

|  |   |   |  |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285177  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>11/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Good Samaritan Society - Atkinson  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>409 Neely Street<br>Atkinson, NE 68713 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |   |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.04(F)(i)(5) Based on record reviews and interviews; the facility failed to notify Resident 1's practitioner of the residents increased lethargy, decreased appetite, lowered blood glucose levels and staff failure to administer insulin; and Resident 3 and 4's practitioner and/or responsible parties of ongoing falls. The sample size was 5 and the facility census was 33. A. Review of the facility policy Notification of Change with a revision date of 12/23/2024 revealed the purpose of the policy was to identify when regulation required notifications to occur. The policy further revealed the facility must immediately inform the resident, the resident's physician and the resident representative when there was:-an accident involving the resident which resulted in an injury and had the potential for requiring physician intervention.-a significant change occurred in the resident's physical, mental or psychosocial status.-there was a need to alter treatment significantly, a need to discontinue or change an existing form of treatment or to commence a new form of treatment. When making notification to the physician, the facility was to ensure that all pertinent information was available and provided upon request.</p> <p>B. Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/10/25 revealed the resident was admitted [DATE] with diagnoses of traumatic spinal cord dysfunction, osteomyelitis of the vertebra in the lumbar region, atrial fibrillation, coronary artery disease, high blood pressure, end stage renal disease, diabetes, arthritis, and Non-Alzheimer's dementia. The following was assessed for the resident:</p> <ul style="list-style-type: none"> <li>-cognition was intact.</li> <li>-frequently incontinent bladder.</li> <li>-required staff assistance with personal hygiene, dressing, transfers, toileting hygiene, and bed mobility.</li> <li>-frequent pain which occasionally interfered with day-to-day activities and the resident rated at an 8 out of 10.</li> <li>-one fall without injury since admission.</li> <li>-functional limitation of range of motion to one side of lower extremities.</li> </ul> <p>(continued on next page)</p> |   |  |

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

|   |           |                                      |
|---|-----------|--------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE     | (X6) DATE                            |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                   | Event ID: | Facility ID:<br>285177               |
|   |           | If continuation sheet<br>Page 1 of 4 |

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285177   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>11/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Good Samaritan Society - Atkinson  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>409 Neely Street<br>Atkinson, NE 68713 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Review of Resident 1's plan of care dated 10/10/25 identified the resident had a diagnosis of diabetes with an intervention to monitor/document/report to the practitioner any signs of hypoglycemia (blood glucose level falls below normal usually below 70). Signs of hypoglycemia were identified as confusion, lethargy, slurred speech, fatigue, and loss of appetite.</p> <p>Review of Resident 1's Nursing Progress Notes revealed the following:</p> <p>-10/8/25 at 5:14 PM the resident's Aspart Insulin (rapid acting insulin used to manage blood sugar levels) was not given as the resident had refused to eat the breakfast and the noon meal.</p> <p>-10/8/25 at 6:56 PM the resident was lethargic.</p> <p>-10/8/25 at 9:14 PM the resident's Glargine insulin (long acting insulin used to manage blood glucose levels) was held as the resident refused the evening meal and the resident's blood sugar was low.</p> <p>-10/9/25 at 8:32 AM the resident's Aspart insulin was again held due to poor meal intake.</p> <p>-10/9/25 at 8:33 AM the resident's Aspart insulin was not administered as the resident continued to refuse to eat.</p> <p>-10/9/25 at 8:45 AM the resident was lethargic, consumed only bites of the breakfast meal, and required 2 staff to assist the resident with transfer into bed.</p> <p>Review of the resident's medical record revealed from 10/8/25 at 8:33 AM to 10/9/25 at 8:33 AM there was no evidence the resident's practitioner was notified of the resident's refusal to eat, lethargy, staff failure to administer the resident's insulin and the resident's need for increased assistance with activities of daily living.</p> <p>During an interview with the Director of Nursing on 10/22/25 at 9:10 AM the following was confirmed:</p> <p>-the resident was admitted [DATE] due to fall at the resident's home with pain related to spinal abscess and osteomyelitis of the lumbar region.</p> <p>-10/8/25 at 5:14 PM to 10/9/25 at 8:45 AM the resident was lethargic and refused to eat or was unable to eat. The facility staff held the resident's ordered Aspart insulin and Glargine insulin due to the resident's poor intake and lowered blood glucose reading.</p> <p>-the staff failed to notify the resident's practitioner of the resident's change in condition and the failure to administer the resident's insulin without ordered parameters.</p> <p>C. Review of a Fall Prevention and Management Policy with a revision date of 10/14/25 revealed if a resident had a fall, the nurse was to assess the resident and perform a full body examination to determine suspected injury. The nurse was to notify the resident's practitioner and representative of the incident and results of the assessment.</p> <p>(continued on next page)</p> |   |  |

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285177   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>11/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Good Samaritan Society - Atkinson  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>409 Neely Street<br>Atkinson, NE 68713 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>D. Review of Resident 3's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of previous stroke, coronary artery disease, high blood pressure, end stage renal disease, diabetes, aphasia, Non-Alzheimer's dementia, depression, and schizophrenia. The following was assessed for the resident:</p> <ul style="list-style-type: none"> <li>-short and long term memory loss with severely impaired decision making needs.</li> <li>-behaviors which included verbal/physical abuse directed at others, other behavioral symptoms not directed toward others, rejection of cares, and wandering.</li> <li>-frequently incontinent of bowel and bladder.</li> <li>-required staff assistance with personal hygiene, dressing, transfers, toileting hygiene, and bed mobility.</li> <li>-use of bed and chair alarms daily.</li> <li>-two or more falls without injury and two or more falls with injury (except major) since the last assessment.</li> </ul> <p>Review of Resident 3's Nursing Progress Notes revealed the following:</p> <ul style="list-style-type: none"> <li>-5/19/25 at 1:37 PM the resident had slurred speech, was cold/clammy and pupils were not responsive. The resident appeared short of breath but refused further assessment. The practitioner indicated the family were to be notified, but there was no evidence the family received notification.</li> <li>-9/11/25 at 8:40 AM the resident had an unwitnessed fall at the south nurse's station. Review of the resident's medical record revealed no injuries were identified and there was no documentation the family was notified.</li> <li>-9/21/25 at 2:35 AM the staff heard the resident's fall alarm and witnessed the resident stumble backwards and fall. No injuries were observed. The resident's physician was notified but there was no evidence the resident's representative received notification.</li> <li>-9/28/25 at 12:34 AM the resident was found on the floor of the bathroom. The fall was reported to the Hospice nurse but there was no indication the residents' physician or representative were made aware of the fall.</li> </ul> <p>Interview with the DON on 10/22/25 at 9:20 AM verified the charge nurses were responsible for notifying the resident's representative and the practitioner whenever a resident had a fall. In addition, the DON confirmed on 5/9/25 at 1:37 PM the resident's representative was unaware of the resident's change in condition and was never notified of the resident's falls on 9/11/25 at 8:40 AM, 9/21/25 at 2:35 AM and on 9/28/25 at 12:34 PM or the practitioner was made aware of the fall on 9/28/25 at 12:34 PM.</p> <p>E. Review of Resident 4's MDS dated [DATE] revealed the resident was admitted on [DATE]. Resident had a diagnosis of history of falling, left foot drop, seizure disorder and had weakness to 1 side of the body. The following was assessed for the resident:</p> <p>(continued on next page)</p> |   |  |

|  |  |   |  |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285177   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>11/20/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Good Samaritan Society - Atkinson  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>409 Neely Street<br>Atkinson, NE 68713 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>-required staff assistance with personal hygiene, dressing, transfers, toileting hygiene, and bed mobility.</p> <p>-1 fall without injury and 1 fall with injury (except major) since the last assessment.</p> <p>Review of Resident 4's Nursing Progress Notes revealed the following:</p> <p>- On 9/20/25 at 3:47 PM resident was found on the floor in the bathroom by the toilet. The resident's family had been notified, no evidence that the physician had been notified.</p> <p>-On 10/11/25 at 4:45 AM resident transferred from bed to wheelchair, the wheel chair brakes were not locked and the wheel chair went out from underneath the resident. No injuries were noted. The resident's physician had been notified, no evidence that the family had been notified.</p> <p>Interview with the DON on 10/22/25 at 11:00 AM verified the charge nurses were responsible for notifying the resident's representative and the practitioner whenever a resident had a fall. The DON confirmed that Resident 4's physician was not notified of resident's fall on 9/20/25 at 3:47 PM and the family was not notified of the resident's fall on 10/11/25 at 4:45 AM.</p> |   |  |