STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bloomfield	300 North Second St Bloomfield, NE 68718

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report to the State Agency, complete an investigation and then to submit the investigation within 5 working days an allegation of staff to resident abuse for 1 (Resident 1) of 3 sampled residents. The facility staff identified a census of 30.Findings are: A. Review of the facility's Abuse and Neglect Policy with a reviewed/revised date of 4/7/25 revealed the policy of the facility was to ensure all alleged or suspected violations involving any mistreatment. neglect, exploitation or abuse, including injuries of unknown origin were to be reported immediately to the Administrator or a delegated individual. The purpose of the policy was to:-ensure employees were knowledgeable regarding reporting and investigating the process of abuse and neglect allegations in the facility.-ensure the facility had an effective system in place that, regardless of the source, prevented mistreatment, neglect, exploitation, and abuse of residents and misappropriation of their property. -ensure residents were not subjected to abuse by anyone including but not limited to employees, other residents, consultants, volunteers, employees of other agencies serving the individual, family members, or legal guardians. -ensure all identified events of alleged or suspected abuse/neglect including injuries of unknown origin were promptly reported and investigated. -ensure a complete review by the investigation team to identify events such as suspicious bruising of residents, occurrences that may constitute abuse and determine the direction of the investigation, patterns, and trends.The following process was to be followed:-intervene in any situation to protect the residents.-remove any individual as necessary from the facility if necessary to protect the residents and/or employees. -call local law enforcement for assistance with interventions necessary for the protection of the residents/employees.-the facility was to have evidence that all alleged or suspected violations were thoroughly investigated and were to prevent further potential abuse while the investigation was in progress.-results of all investigations were to be reported to the Administrator or designated representative and to other officials in accordance with state law, including the State Survey and Certification Agency within 5 working days of the event. If the alleged or suspected violation was verified, appropriate corrective action was to be taken. B. Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/26/25 indicated the resident was admitted [DATE] with diagnoses of heart failure, previous stroke, paralysis to one side of his body, sepsis (extreme response to infection leading to widespread inflammation, organ damage and potential organ failure), obstructive uropathy (medical condition where the flow of urine is blocked. causing it to back up and potentially damage the kidneys), anxiety, depression, and diabetes. The assessment identified the resident's cognition was intact, the resident required total staff assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transfers, was frequently incontinent of bowel and had an indwelling urinary catheter (thin tube inserted into the bladder to drain urine continuously into a collection bag). During an interview on 11/25/25 at 10:30 AM with Resident 1 and the resident's spouse the following was identified:-11/5/25 the resident had turned their call light on at 7:00 AM.-Nurse Aide (NA)-D had entered the resident's room, turned the call light off and then exited the room.-the resident turned the call light back on and NA-D returned to the room, shut the call light off and then removed the call light from the resident's reach. -it was a common occurrence for staff to remove the resident's call light from reach whether intentional or not as the resident required almost total assistance of x2 staff with cares and cares took a long time to be completed. -the resident and spouse reported the incident to the facility Administrator. The Administrator indicated staff was counseled after the staff member admitted they had done this. Review of facility investigations of potential abuse/neglect from 9/29/25 to 11/24/25 revealed no evidence Resident 1's allegation of potential staff to resident abuse was reported to the State Agency. In addition, there was no evidence that an investigation was completed by the facility and then submitted within 5 working days. An interview with the Director of Nursing (DON) on 11/24/25 at 11:30 AM confirmed the facility did not report the allegation of potential abuse involving Resident 1, complete and then submit an investigation to the State Agency within the required time frame.

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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)(iii)Based on record review and interview; the facility failed to update Resident 1's comprehensive care plan to reflect the resident's preference for getting up in the morning. The sample size was 3 and the facility census was 30. Findings are:Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/26/25 indicated the resident was admitted [DATE] with diagnoses of heart failure, previous stroke, paralysis to one side of his body, sepsis (extreme response to infection leading to widespread inflammation, organ damage and potential organ failure), obstructive uropathy (medical condition where the flow of urine is blocked. causing it to back up and potentially damage the kidneys), anxiety, depression, and diabetes. The assessment identified the resident's cognition was intact, the resident required total staff assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transfers, was frequently incontinent of bowel and had an indwelling urinary catheter (thin tube inserted into the bladder to drain urine continuously into a collection bag). Review of a Care Conference Progress Note dated 7/9/25 at 11:18 AM revealed the resident and spouse had attended the resident's care plan conference and had identified a preference for the resident to be up and out of bed at 7:00 AM each morning and to be put to bed at 8:30 PM in the evening. Review of the resident's current Care Plan with a revision date of 11/5/25, revealed the resident had an activity of daily living self-care performance deficit related to a previous stroke with weakness, right side paralysis, and weakness. Interventions included to position the resident up in bed with 2 staff and to use the full sling lift for all transfers. Further review of the resident's care plan revealed no evidence the resident's preferences for what time to get up in the morning or for the time the resident preferred to go to bed at night were identified on the care plan. An interview on 11/24/25 at 1:15 PM with the Director of Nursing confirmed the resident's care plan had not been updated regarding the resident's preferences.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(3)Based on observations, record review, and interview; the facility failed to provide timely toileting assistance/incontinence management for Resident 1 who required assistance with activities of daily living. The total sample size was 3 and the facility census was 30. Findings are: Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/26/25 indicated the resident was admitted [DATE] with diagnoses of heart failure, previous stroke, paralysis to one side of his body, sepsis (extreme response to infection leading to widespread inflammation, organ damage and potential organ failure), obstructive uropathy (medical condition where the flow of urine is blocked. causing it to back up and potentially damage the kidneys), anxiety, depression, and diabetes. The assessment identified the resident's cognition was intact, the resident required total staff assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transfers, was frequently incontinent of bowel and had an indwelling urinary catheter (thin tube inserted into the bladder to drain urine continuously into a collection bag). Review of Resident 1's current Care Plan with a revision date of 11/13/25 revealed the resident had an activity of daily living self-care performance deficit related to a previous stroke, right side paralysis, and weakness. The following interventions were identified:-staff to provide assistance with bed mobility, transfers, dressing, toilet use and personal hygiene.-x2 staff to assist with use of the full lift for all transfers. -resident to be transferred onto the commode and then transferred into the bathroom with the commode placed over the toilet for elimination. -resident to be checked and changed every 2 hours when in bed. Observations of Resident 1 on 11/24/25 from 7:00 AM to 10:00 AM revealed the following:-7:00 AM the resident was lying supine in the bed with the resident's call light attached to the resident's chest area. The resident was wearing a mask and was receiving a nebulizer breathing treatment (a medical procedure where a machine turns liquid medication into a fine mist that is inhaled directly into the lungs). -7:15 AM the resident's call light was activated. Interview with the resident revealed the nebulizer treatment was completed and the resident was ready to get up and needed to use the commode for a bowel movement. -7:21 AM Medication Aide (MA)-C entered the resident's room, the call light was turned off, and the breathing treatment was removed. MA-C exited the room without providing assistance with toileting needs. -7:43 AM the resident's call light was again activated and the resident indicated a continued need to use the commode.-8:19 AM (35 minutes and 38 seconds later) Housekeeper (HK)-F entered the resident's room, turned on the overhead lights, and turned off the resident's call light. HK-F reported the direct care staff had requested HK-F turn the resident's call light off and to let the resident know they would be in as soon as possible to assist the resident. -8:21 AM the resident's call light was turned back on. -8:39 AM (18 minutes after the call light was last activated and 1 hour and 24 minutes since the resident first indicated a need for assistance) Nurse Aide (NA)-E and NA-D entered the resident's room and turned off the call light to assist the resident with getting out of bed and with use of the bedside commode. The resident's disposable incontinence brief was soiled with feces. During an interview on 11/24/25 at 10:22 AM, NA-D confirmed the following regarding Resident 1:-the resident's call light was first turned on that morning at 7:15 AM and the resident reported a need to use the commode for a bowel movement.-the resident required 2 staff assist and the full lift for transfers out of bed and onto the commode. -the facility only had x2 direct care staff working 11/24/25. The resident was left until later as staff were assisting other residents with getting ready for breakfast and Resident 1 took a long time with cares. -Resident 1 waited for 1 hour and 24 minutes for staff to assist the resident out of bed and onto the commode.-the resident was involuntarily incontinent of feces by the time assisted the resident with toileting cares.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.04(D)Based on observations, record reviews, and interviews: the facility staff failed to ensure sufficient staff were available to provide timely toileting/incontinence cares for Resident 1 and to respond to call lights within expected timeframes. The total sample size was 3 and the facility census was 30. Findings are: A. Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/26/25 indicated the resident was admitted [DATE] with diagnoses of heart failure, previous stroke, paralysis to one side of his body, sepsis (extreme response to infection leading to widespread inflammation, organ damage and potential organ failure), obstructive uropathy (medical condition where the flow of urine is blocked. causing it to back up and potentially damage the kidneys), anxiety, depression, and diabetes. The assessment identified the resident's cognition was intact, the resident required total staff assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transfers, was frequently incontinent of bowel and had an indwelling urinary catheter (thin tube inserted into the bladder to drain urine continuously into a collection bag). Observations of Resident 1 on 11/24/25 from 7:00 AM to 10:00 AM revealed the following: -7:00 AM the resident was lying in the bed with the resident's call light attached to the resident's chest area. The resident was wearing a mask and was receiving a nebulizer breathing treatment (a medical procedure where a machine turns liquid medication into a fine mist that is inhaled directly into the lungs). -7:15 AM the resident's call light was activated. Interview with the resident revealed the nebulizer treatment was completed and the resident was ready to get up and needed to use the commode for a bowel movement. -7:21 AM Medication Aide (MA)-C entered the resident's room, the call light was turned off, and the breathing treatment was removed. MA-C exited the room without providing assistance with toileting needs. -7:43 AM the resident's call light was again activated and the resident indicated a continued need to use the commode. -8:19 AM (35 minutes and 38 seconds later) Housekeeper (HK)-F entered the resident's room, turned on the overhead lights, and turned off the resident's call light. HK-F reported the direct care staff had requested HK-F turn the resident's call light off and to let the resident know they would be in as soon as possible to assist the resident. -8:21 AM the resident's call light was turned back on. -8:39 AM (18 minutes after the call light was last activated and 1 hour and 24 minutes since the resident first indicated a need for assistance) Nurse Aide (NA)-E and NA-D entered the resident's room and turned off the call light to assist the resident with getting out of bed and with use of the bedside commode. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/24/25 at 10:22 AM, NA-D confirmed the following regarding Resident 1: -had requested with the resident's care plan to be assisted out of bed between 7:00 AM and 7:30 AM each morning. -the resident's call light was first turned on that morning at 7:15 AM and the resident reported a need to use the commode for a bowel movement. -the resident required 2 staff assist and the full lift for transfers out of bed and onto the commode. -the facility only had 2 direct care staff working 11/24/25. The resident was left until later as staff were assisting other residents with getting ready for breakfast and Resident 1 took a long time with cares. -staff were trained to answer resident's call lights within 15 minutes of activation. -Resident 1 waited for 1 hour and 24 minutes for staff to assist the resident out of bed and onto the commode. An interview with Resident 1 and the resident's spouse on 11/24/25 at 10:30 AM revealed the following: -the resident had requested that morning to get up at 7:15 AM and was not assisted out of bed until 8:39 AM. The resident needed to use the bedside commode for a bowel movement and had then been involuntary of bowels due to the length of time the resident waited for assistance. -the resident was commonly left until one of the last residents to get out of bed as the facility frequently did not have enough staff. In addition, it was common for the resident to wait greater than 15 minutes for the residents' call light to be answered. An interview on 11/24/25 at 7:30 AM with Registered Nurse (RN)-B confirmed that there were 2 CNA's working 6 AM to 2:30 PM that day and no bath aide, the facility census was 30. Record review of Resident 1's Device Activity Report (DAR, a report of when call lights are turned on and off) revealed the following dates and times the resident's call light response times exceeded 15 minutes: -10/24/25 the call light was on from 10:03 AM to 10:35 AM (a total of 31 minutes) and from 9:49 PM to 10:10 PM (a total of 21 minutes). -10/26/25 the call light was on from 6:17 AM to 6:39 AM (21 minutes), from 8:12 AM to 8:29 AM (17 minutes), from 9:25 AM to 9:44 AM (19 minutes) and from 7:44 PM to 8:03 PM (a total of 19 minutes). -10/26/25 the call light was activated from 6:17 AM to 6:39 AM (21 minutes), from 8:12 AM to 8:29 AM (17 minutes), from 9:25 AM to 9:44 AM (19 minutes and from 7:44 PM to 8:03 PM (19 minutes). -10/27/25 the call light was activated from 11:15 AM to 11:37 AM (22 minutes). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/28/25 the call light was activated from 10:42 AM to 10:58 AM (16 minutes), from 6:49 PM to 7:11 PM (22 Minutes) and from 8:23 PM to 8:47 PM (a total of 24 minutes).-10/29/25 the call light was activated from 6:12 AM to 6:44 AM (31 minutes), from 7:30 AM to 8:00 AM (30 minutes), from 4:30 PM to 4:54 PM (23 minutes), from 6:39 PM to 7:25 PM (46 minutes) and from 8:19 PM to 8:35 PM (16 minutes). -10/30/25 the call light was activated from 10:04 AM to 10:20 AM (16 minutes). -10/31/25 the call light was activated from 1:24 AM to 1:56 AM (32 minutes), 5:44 AM to 6:29 AM (45 minutes), and from 7:58 PM to 8:21 PM (23 minutes). -11/1/25 the call light was activated from 6:37 AM to 7:24 AM (46 minutes), from 8:03 AM to 8:34 AM (31 minutes), from 9:07 AM to 9:47 AM (40 minutes), and from 10:36 AM to 10:55 AM (a total of 18 minutes). -11/2/25 the call light was activated from 7:17 AM to 7:40 AM (22 minutes), from 8:17 AM to 8:48 AM (30 minutes), from 8:53 AM to 9:40 AM (27 minutes) and from 8:03 PM to 8:23 PM (20 minutes).-11/3/25 the call light was activated from 6:00 AM to 6:45 AM (45 minutes) and from 10:34 AM to 10:51 AM (16 minutes). -11/4/25 the call light was activated from 6:18 PM to 7:51 PM (1 hour and 33 minutes). -11/5/25 the call light was activated from 7:20 AM to 7:45 AM (24 minutes), from 8:49 AM to 9:19 AM (30 minutes) and from 8:22 PM to 8:38 PM (16 minutes). B. Review of the facility policy Call Light with a revision date of 7/8/25 revealed when a resident's call light was observed or heard staff were to respond to the call light promptly. C. Review of the facility's call light activity report from 10/22/25 to 11/5/25 revealed the following call light response times that took more than 15 minutes to be answered: -On 10/24/25 there were 9 times that ranged from 17 minutes to 55 minutes. -On 10/25/25 there were 19 times that ranged from 16 minutes to 49 minutes. -On 10/26/25 there were 22 times that ranged from 16 minutes to 48 minutes. -On 10/27/25 there were 21 times that ranged from 16 minutes to 32 minutes. -On 10/28/25 there were 15 times that ranged from 16 minutes to 94 minutes. -On 10/29/25 there were 21 times that ranged from 16 minutes to 127 minutes. -On 10/30/25 there were 15 times that ranged from 16 minutes to 65 minutes. -On 10/31/25 there were 17 times that ranged from 16 minutes to 45 minutes. -On 11/1/25 there were 21 times that ranged from 17 minutes to 51 minutes. -On 11/2/25 there were 23 times that ranged from 16 minutes to 138 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/3/25 there were 15 times that ranged from 16 minutes to 45 minutes. -On 11/4/25 there were 16 times that ranged from 16 minutes to 105 minutes. -On 11/5/25 there were 14 times that ranged from 16 minutes to 40 minutes. An interview with the Director of Nursing on 11/24/25 at 12:10 PM confirmed that call lights were to be answered in 15 minutes and there were call lights that did not get answered timely in the facility. D. Review of the facility's nursing schedule from 10/22/25 to 11/5/25 revealed the following: -On 10/22/25 there were 3 CNA's from 6 AM to 2:30 PM, -On 10/25/25 (Saturday) there were 2 CNA's from 6 AM to 2:30 PM, -On 10/26/25 (Sunday) there were 2 CNA's from 6 AM to 2:30 PM, -On 10/28/25 from 10 PM to 6:30 AM there was 1 CNA for 8 hours and 1 CNA for 4 hours, -On 10/29/25 there were 3 CNA's from 6 AM to 2:30 PM, and -On 11/2/25 there was 1 CNA from 6 PM to 10 PM and 1 CNA from 10PM to 6:30AM. An interview with the DON on 11/24/25 at 1:15 PM confirmed the following numbers of Certified Nursing Assistants should be scheduled: -Monday through Friday 6 AM to 2:30 PM 4 Certified Nursing Assistants (CNA's), -Saturday and Sunday 6 AM to 2:30 PM 3 CNA's, -from 2:00PM to 10:30 PM there should be 2-3 CNA's, and -from 10:00PM to 6:30 AM 2 CNA's were to be scheduled.

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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 12-006.18(B)&(C) Based on observations, record review, and interview; the facility failed to complete hand hygiene at appropriate intervals during the provision of cares and to provide care and management of Resident 1's indwelling urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) to prevent the potential for cross contamination and urinary tract infections. The sample size was 3. In addition, the facility failed to prevent the potential spread of COVID-19 related to failure to test staff who displayed signs and symptoms of COVID-19, this had the potential to affect all residents. The facility census was 30. Findings are: A. Review of the facility policy titled Handwashing/hand hygiene revised on 1/30/25 revealed the facility considered hand hygiene the primary means to prevent the spread of infection. The policy indicated staff were to wash hands with an antimicrobial or a non-antimicrobial soap and water when hands were visibly soiled and after contact with a resident with infectious diarrhea. An alcohol-based hand rub containing at least 62% (percent) alcohol or soap and water could be used for the following situations: -before and after direct contact with residents; -before donning gloves; -before and after handling an invasive device; -after contact with bodily fluids; and -after removing soiled gloves. B. Review of the facility policy Catheter Care with a revision date of 4/6/25 revealed the following policies: -indwelling catheters were to be changed only when necessary and were to be connected to closed drainage systems. -all closed collection systems that become contaminated by inappropriate techniques, leaks, or other means are to be immediately replaced. -every effort was to be made to keep the resident's catheter bag covered or out of sight. -catheters are always properly secured, connected, and maintained using a sterile closed drainage system. -catheter tubing should never be allowed to touch the floor. -always make sure the drainage bag and tubing remain below the level of the catheter and bladder and coil tubing to promote drainage. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	C. Review of Resident 1's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/26/25 indicated the resident was admitted [DATE] with diagnoses of heart failure, previous stroke, paralysis to one side of his body, sepsis (extreme response to infection leading to widespread inflammation, organ damage and potential organ failure), obstructive uropathy (medical condition where the flow of urine is blocked. causing it to back up and potentially damage the kidneys), anxiety, depression, and diabetes. The assessment identified the resident's cognition was intact, the resident required total staff assistance with toileting hygiene, dressing, personal hygiene, bed mobility and transfers, was frequently incontinent of bowel and had an indwelling urinary catheter (thin tube inserted into the bladder to drain urine continuously into a collection bag). During an observation of Resident 1's catheter care and management and toileting/incontinence cares on 11/24/25 from 8:40 AM to 10:00 AM the following was observed: -8:43 AM Nurse Aide (NA)-E entered the resident's room and failed to complete hand hygiene before putting on a disposable gown and a pair of gloves. -8:51 AM NA-D after completing hand hygiene, placed on a gown and gloves, removed the urinary catheter drainage bag from the side of the resident's bedframe, and threaded the drainage bag through the leg opening of the resident's shorts. The drainage bag was then laid directly on the resident's bed linens. The drainage bag was not below the level of the resident's bladder. -8:59 AM NA-D and NA-E positioned the sling for the full lift under the resident and attached the sling to the lift. The staff removed the drainage bag from the bed and attached it to the lift next to the sling strap above the level of the bladder and above the resident's head. Resident 1 was transferred from the bed and was positioned on the bedside commode (a piece of furniture which functions as a toilet with a toilet seat and a hole which can be placed over a toilet or has a bucket beneath the hole for collecting waste). When staff removed the catheter drainage bag and the lift straps from the lift, NA-D hung the drainage bag directly from the seat of the commode. NA-D removed soiled gloves but failed to complete hand hygiene before placing on a clean pair of gloves. The commode chair was pushed into the bathroom and positioned over the toilet. -9:10 AM the resident was involuntary of loose feces which was observed on the disposable incontinence brief and on the resident's mattress. NA-E used pre-moistened cleansing cloths to clean the mattress, removed gloves, and failed to complete hand hygiene before placing on a clean pair of gloves. -9:22 AM the resident indicated completion of toileting and staff pulled the commode chair out of the bathroom and into the center of the resident's room. NA-D used several pre-moistened cleansing cloths to cleanse stool from the resident's buttocks. When care was completed, NA-D removed gloves but failed to complete hand hygiene before putting on a new pair of gloves. -9:28 AM the lift was positioned in front of the resident on the commode chair and the sling was attached to the lift bar above the resident's head. NA-D removed the catheter drainage bag from the seat of the commode chair and attached the bag to the lift by the sling above the level of the resident's head and/or bladder. The resident was transferred back into the bed, the lift was removed, and the urinary catheter drainage bag was placed directly back onto the bed linens. -9:35 AM staff completed incontinence/catheter cares as the resident was lying in bed. Staff continued to remove feces from the resident's buttocks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285156	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Bloomfield	300 North Second St Bloomfield, NE 68718

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-when cares were completed, staff removed gloves, completed hand hygiene, and placed on clean gloves. -9:49 AM the resident was again attached to the lift with the catheter bag removed from the bed linens and placed on the lift above the resident's head. The resident was transferred into the recliner and the lift was removed with the urinary catheter drainage bag placed inside of a privacy bag and hung next to the recliner on the drawer of a dresser, below the level of the resident's bladder. An interview with the Registered Nurse (RN)-G on 11/24/25 at 11:00 AM confirmed the staff were to perform hand hygiene whenever removing soiled gloves and before putting on clean gloves. In addition, RN-G confirmed staff should not have placed the resident's urinary catheter drainage bag directly on the resident's bed linens and the drainage bag should not have been positioned above the resident's head and above the level of the resident's bladder when transferring the resident with the lift. D. Review of the Skilled Nursing Facility Covid-19 Work Guidelines with a reviewed date of October 2025 revealed the following; -Symptomatic employees were to be restricted from the workplace until Covid-19 infection was ruled out by testing. E. An observation of the Director of Nursing (DON) on 11/24/25 at 7:30 AM revealed the DON had a blue mask on, voice was hoarse and cough was noted. An interview with the DON on 11/24/25 at 7:45 AM revealed that the DON had not completed a Covid-19 test and was not going to complete one. An interview with Registered Nurse (RN)-B on 11/24/25 at 1:45 PM confirmed that the facility does not test staff or residents when presenting with respiratory symptoms or increased temperature.