabinet and replaced the keys into the same pocket. With the same gloves in place and no hand hygiene performed, LPN C placed 3 cups on the barrier and retrieved a bottle of tube feeding from a box on the floor. LPN C shook the tube feeding well, opened and poured the contents of the bottle into a cup. LPN C retrieved an open bottle of distilled water from the floor and poured 240 cc into one of the cups. LPN C proceeded to check placement and administer tube feeding with water flushes as ordered. During the administration LPN C did not change gloves or perform hand hygiene. LPN C disconnected the syringe and capped the gastrostomy tube. With the same gloves in place and no hand hygiene performed, LPN C adjusted the 4x4 gauze dressing at the gastrostomy site, then adjusted Resident 17's clothing. With the same gloves in use and no hand hygiene, LPN C rinsed out the syringe and placed it back into the cabinet where clean supplies were stored.</p> <p>Interview on 01/15/25 at 8:35 AM with LPN C confirmed that the facility always keeps tube feeding supplies on the floor and that soiled gloves should have been removed and hygiene performed after the keys were touched. LPN C confirmed that the keys would have been considered soiled because they were in a pocket.</p> <p>Interview on 01/15/25 at 02:04 PM with Clinical Care Lead Coordinator (CCLC) confirmed that tube feeding supplies and water should not be stored on the floor and that hand hygiene and a glove change should have been performed after the keys were touched. The CCLC confirmed that the keys would be considered soiled as they were in a pocket.</p>		