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	07/01/2025

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

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview; the facility failed to have documented clinical rationale for not completing Gradual Dose Reductions (GDR)'s for Residents 13 and 18 Psychotropic (drugs that affect the mind, emotions, and behavior) medications. The sample size was 5 and the facility census was 29. Findings are: A. Review of the facility policy Psychotropic Medications with a revision date of 5/12/25 revealed the following: -The facility evaluated behavior interventions before using psychotropic medications and eliminated unnecessary psychotropic medications. The residents would be free from chemical restraints imposed for purposes of discipline or convenience or not required to treat the residents' medical symptoms. -Resident were not given psychotropic drugs unless the medication was necessary. -Residents who used psychotropic medications received gradual dose reductions unless clinically contraindicated, in an effort to discontinue the medications. -A consent form must be signed for the use of psychotropic medications. -The use of as needed psychotropic medications was not encouraged, and the facility ensured clear parameters, and a clear duration for use beyond 14 days. -Mood and behavior documentation was completed to monitor the effects of the psychotropic medication. -Gradual dose reductions were completed in accordance with federal regulations. -The facility psychotropic medication reduction committee reviewed the need for psychotropic medications at least every 3 months and documented the rationale for continuing the medication. -The purpose of tapering medication was to find an optimal dose or to determine if continued use of the medication was a benefit to the residents. (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Within the first years a resident admitted taking psychotropic medication or after the location had initiated the medication a gradual dose reduction was attempted unless clinically contraindicated. Dose reductions were attempted or must be clinically contraindicated annually. Review of the undated facility policy Medication Regimen Review revealed the following: -The Medication Regimen Review (MRR) was a thorough process of review and assessment conducted by a consultant pharmacist of the medications ordered for each resident with a goal of promoting positive outcomes and minimizing adverse consequences associated with medications. -The process occurred at least monthly for each resident. -Findings and recommendations were reported to the facility Administrator, Director of Nursing (DON), the Attending Physician and or Medical Director as it applied. -The Consultant Pharmacist utilized federally mandated standards of care, in addition to other applicable standards. -Concerns and irregularities identified were forwarded to the Administrator, DON and Attending Physician. -The facility notified and obtained responses from the Attending Physicians in a timely manner. B. Review of Resident 13's Care Plan with a revision date of 5/27/25 revealed the resident had impaired cognition, dementia, and impaired thought processes. In addition, the resident had anxiety, depression and behavioral symptoms related to psychosis such as pinching, hitting and biting the staff. The resident was taking the antipsychotic medication Seroquel. Review of Resident 13's Medication Administration Record (MAR) dated June 2025 revealed the resident took the antipsychotic medication Seroquel 12.5mg one time daily for abuse behaviors related to psychosis and the antidepressant medication Paroxetine 20mg daily. Review of Resident 13's Note to Attending Physician/Prescriber dated 5/8/25 revealed the Consultant Pharmacist requested a review for dosage reduction, and the provider on 6/23/25 responded by indicating No however did not document a clinical rationale as to why a reduction was contraindicated. During an interview on 6/26/25 at 12:29 PM Register Nurse (RN)-A confirmed the facility had not addressed pharmacist requests for gradual dose reductions of Resident 13's Seroquel and Paxil that was dated 5/8/25 until 6/23/25 (45 days) and when the provider addressed the request for review, no clinical contraindication to reduce the doses were documented. C. (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 18's Care Plan with a revision date of 1/21/25 revealed the resident had sleep disturbance related to sleep apnea and insomnia and took the medications Melatonin (naturally occurring hormone supplement that affects sleep and wake cycles) and Trazadone (antidepressant medication) to help with nighttime sleeping. Review of Resident 18's MAR dated June 2025 revealed the resident took the antidepressant medication Trazadone 100mg daily at bedtime and the supplement Melatonin 10mg daily at bedtime. Review of Resident 18's Note to Attending Physician/Prescriber dated 6/7/25 generated by the consultant pharmacist indicating the resident's Trazadone was due to be reviewed for a dosage reduction. On 6/23/25 the Provider indicated No to the dosage reduction but did not document a clinical rationale for not attempting to reduce the dose. During an interview on 6/26/25 at 12:29 PM RN-A confirmed the pharmacist recommendation for review of Resident 18's Trazadone that was dated 6/7/25 and signed by the provider on 6/23/25, addressed the request for review, however, no clinical rationale to not reduce the dose was documented.

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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 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. Licensure Reference Number 175 NAC 12-006.09D Based on interview and record review; the facility failed to ensure practitioner's orders were followed for 1 (Resident 25) of 1 sampled resident. The facility identified a census of 29. Findings are: Review of the facility policy Medication Administration with a revision date of 4/8/25 revealed if a medication was not available for 24 hours, the practitioner was to be notified the medication was not available and the staff were to be given directions for how to proceed. If the resident chose not to take the medication, this should be reported to the charge nurse and documented on the Medication Administration Record (MAR). The practitioner should also be notified if the resident continues to choose not to take the medication for more than 3 doses so that the prescriber can consider an alternative. Review of Resident 25's Medication Administration Record (MAR) dated 5/2025 revealed an order dated 4/25/25 for Yupelri (a medication which is used in the treatment of respiratory disease by relaxing the muscles around the airways in the lungs to make it easier to breath) Inhalation Solution 175 micrograms (mcg)/3 milliliters (ml) once daily for treatment of shortness of breath. Further review of the MAR revealed the medication was not available and had not been administered from 5/14/25 to 5/31/25 (18 out of the 31 days the medication was to have been received). Review of the resident's electronic medical record revealed no evidence the resident's practitioner was aware the Yupelri Inhalation Solution had not been available and had not been administered to the resident from 5/14/25 to 5/31/25. In addition, there was no documentation to indicate an alternate treatment/medication was provided for the resident. Further review of the resident's MAR dated 5/2025 revealed the resident had an order dated 4/23/25 for Novolog (rapid-acting insulin used to manage blood sugar levels in residents with diabetes) to inject 5 units before meals and at bedtime. From 5/3/25 to 5/12/25 the resident refused the scheduled Novolog insulin on 5/3 at 4:00 PM, 5/4 at 4:00 PM, 5/5 at 7:00 AM, at 11:00 AM, at 4:00 PM and at 9:00 PM, 5/6 at 7:00 AM, 11:00 AM and at 9:00 PM, on 5/7 at 7:00 AM, 11:00 AM. 4:00 PM, and 9:00 PM, 5/8 at 7:00 AM, 11:00 AM, 4:00 PM and 9:00 PM, 5/9 at 7:00 AM, 4:00 PM and 9:00 PM, on 5/11 at 9:00 PM and on 5/12 at 7:00 AM, 11:00 AM, 4:00 PM and at 9:00 PM (a total of 25 doses). Review of the resident's electronic medical record from 5/3/25 to 5/11/25 revealed no evidence the practitioner was aware of the resident's multiple refusals of the Novolog insulin. In addition, there was no documentation to indicate an alternate treatment was provided for the resident. Review of the Resident's MAR dated 6/2025 revealed the resident had an order dated 4/23/25 for Oxycodone (opioid analgesic used for treatment of moderate to severe pain) 5 milligram (mg) once in the AM and once in the PM. Further review of the MAR revealed the resident had refused the AM oxycodone dose from 6/1 to 6/6, from 6/9 to 6/15, from 6/18 to 6/20, on 6/23 and 6/24 and from 6/26 to 6/28 (a total of 21 out of 30 doses). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic medical record from 6/1/25 to 6/30/25 revealed no evidence the practitioner was aware of the resident's multiple refusals of the Oxycodone and that an alternate treatment/medication was ordered. During interviews on 7/1/25 at 7:11 AM and at 8:35 AM with the resident and the resident's spouse the following was identified. -the resident's Yupelri Inhalation Solution had not been available from the pharmacy and the resident was never offered any alternate treatment option. -the resident had been at home prior to the resident's admission to the facility on 4/23/35. While at home the resident only took the Novolog insulin with sliding scale (diabetes management method where the amount of insulin administered changes based on a person's current blood sugar level) to keep the resident's blood sugar from getting too low. -the resident had been refusing the AM dose of the Oxycodone as it made the resident too sleepy to participate in therapy or to visit with spouse. The resident was not offered any alternative pain medication. An interview with the Director of Nursing on 7/1/25 at 8:38 AM confirmed the resident had not received the Yupelri Inhalation therapy, the scheduled dose of Novolog insulin and the scheduled doses of Oxycodone as ordered by the resident's physician.

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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** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on record review and interviews; the facility failed to evaluate pressure ulcers (localized injury to the skin and underlying tissue, typically caused by prolonged pressure on the skin), to monitor interventions to ensure healing and to prevent the development of further pressure ulcers for 1 (Resident 21) of 3 sampled residents. The facility staff identified a census of 29. Findings are: Review of the facility policy Skin Assessment, Pressure Ulcer Prevention and Documentation with a revision date of 4/6/25 revealed the purpose of the policy was to systematically assess residents regarding potential risk of skin breakdown, to accurately document observations and assessments of residents, and to appropriately use prevention techniques and pressure re-distribution surfaces on those residents at risk for pressure ulcers. The following procedures were identified: -all residents were to be assessed/identified for their risk of developing pressure ulcers on admission/readmission by a Registered Nurse (RN) using the Braden Scale for Predicting Pressure Sore Risk form. -the assessment was to be completed quarterly or with a change in condition that could affect their risk for developing an ulcer. -all residents were to have a comprehensive skin assessment/inspection to identify any skin issues present including but not limited to pressure ulcers on admission/readmission and the results were to be documented in the medical record. -a comprehensive assessment was to be completed by the licensed nurse evaluating risk factors, the resident's skin condition and the nature of the pressure to which the resident may be subjected. The assessment was to identify which risk factors could be removed or modified. -when a pressure ulcer was present, staff were to complete the Wound Data Collection form daily. Documentation should include an evaluation of the ulcer if no dressing was present, the status of the dressing if present, the status of the area surrounding the ulcer and the presence of complications such as signs of infection, and an increase in area of ulceration. -the Primary Care Provider (PCP) was to be notified of the wound to obtain orders for treatment. -the dietary department was to be notified of the wound. -if the pressure ulcer was not determined to be clinically unavoidable, the ulcer should show signs of improvement. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the ulcer should be assessed weekly and documented on the Wound RN Assessment form. Observations of the wound's characteristics were to be documented by a licensed nurse and should include measurements: length, width and depth, characteristics of the ulcer including the wound bed, undermining, and tunneling exudate (fluid that leaks out of blood vessels into nearby tissues) surrounding skin, the presence of pain and the current treatment. Review of the resident's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 3/22/25 revealed the following regarding Resident 21: -cognitively intact. -was dependent on staff for assistance with toileting hygiene, showering/bathing, dressing, personal hygiene, bed mobility and transfers. -occasionally incontinent of bowel and bladder. -diagnoses of hip fracture, atrial fibrillation, diabetes, arthritis, and end stage renal disease. -at risk for pressure ulcer development, but no current pressure ulcers. Review of a Nursing Progress Note dated 4/15/25 at 6:21 PM revealed the resident's family was notified the resident had a wound to the resident's right heel. Review of Wound Data Collection forms revealed the following: -4/15/25 at 6:35 PM the resident had a stage 2 (the staging system is a method of summarizing characteristics of pressure ulcers, including the extent of tissue damage, a stage 2 pressure ulcer is a partial thickness skin loss that presents as an abrasion, blister or shallow crater) pressure ulcer which measured 1.9 centimeter (cm) by 1.8 cm with a depth of .1 cm. A new treatment was identified for the use of padded dressings and heel protectors (devices such as padded boots which are designed to reduce pressure to the heels). -4/20/25 at 7:10 AM the borders to the wound were reddened and the resident reported pain to the wound site. Bilateral heel protectors were in place and heels were offloaded (raise heels from surfaces to relieve pressure to the heels) as the resident allowed. -4/24/25 at 9:40 PM a minimal amount of serosanguineous (containing both blood and a thin watery fluid) drainage was observed to the right heel. No measurements were completed and there was no further assessment of the wound characteristics. -4/30/25 at 7:10 PM the pressure ulcer remained at a stage 2. There were no measurements and/or assessments of the wound to identify potential healing or a decline in the wound. -5/2/25 (2 weeks and 3 days after the ulcer was first identified) at 5:58 AM the resident's pressure ulcer measured 1.5 cm by 1.8 cm. The assessment indicated that the resident now had a pressure ulcer to the left heel which measured 1 cm by 0.8 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/11/25 at 5:59 PM the resident voiced complaints of pain to the pressure ulcers to both heels and there was a moderate amount of drainage. Further review revealed no measurement or further assessments of the ulcers. -5/20/25 at 7:26 PM the right heel pressure ulcer had now been assessed as a stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough (dead tissue) may be present but does not obscure the depth of tissue loss). The right heel pressure ulcer had an increasing area of ulceration, there was increased redness and swelling around the wound with increased drainage. The pressure ulcer was larger in diameter and was musty, foul, and odorous. There were no measurements included with this assessment. -5/23/25 at 3:20 PM the pressure ulcer to the right heel had brown/green exudate to the wound bed and measured 6.5 cm x 6 cm with a depth of 0.1 cm. The wound bed had a foul odor with heavy serosanguineous drainage. The resident's left heel pressure ulcer measured 1 cm by 1.4 cm with a depth of 0.2 cm. Review of a Nursing Progress Note dated 5/23/25 at 3:41 PM revealed the resident was seen by the Wound Nurse. New orders were received to cleanse the pressure ulcers with soap and water, apply a zinc-based cream to the wound edges, then place a Dankin's (antimicrobial wound cleanser) soaked gauze pad to the wound bed and cover with a padded dressing. The resident was started on Amoxicillin (antibiotic) 875-125 milligrams twice a day for 10 days due to the infection of the resident's right heel. Review of Wound Data Collection forms revealed the following: -5/24/25 at 10:42 AM the pressure ulcer to the right heel was noted to have a brown wound bed, moderate drainage to the dressing when removed, foul odor, and macerated (broken down due to prolonged exposure to moisture) wound edges. The skin to the wound edges of the left heel pressure ulcer was also macerated and the wound bed was covered with brown exudate. -5/25/25 at 1:10 AM the resident's right heel pressure ulcer had a brown/blackish wound bed, a moderate amount of purulent drainage with a foul odor and macerated wound edges. -5/26/25 at 2:24 PM the right heel was a full thickness pressure ulcer. The tissue surrounding the dressing was reddened with purulent (consisting of pus, a thick, yellowish-white fluid typically associated with infection)/serosanguinous drainage. The left heel was also identified as a full thickness pressure ulcer. Review of Dietary Progress Note dated 5/27/25 at 3:13 PM revealed a recommendation by the Registered Dietitian for Arginaid (nutritional supplement with added protein to aid in wound healing) to be provided at all meals. Review of the resident's electronic medical record revealed no evidence the Arginaid was implemented for the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Physician Visit form dated 5/29/25 revealed the resident was seen at the Wound Clinic. New orders were received for Enluxtra (dressing which provides moist healing of chronic to acute wounds with heavy drainage) dressing to both heels. The dressings were to remain in place until the next Wound Clinic appointment and the resident was to wear Prevalon boots (heel protectors). The resident was to have legs elevated above the level of the heart as much as possible and to avoid sitting with legs down. Cultures (process of growing microorganisms to determine the type of bacteria in a wound) were completed of the wounds to both heels. Review of a Nursing Progress Note dated 6/2/25 at 2:31 PM revealed a new order was received for Doxycycline (antibiotic) 100 mg twice a day for 20 administrations for wound healing. Review of a Nursing Progress Note dated 6/3/25 at 12:19 PM revealed the facility had received a phone call from the wound clinic advising the facility the resident needed to be transferred to the hospital for further evaluation of vascularization (the process where new blood vessels develop, either naturally or as a result of a medical condition, within a tissue or organ) to lower extremities. The wound nurse indicated that due to the resident's poor vascular status, the wounds would have gotten worse no matter what interventions were put into place. Review of a Progress Note dated 6/5/25 at 8:10 AM revealed the resident left the facility at 7:15 AM for admission to the hospital. During an interview on 6/30/25 at 8:34 AM, the Director of Nursing (DON) identified the following regarding Resident 21's pressure ulcers: -the resident was admitted [DATE] after a fall at home with subsequent left shoulder and left hip fracture. No pressure ulcers were assessed with the resident's admission assessment. -the resident had ongoing pain management issues related to the resident's back and recent fractures. The resident was not always compliant with getting up and out of bed and with repositioning due to pain. -a Wound Data Collection form was completed 4/15/25 at 6:35 PM and indicated the resident had a stage 2 pressure ulcer to the right heel. The wound was measured and assessed with a treatment initiated. Staff were to float the resident's heels and heel protectors were placed on the resident when in bed. -the right heel ulcer was not measured again until 5/2/25 (2 weeks and 2 days later) and the wound was 1.5 cm x 1.8 cm. Also at this time, a new pressure ulcer was identified to the left heel which measured 1 cm x 0.8 cm. -treatment was not initiated to the left heel pressure ulcer until 5/5/25. -5/20/25 the pressure ulcer to the resident's right heel was now assessed as stage 3. The wound was larger in size, with increased drainage and had a foul odor. No measurements of the wound were completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the right heel pressure ulcer was not measured again until 5/23/25 (3 weeks later) and the ulcer now measured 6.5 cm x 6 cm with a depth of 0.1 cm. The wound continued to have a foul odor with heavy drainage and brown/green exudate to the wound bed. The wound nurse evaluated, and new treatment orders were implemented. An antibiotic was started for signs of infection. -5/23/25 (3 weeks since previous measurement) the left heel was measured at 1 cm x 1.4 c x 0.2 cm. No further measurements were completed of the resident's heel pressure ulcers. -5/27/25 at 3:13 PM a recommendation was received by the RD for a nutritional supplement with added protein for wound healing to be given with each meal. There was no documentation in the medical record that this supplement was given and/or accepted by the resident. -5/29/25 the resident was seen at the wound clinic and new orders implemented for the pressure ulcers. Cultures were completed on both residents' pressure ulcers. -6/2/25 at 2:31 PM the resident was started on an additional antibiotic based on results of the wound cultures. -6/3/25 the resident was sent to a follow up appointment at the wound clinic with a recommendation for hospitalization. -6/5/25 at 7:15 Am the resident was sent to the hospital. -staff failed to ensure a weekly assessment was completed to include documentation of the pressure ulcers measurements and characteristics of the wound to ensure healing of the pressure ulcers and to determine a need for a change in treatment of the ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I) Based on record review and interviews; the facility failed to implement and monitor Care Plan fall prevention interventions for Resident 20. The sample size was 1 and the facility census was 29. Findings are: Review of the facility policy Fall Prevention and Management dated 4/8/25 revealed the following: -The facility promoted resident well-being by developing and implementing a fall prevention and management program to identify risk and implement measures before falls occurred. -Communicated that a fall had occurred and updated the Care Plan with any changes or new interventions, and -monitored the condition and effectiveness of interventions. Review of Resident 20's Falls Tools (tool used to evaluate fall risk) revealed the following: -on 5/19/25 at 1:58 PM the fall tool revealed the resident was at high risk for falling, -on 6/16/25 at 8:30 PM the fall tool revealed the resident was at high risk for falling. Review of the Resident 20's Event Abstract dated 5/18/25 at 1:30 PM revealed Resident 20 was trying to hurry to the toilet and sat on the bathroom floor. The intervention was telling the resident to call for help when needed. Review of the Resident 20's Event Abstract dated 6/15/25 at 8:30 PM revealed Resident 20 fell trying to get into the w/c to use the bathroom when the w/c moved and caused the resident to slide off the side of the bed. The resident was observed sitting on the floor next to the bed and the w/c, and the left w/c brake was unlocked. The intervention was for routine toileting in the morning, before and after meals, at bedtime and as needed. Review of Resident 20's Care Plan with a revision date of 6/16/25 revealed the resident was at risk for falling, had weakness, and difficulty walking. The following interventions were added to the Care Plan following falls: -On 6/2/25 an anti-roll back device was added to the resident's wheelchair on 5/18/25, and staff were to keep the wheelchair (w/c) locked at bedside, for the resident to use when transferring and ambulating in the room. -On 6/16/25 the facility was to review the resident's bowel and bladder continence status and establish and/or review the toileting plan based on resident's needs and provide routine toileting before and after meals, at bedtime and as needed through the night. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25 at 9:13 AM Registered Nurse (RN)-A reported that when the RN asked nursing staff about cares and a toileting schedule the Nurse Aides on duty reported that the resident was independent. During an interview on 6/26/25 at 11:50 AM with Nurse Aide (NA)-C revealed we help the resident get ready in the morning, but then the resident took self to the bathroom throughout the day. The NA was not aware of any routine toileting plan for Resident 20. During an interview on 6/30/25 at 8:40 AM NA-F revealed the resident was normally independent. Staff set up the clothing in the morning and provided reminders about mealtimes, activities or other things. The resident toileted independently during the day, was normally continent, and the staff did check for incontinence products in the trash throughout the day. NA-F was not aware of any routine toileting plan for Resident 20. During an interview on 7/1/25 at 10:24 AM the Director of Nursing (DON) confirmed the following: after falling on 6/15/25 the facility reviewed the Resident 20's fall and implemented a measure for toileting with morning and bedtime cares and before and after meals. The DON was not aware staff were not completing this approach to fall prevention and confirmed staff should have been doing so. Further interview confirmed the fall intervention was not effectively communicated or being monitored.

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	07/01/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview; the facility failed to ensure Resident 6, was offered the COVID-19 vaccine, or was provided with education on the benefits and risks of the vaccine in order to make an informed decision on staying up to date on the COVID-19 vaccination status. The sample size was 5 and the facility census was 29. Findings are: Review of the facility policy Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, and Other with a revision dated of 11/20/24 revealed the following: -The facility provided residents with the opportunity to receive immunizations as they fit into their healthcare goals and to provide guidance for the facilities program including recommended vaccines. -The facility reviewed each resident's immunizations upon admission, and on an ongoing basis. -The facility provided vaccine information statements for influenza, pneumococcal, and COVID-19 vaccines. -The facility provided documented education on the benefits and potential side effects of the vaccinations for which residents were eligible, obtained written consent if required, and -administered the vaccine or referred the resident to a provider, pharmacy, or 3rd party administering the vaccines. Review of Resident 6's Care Plan with a revision date of 5/27/25 revealed the resident was admitted to the facility on [DATE], had heart failure and heart disease as well as mild cognitive impairment. The resident had received treatment with an antibiotic for an upper respiratory infection starting 5/19/25. Review of Resident 6's Vaccine Consent dated 6/19/25 revealed the resident did not consent to or decline the COVID-19 vaccine. Review of Resident 6's Immunization Report dated July 1, 2025, revealed the resident's most recent COVID-19 Booster Vaccine was received on 11/21/23. During an interview on 6/30/25 at 2:06 PM the facility Infection Preventionist Register Nurse confirmed Resident 6 was admitted to the facility on [DATE] and was not offered a COVID 19 vaccine booster at the time of admission or since, thus the resident was not current on the COVID vaccine.