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	07/09/2024

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 29638 Licensure Reference Number 175 NAC 12-006.06 Based on record review and interviews; the facility failed to address repeat grievances, and to ensure sustainable resolutions of concerns related to the provision of cares and activities for Resident 21. The sample size was 1 and the facility census was 24. Findings are: Review of the facility's Grievances, Suggestions and Concerns Policy with a revision date of 11/14/23 revealed the purpose of the policy was to document concerns, investigative findings, and plans of correction and to develop a systematic approach in resolving grievances as a tool to ensure continuous quality of care. The following procedure was identified: -a grievance was to be documented and then submitted to the grievance official Social Service Director (SSD), -the grievance official was to route the grievance to the appropriate department manager as soon as reasonably possible, -an investigation was to be completed for all grievances. The investigation could be informal, but it was to be thorough, -the grievance official was to issue a written grievance decision to the individuals filing the concern and to the Administrator. The decision needed to include the date the grievance was received, a summary statement of the grievance, the steps taken to investigate the grievance, a summary of pertinent findings or conclusions, a statement whether the grievance was confirmed or not, any corrective action because of the grievance and the date the written decision was issued, and -if the individual was not satisfied with the response and/or resolution to the grievance, the Administrator was to be notified. Review of a Suggestion/Concern/Grievance form dated 8/22/23 revealed Resident 21's family had the following concerns: -oral cares were not completed, (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-towels/wash cloths were rarely use in the resident's bathroom, -the resident's fall alarm had been left unplugged from 8/19/23 to 8/23/23, and -the resident was not being toileted before the breakfast meal. Further review of the form revealed a resolution dated 8/31/23 for training and education to be provided to the direct care staff regarding these concerns. In addition, documentation dated 9/5/23 revealed the family had no further concerns. Review of a Suggestion/Concern/Grievance form dated 8/28/23 revealed Resident 21's family did not feel the resident was receiving the needed assistance with the resident's meals. A resolution dated 9/5/23 revealed the Director of Nursing (DON) was to ensure the resident received adequate assistance at mealtimes. A resolution dated 9/5/23 revealed no further concerns. Review of a Suggestion/Concern/Grievance form dated 11/1/23 revealed family did not feel Resident 21 was receiving 1:1 activity on a weekly basis as documented in the resident's Care Plan. A resolution dated 11/1/23 revealed the resident's 1:1 activity would be increased to 2-3 times a week. Staff documented on 11/8/23 the family was happy with this resolution. Review of a Suggestion/Concern/Grievance form dated 11/11/23 revealed Resident 21's family came to the facility to assist the resident with eating the breakfast meal. The family found a room tray from the previous evening left uncovered on a bedside table in the resident's room. Family was upset as the resident had been losing weight and it did not seem as if staff were providing assistance to the resident with eating/drinking. 11/14/23 a documented resolution revealed staff had received re-education regarding the need to assist residents with intakes especially when having weight loss. 11/30/23 the Administrator and the SSD followed up with the family and they indicated they were happy with resolution. Review of a facility document labeled Education/Counseling dated 11/30/23 revealed 3 staff, Nurse Aides (NAs)-C, E and Q received education regarding accurate documentation of a nutritional supplement, checking/changing and toileting residents every 2 hours and making sure all residents were toileted when they were provided morning cares, and before/after each meal. Review of a Documentation Survey Report (form used to document the resident's participation in activities) from 11/1/23 to 11/30/23 revealed Resident 21 received no 1:1 activity during this time frame. Review of a Documentation Survey Report from 12/1/23 to 12/31/23 revealed the resident received a 1:1 activity on only 1 day, 12/23/23. Review of a Suggestion/Concern/Grievance form dated 1/31/24 revealed Resident 21's family were concerned the resident's fall alarm was not being plugged in; the resident was not being toileted every 2 hours; and the resident's nutritional supplement was not documented correctly. 2/7/24 the nursing staff were educated regarding proper use of the fall alarms, documentation of nutritional supplements and toileting schedules. 2/15/24 the family indicated no further concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Documentation Survey Report from 1/1/24 to 1/31/24 revealed Resident 21 received no 1:1 activity during this time frame. Review of a Documentation Survey Report from 5/1/24 to 5/31/24 revealed Resident 21 received a 1:1 activity on only 1 day, 5/9/24. Review of a Documentation Survey Report from 6/1/24 to 6/30/24 revealed Resident 21 received no documented 1:1 activity during this time frame. During interviews on 7/2/24 at 2:20 PM and on 7/3/24 at 1:44 PM, Resident 21's family reported continued concerns related to 1:1 activity provision, assistance with food/fluids at meals, toileting assistance, oral cares, and repositioning. Interview with the DON and the Administrator on 7/8/24 at 2:57 PM verified no further documentation other than the counseling provided to staff on 11/30/23 that direct care staff had received re-education regarding the provision of cares for Resident 21 to address the family's ongoing concerns. Interview with the SSD on 7/9/24 at 10:03 AM confirmed there was no evidence additional 1:1 activity was provided for Resident 21 despite the family's continued concerns.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 29638 Licensure Reference Number: 175 NAC 12-006.04(F)(i)5 Based on record review and interviews; the facility failed to notify Resident 21's family/responsible party of changes in the resident's condition related to weight loss and the initiation of nutritional interventions to address weight loss. The sample size was 1 and the facility census was 24. Findings are: A. Review of the facility policy Notification of Change with revision date of 12/4/23 revealed the facility was to monitor residents for changes in their condition, to respond appropriately to these changes and to notify the physician and the responsible party/family members of the changes. B. Review of Resident 21's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 4/10/24 revealed diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, and depression. The resident required substantial to moderate assistance with dressing, personal hygiene, bed mobility and transfers and was dependent with oral and toileting hygiene; was incontinent of bowel and bladder; and cognition was severely impaired. Review of Resident 21's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed the following regarding the resident's weights: -9/7/23 weight was 132 pounds (lbs.). -11/13/23 weight was 118 lbs. (down 14 lbs. or an 11% weight loss in 2 months). Review of Resident 21's Nursing Progress Note dated 11/15/23 at 3:42 PM revealed the resident's Primary Care Physician (PCP) was notified of the resident's substantial weight loss and that Magic Cup (nutritional supplement which was like ice cream when frozen and was like pudding when refrigerated) was started to prevent further weight loss. Review of Resident 21's medical record revealed no evidence the resident's responsible party/family had been notified of the resident's weight loss or of the initiation of the Magic Cup nutritional supplement. Review of Resident 21's Nursing Progress Note dated 11/28/23 at 6:37 PM revealed a new order to change the resident's diet to soft, bite sized food. Review of Resident 21's medical record revealed no evidence the family/responsible party was notified of the resident's diet change. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's Nutritional Progress Note by the Registered Dietician dated 12/22/23 at 9:04 AM revealed the resident had an open area to the resident's coccyx and made a recommendation to start Arginaid (nutritional supplement with added protein for wound healing) 240 cubic centimeters (cc) daily. Review of Resident 21's Progress Note dated 2/3/24 at 1:26 PM revealed a new order to discontinue use of the Magic Cup nutritional supplement as it was no longer available from the supplier. Review of Resident 21's Medication Administration Record (MAR) dated 6/2024 revealed the resident was re-started on the Magic Cup 6/18/24 to maintain the resident's weight. Review of Resident 21's medical record from 12/22/23 to 6/20/24 revealed no evidence the family/responsible party was notified of: -initiation of the Arginaid on 12/23/23, -discontinuation of the Magic Cup on 2/3/24, and -re-starting of the Magic Cup on 6/18/24 to maintain the resident's weight. During an interview on 7/3/24 at 1:44 PM, Resident 21's family member reported a concern regarding lack of notification related to the resident's weights and weight loss interventions to maintain the resident's weight. Interview with the Director of Nursing (DON) on 7/8/24 at 9:58 AM confirmed staff should have notified Resident 21's responsible party/family of the resident's significant weight loss on 11/13/23, initiation of the Magic Cup on 11/15/23, change in diet order on 11/28/23, starting the Arginaid on 12/22/23 for wound healing, discontinuation of the Magic Cup on 2/3/24 and the re-starting of the Magic Cup on 6/18/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.09D7 Based on observations, interview, and record review; the facility failed to identify causal factors and to revise and/or develop fall interventions to prevent ongoing falls for Residents 79, 25, and 6 and to implement fall interventions for Resident 6. The sample size was 4 and the facility census was 24. Findings are: A. Review of the facility policy Fall Prevention and Management last reviewed on 4/2/24 revealed the following: -the facility would care plan the appropriate interventions, -communicate fall risks and interventions to prevent a fall before it occurred, care plan it, add to the daily standup meetings and/or fall committee meetings, -communicate any identified environmental changes and/or referral needs, -if any teaching was done, it would be documented in the medical record, -fall occurrences would be communicated during shift change and daily stand-up meetings, -care plans would be updated with any changes and new interventions, and -the effectiveness of interventions would be monitored. B. Review of Resident 6's Minimum Data Set (MDS), a federally mandated assessment tool used in care planning, dated 5/31/24 revealed the following: - the resident admitted on [DATE], - the resident had diagnoses of: depression, arthritis, and epilepsy (seizure disorder), - the resident was severely cognitive impaired, - the resident was dependent with toileting, and required substantial assistance with dressing, hygiene, and transfers, and - the resident had 1 fall with no injury. Review of Resident 6's Care Plan last revised 6/9/24 revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the resident had impaired cognitive function related to a genetic disability, -the resident required assistance with transfers, dressing, toilet use and personal hygiene, and -fall interventions included: education to family, ensure resident was wearing appropriate footwear, avoid clothing that was a fall risk such as loose, slippery, and too long, review bowel and bladder continence, and establish a toileting plan. Review of Resident 6's nursing order administration record for July 2024 revealed the resident had an order implemented on 6/14/24 for a pull tab alarm on their recliner/wheelchair and staff were to check the function every shift. The alarm was documented as on and functioning normally July 1, 2024 through July 8, 2024. Review of the facility form Incident Reports for Resident 6 regarding falls revealed the following: -5/27/24 at 4:15 AM the resident had a fall while attempting a self-transfer with no long-term intervention implemented, -6/8/24 at 3:45 PM the resident had a fall where the resident was found on the floor in their room with no long-term intervention implemented, -6/14/24 at 4:20 PM the resident slid out of the recliner and was found on the floor in the resident room with no intervention implemented (this report was not fully completed or signed), -6/16/24 at 6:00 PM the resident was found on the floor in the resident's room, the pull tab alarm was not hooked up and an intervention to toilet at 4 PM had been implemented, -6/23/24 at 10:30 AM the resident was found in the dining room on the floor after reaching for an item, the report did not indicate whether the alarm was on and functioning, and no long-term intervention had been implemented, and -7/6/24 at 4:05 PM the resident had a fall while attempting a self-transfer, the resident's pull alarm had been removed and no long-term intervention had been implemented. Observation on 7/3/24 at 11:30 AM with Nursing Assistant (NA)-E revealed Resident 6's pull tab alarm was on the recliner and not hooked up to the resident. NA-E assisted the resident to the bathroom, and when finished NA-E did not secure the alarm to the resident. The resident self-propelled the wheelchair independently out of the resident's room. Observation on 7/3/24 at 11:40 AM revealed Resident 6 was self-propelling their wheelchair to the dining room. There was no alarm in place. Observation on 7/3/24 at 2:40 PM revealed Resident 6's pull tab alarm remained on the resident's recliner in the resident's room. The resident was in the commons area and no alarm was in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/3/24 at 2:42 PM with Registered Nurse (RN)-D confirmed Resident 6 was to have an alarm in place when in the recliner and in the wheelchair. Further interview confirmed the resident did not have an alarm on. Observation on 7/8/24 at 10:35 AM revealed Resident 6's pull tab alarm was in the resident's room on the resident's recliner. The resident was in their wheelchair in the dining room working on a puzzle with no alarm in place. Interview on 7/8/24 at 10:35 AM with Licensed Practical Nurse (LPN)-H confirmed the resident had an order for a pull tab alarm in the recliner and in the wheelchair. Further interview confirmed the resident did not have the alarm in place. Interview on 7/8/24 at 10:40 AM with the Director of Nursing (DON) confirmed the resident should always have the pull tab alarm on when in the recliner and in the wheelchair. Further interview at 12:33 PM confirmed interventions had not been implemented to prevent future falls. C. Review of Resident 25's MDS dated [DATE] revealed the following: - the resident admitted on [DATE], - the resident had diagnoses of: dementia, high blood pressure, atrial fibrillation (irregular heartbeat), and kidney disease, - the resident had severe cognitive impairment, - the resident was dependent with toileting, dressing, transfers, and hygiene needs, and - the resident had 2 or more falls with no injuries. Review of Resident 25's Care Plan last revised 5/31/24 revealed the following: - the resident had impaired cognitive function related to dementia, - the resident required assistance with transfers, toileting, and dressing, - the resident had a personal alarm to alert staff of ambulation attempts, and - the resident's fall interventions included: ensure the resident was wearing appropriate footwear, avoid clothing that is too loose, personal alarm in bed, wheelchair, and recliner. Review of the facility form Incident Reports regarding Resident 25's falls revealed the following: -5/31/24 at 8:35 PM the resident had a fall while attempting to self-transfer out of the recliner with no long-term intervention implemented, -6/10/24 at 9:45 PM the resident had a fall while attempting to self-transfer to the toilet with no long-term intervention implemented, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/12/24 at 10:20 AM the resident had a fall while attempting to self-transfer with no long-term intervention implemented, and -6/16/24 at 8:50 PM while attempting to self-transfer the resident slid out of the wheelchair with no long-term intervention implemented. Interview with the DON on 7/8/24 at 12:33 PM confirmed interventions were not implemented for Resident 25 to prevent future falls. 29638 D. Review of Resident 79's MDS dated [DATE] revealed the following: - the resident had diagnoses of a hip fracture, arthritis, and anxiety, - the resident required substantial assistance with toileting, bed mobility and transfers, and - the resident had moderate cognitive impairment. Review of Resident 79's current Care Plan dated 11/1/23 revealed the resident was at risk for falls related to a previous fall at home and a subsequent hip fracture. The following fall interventions were identified: -educate/instruct the resident on safe use of assistive devices, -remind the resident not to bend over to pick items up from the floor, -ensure use of appropriate footwear, and -avoid clothing which increases risk of falls. Review of facility Incident Reports for Resident 79 regarding falls revealed the following: -11/7/23 at 11:25 PM the resident was found on the floor of the resident's room. The resident had attempted to self-transfer and fell . A new intervention for a pull tab alarm to be always on the resident. -11/13/23 at 11:20 AM the resident was found on the floor in the corridor outside of the resident's room. Further review of the report revealed no causal factors were identified, there was no documentation to indicate if the pull tab alarm was in place and/or functioning and current fall interventions were not revised or new interventions developed. -11/25/23 at 2:15 PM the resident was found on the floor of the resident's room. Staff were to monitor the resident for the remainder of the shift for any changes. No causal factors were indicated, there was no evidence the pull tab alarm was in place or if the alarm was functional. No long-term interventions were developed to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/6/23 at 11:50 AM the resident was found on the floor of the resident's room. The assessment made no mention as to whether the resident's pull tab alarm was in use. A new intervention for a silent fall alarm was established. -12/8/23 at 9:15 PM the resident was found on the floor in the doorway of the bathroom. No causal factors were indicated, and the staff failed to document if the pull tab alarm and/or the silent alarm were in use at the time of the fall. No additional interventions were identified. -12/14/23 at 1:11 PM the resident was found on the floor of the resident's room. The resident had slid off the footrest of the recliner. The fall alarms were in place and were sounding. The resident was wearing a regular pair of socks and staff indicated a new intervention for gripper socks. -12/27/23 at 6:20 PM the resident was found on the floor of the corridor. The resident was in the wheelchair and leaned forward, falling out of the chair, and triggering the fall alarms. Staff identified an intervention to place the resident in the recliner or in the bed if the resident was having increased restlessness and to not leave the resident in the wheelchair. -1/6/24 at 6:15 PM the resident was found on the floor of the resident's room. The resident had slipped out of the recliner. No causal factors were indicated, and the staff failed to document if the pull tab alarm and/or the silent alarm were in use at the time of the fall. A new intervention was indicated for the staff to place the resident in a recliner in the commons/television room for increased supervision. -1/9/24 at 5:20 AM the resident had been found on the floor of the commons/television area. The report identified the resident's alarms were in place, however, did not alarm. Further review revealed no evidence an investigation was completed to determine why the alarms did not sound and no new interventions were developed. An interview with the DON on 7/8/24 at 10:01 AM, confirmed the following for Resident 79: -11/7/23 a pull tab alarm was placed on the resident for fall prevention. -the resident had falls on 11/13/23 at 11:20 AM, on 11/25/23 at 2:15 PM, and on 12/8/23 at 9:15 PM. No causal factors were identified. there was no evidence the pull tab alarm was in place and there were no additional interventions identified to prevent ongoing falls. -the resident had a fall on 1/6/24 at 6:15 PM. No causal factors were identified, and staff failed to document if fall alarms were in place and functional at the time of the fall. -the resident had a fall on 1/9/24 at 5:20 AM. The pull tab and silent alarms were in place at the time of the fall, but they did not alarm. There was no investigation to determine why the alarms had malfunctioned and no new fall interventions were developed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 29638 Licensure Reference Number 175 NAC 12-006.12(D) Based on observation, interview and record review, the facility failed to ensure 4 residents' (Residents 6, 8, 17, and 83) medications had a record of accounting to prevent loss or theft of medications while awaiting disposition. The sample size was 4 and the facility census was 24. Findings are: A. Review of the undated facility policy Medication: Disposition with a revised dated of 8/1/23 revealed the purpose of the policy was to ensure accurate disposal of medications and provided instruction for the disposition of medications. The following procedures were identified: -physician orders to discontinue medications were to be recorded and the medication immediately removed from the resident's supply, -discontinued medications were to be kept in a secure place in the medication room until returned to the pharmacy or destroyed, -disposal of any medication was to be carried out in accordance with local, state, and federal guidelines, and -documentation of medications to be returned to the pharmacy or destroyed was to include the resident's name, medication name, prescription number, quantity, date of disposition and the involved staff member or applicable individuals. B. An observation of the medication storage room on 07/08/24 at 10:09 AM revealed a locked cabinet drawer which was unlabeled, and which contained 5 medications stored inside. Interview on 07/09/24 at 10:15 AM with Licensed Practical Nurse (LPN)-H revealed the medications were awaiting destruction. Further observation on 07/08/24 at 10:20 AM of the medication room revealed no evidence of record keeping/accounting for each medication stored in the drawer and awaiting destruction. Interview with Registered Nurse (RN) Consultant-P on 07/08/24 at 10:30 AM confirmed there was no documentation related to medications which had been discontinued and were to be destroyed for the following residents and medications: -Resident 6 (Erythromycin ophthalmic ointment (medication used to treat infections of the eye) and Moxifloxacin (medication used to treat a bacterial infection) solution 0.5 percent), -Resident 8 (Naphcon A (medication used to treat allergies) ophthalmic drops). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In addition, the RN Consultant-P confirmed the residents' medications were at risk of potential loss or theft without the required documentation and should have included the residents' name, date, medication name, dosage, and quantity of each medication, -Resident 17 Ativan (medication used to treat anxiety) 2 milligrams per milliliter, and -Resident 83 Lorazepam (medication used to treat anxiety) 2 milligrams per milliliter. In addition, the RN Consultant-P confirmed the residents' medications were at risk of potential loss or theft without the required documentation and should have included the residents' name, date, medication name, dosage and quantity of each medication.