STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285177	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Atkinson	409 Neely Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 51391 Licensure Reference Number 175 NAC 12-006.09(H) Based on observation, record review and interview; the facility failed to meet the Activities of Daily Living (ADL) needs for Resident 20 and the bathing needs for Resident's 3, 11, 16 and 24. The sample size was 20 with a census of 31. Findings are: A. Review of Resident 20's Minimum Data Set (MDS-federally mandated comprehensive assessment use to develop resident care plans) dated 12/12/24 revealed the resident received substantial to maximal assistance with toileting cares and transfers and was frequently incontinent of bowel and bladder. The resident had a diagnosis of non-traumatic brain dysfunction, Alzheimer's Dementia with short- and long-term memory loss with severely impaired decision-making skills. Review of Resident 20's Care Plan with a revision date of 11/27/24 revealed the resident required extensive assist to use the toilet, was dependent on staff for perineal hygiene and required extensive assist with transfers. The resident did not recognize the need to use the bathroom, was frequently incontinent of bowel and bladder and the staff were to check the resident for incontinence before and after each meal and as needed (PRN). During an observation of the provision of care for Resident 20 on 1/12/25 at 9:30 AM the resident was sitting in a wheelchair in the dining room, breakfast was completed, and staff then pushed the resident to the aviary area to watch the birds. At 11:30AM the resident continued to sit in the aviary area in the wheelchair. At 12:20 PM staff pushed the resident from the aviary area to the dining room for the noon meal. At 1:40 PM the resident was assisted out of the dining room to the resident's room to complete toileting cares. During an interview on 1/12/25 at 11:00 AM Registered Nurse (RN-B), verified Resident 20 had been sitting in the aviary area since after breakfast. During an interview on 1/12/24 at 2:00 PM Nursing Assistant (NA-L), verified that Resident 20 was to be assisted to the bathroom with morning cares, before and after meals, in the afternoon and at bedtime and the resident had not been assisted to the bathroom since before breakfast. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During an interview with Resident 24 on 1/12/25 at 9:40 AM, the resident voiced that weekly baths were not being done by the facility all of the time. Review of Resident 24's MDS dated [DATE] revealed the resident received partial assistance with bathing and supervision with a tub transfer. Review of Resident 24's Care Plan with a revision date of 12/2/24 revealed the resident required extensive assist with taking a whirlpool. Review of Resident 24's Bathing Records from December 16th, 2024, through January 10th, 2025, revealed the following: -Bathing occurred on the following days in December 2025: December 20th -Bathing occurred on the following days in January 2025: January 4th -There was no evidence of bathing on December 27th, 2024, or January 10th, 2025. -There was no evidence of bathing from the facility from 12/21/24 to 1/4/25. During an interview on 1/14/25 at 2:00 PM, NA-C and RN-H, verified that Resident 24 required assistance with bathing. During an interview on 1/14/25 at 2:45 PM, RN-G, verified that the resident had not received a bath weekly from the facility. 42360 C. Review of Resident 16's MDS revealed the resident was cognitively impaired, had Diabetes, had a dementia diagnosis, and received substantial assistance with bathing. Review of Resident 16's Care Plan with a revision date of 12/27/24 revealed the resident had impaired cognitive function and confusion, self-care deficits and requested one bath weekly and needed staff assistance to bathe. Review of Resident 16's Bathing Records from December 1st, 2024, through January 15th, 2025, revealed the following: -Bathing occurred on the following days in December 2024: December 4th, 11th, and 18th. -Bathing occurred on the following days in January 2025: No documented baths as of January 15, 2025. -There was no evidence of bathing from December 18th, 2024, through January 15th, 2025 (28 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/15/25 at 10:15 AM RN-G confirmed Resident 16 was not receiving baths at least weekly as care planned. D. Review of Resident 3's MDS dated [DATE] revealed the resident had severe cognitive impairment, had a dementia diagnosis, and was dependent for all ADL's including bathing. Review of Resident 3's Care Plan with a revision date of 12/30/24 revealed the resident had self-care performance deficits including being unable to walk, and dependence on the staff for moving in bed, dressing and grooming, eating, oral care, hygiene, toilet use, and bathing. Review of Resident 3's Bathing Records from October 1st, 2024, through January 15th, 2025, revealed the following: -Bathing occurred on the following days in October 2024: October 6th, and October 17th. -Bathing occurred on the following days in November 2024: November 7th, 14th, 21st, and 28th. (20 days between the baths on October 17th and November 7th). -Bathing occurred on the following days in December 2024: [DATE]th, 12th, and 27th. (15 days between the baths on December 12th and December 27th). -Bathing occurred on the following days in January 2025: January 10th. (14 days between the baths on December 27th and January 10th). During an interview on 1/15/25 at 10:15 AM RN-G confirmed Resident 3 was not receiving baths at least weekly as care planned. 45739 E. Review of Resident 11's MDS dated [DATE] revealed the resident had severe cognitive impairment; was dependent with toileting, showering, dressing, transfers, and hygiene; and had diagnoses of stroke, dementia, anxiety, weakness of one side of the body, and depression. Review of Resident 11's Care Plan last revised 1/1/25 revealed the resident was cognitively impaired, requested 1 bath per week, and required assistance with bathing, bed mobility, dressing, personal hygiene, toileting, and transfers. Review of Resident 11's Bathing Documentation for October, November, and December of 2024 and January 2025 revealed the resident received baths on: -10/5/24, 10/9/24, 10/17/24 (8 days between baths), 10/24/24, 11/7/24 (14 days between baths), 11/14/24, 11/21/24, 11/28/24, 12/5/24, 12/12/24, a sponge bath on 12/21/24 (9 days between baths), 12/28/24, and a bed bath on 1/3/25. There was no further documentation of a bath in January as of 1/15/25 (12 days since last bath). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/15/25 at 10:10 AM with RN-G confirmed Resident 11 did not receive a bath at least weekly.

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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	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** 29638 Licensure Reference Number 175 NAC 12-006.09D7 Based on record review and interviews; the facility failed to develop new interventions and/or revise current interventions to prevent ongoing falls for Residents 182 and 26. The sample size was 4 and the facility census was 31. Findings are: A. Review of the Fall Prevention and Management Policy with a revision date of 7/29/24 revealed the purpose of the policy was to promote the resident's well-being by developing and implementing an individualized fall prevention and management program. Staff were to identify risk factors and implement interventions before a fall occurred. The following procedure was identified: -observe the fall scene. -determine if there may be a suspected injury. -if the fall was not witnessed then staff are to complete neurological checks per policy. -review the resident's current interventions to determine if a revision is needed or new interventions developed. -if any teaching is done as an intervention, then to document in the resident's medical record. -review and update the care plan with any changes/new interventions. B. Review of Resident 182's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/21/24 revealed the resident was admitted [DATE] with diagnoses of colon cancer, anemia (a blood disorder that occurs when the body doesn't produce enough healthy red blood cells), and high blood pressure. The following was assessed regarding the resident: -cognition was moderately impaired. -required substantial to maximal assist with oral, personal and toileting hygiene, transfers, dressing, and showering/bathing. -occasionally incontinent of urine. -has a condition or a chronic disease that may result in a life expectancy of less than 6 months. (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	-2 or more falls without injury since previous assessment. -bed and chair alarm used daily. Review of Nursing Progress Note dated 5/7/24 at 11:52 PM revealed the resident was found on the floor in front of the resident's recliner. The resident identified standing and then sliding down the front of the recliner as the resident was not wearing shoes. A new intervention was identified for a non-slip pad to be placed in the seat of the recliner and to ensure the resident was wearing gripper socks or shoes. Review of a Nursing Progress Note dated 6/9/24 at 2:10 AM revealed the resident's call light was on and the resident was found on the floor. The resident was incontinent and indicated a need to use the bathroom. No new interventions were identified, and current fall interventions were not revised. Review of a Nursing Progress Note dated 6/11/24 at 11:38 AM revealed at 7:00 AM the resident was heard calling out for help. The resident was found on the bathroom floor with the walker and the resident's oxygen tubing was wrapped around the wheel of the walker. Staff placed a urinal next to the resident's bed to try and prevent the resident from getting up without assistance. A new toileting plan for the resident was identified with the resident to be toileted before and after meals and every 2 hours at night. Review of a Nursing Progress Note dated 6/28/24 at 5:50 PM revealed the staff lowered the resident to the floor when attempting to ambulate the resident. Further review revealed no evidence a new intervention was developed or that current fall interventions were revised. Review of a Nursing Progress Note dated 8/7/24 at 7:05 AM revealed the resident was found on the floor. The resident's call light was on, and the bed alarm was in place and was connected but had not sounded. A new intervention was put into place to change the fall alarm to a push button alarm to prevent the resident from turning the alarm off. Review of a Nursing Progress Note dated 8/23/24 at 6:54 PM revealed the resident was founding sitting on the floor of the resident's room. The resident's call light was on, and the fall alarm was sounding. Further review revealed no evidence of new interventions or that current interventions were revised to prevent further falls for Resident 182. During an interview on 1/14/25 at 9:22 AM, the Director of Nursing (DON) confirmed the staff were to assess residents after a fall and were to determine causal factors and either revise current interventions or develop new interventions at the time of the fall. Otherwise, falls would be reviewed with the next risk meeting and interventions reviewed and/or revised at that time. During an interview on 1/14/25 at 10:51 AM, Registered Nurse (RN)-B indicated the Charge Nurses were responsible for assessing a resident after a fall and were then to complete an incident report. Staff were to document causal factors and then document any revised fall interventions or new interventions. The Charge Nurse was then responsible for updating the care plan. RN-B verified the following: regarding Resident 182: -admitted on hospice and was at the facility for end-of-life cares. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-multiple falls while at the facility. -the facility failed to revise interventions or to develop new interventions to prevent further falls on 6/9/24 at 2:10 AM, 6/28/24 at 5:50 PM and on 8/23/24 at 6:05 PM. 51391 C. Review of resident 26's MDS dated [DATE] revealed the resident had a diagnosis of Stroke (a medical emergecny that occurs when blood flow to the brain is interrupted), Aphasia (loss or impairment of the power to use or comprehend words usually resulting from brain damage.), Dementia (a usually progressive condition marked by the development of multiple cognitive deficits ((such as memory impairment, aphasia, and the inability to plan and initiate complex behavior)), Depression(a mental health condition that involved a prolonged low mood and loss of interest in activities)and Schizophrenia (a mental illness that is characterized by disturbances in thought, perception, and behavior, by a loss of emotional responsiveness and extreme apathy, and by noticeable deterioration in the level of functioning in everyday life.) . The following was assessed regarding the resident: -received substantial assistance with toileting cares, bathing, dressing and personal hygiene and partial assistance with transfers, -is frequently incontinent of bowel, -occasionally incontinent of urine, -ambulates with a walker, 1 assistance, -bed and chair alarm used daily, -1 fall since previous assessment with minor injury, -received antipsychotic medications and antidepressants, -had short- and long-term memory issues, and -cognition was severely impaired. Review of Nursing Progress Note dated 9/18/24 at 5:50 AM revealed that at 4:24 AM Resident 26 was found on the floor laying in-between the bed and the bathroom door on their back. Review of the Internal Risk note dated 9/18/24 at 4:24 AM revealed that the pressure pad alarm was not sounding. Review of the resident care plan revealed that a new intervention was identified for a fall mat to be placed in front of the bed. The fall mat was then removed due to being a fall risk (unsure when it was removed). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Progress Notes dated 9/28/24 at 6:10 PM revealed the resident was in the wheelchair with staff pushing the wheelchair, the resident stood up out of the wheelchair, and ambulated through the dining room into the chapel. The resident walked up to the alter and tried to step up, grabbed the alter, and pulled it over. The resident rolled onto their left side then to the ground. Review of the resident's care plan and Internal Risk Note revealed that no new fall interventions were put into place. Review of Nursing Progress Notes dated 10/7/24 at 5:50 AM revealed the resident was found on the floor next to the bed, face down, and tangled in blankets. A small amount of red drainage was noted to the left nare. The resident's vital signs were difficult to obtain. The resident was sent to the emergency room at 6:39 AM and returned to facility at 10:11 AM with no new orders. Review of the resident's care plan and Internal Risk Note revealed that no new fall interventions were put into place. Review of Nursing Progress Notes dated 10/31/24 at 4:52 PM revealed the resident had a witnessed fall at 8:31 AM. Resident had feet tangled in the bed sheets, the alarm had sounded, and staff responded to the the alarm right away. Review of the resident's care plan revealed that no new fall interventions were put into place. Review of Nursing Progress Notes dated 11/18/24 at 6:57 AM revealed that the resident was found on the floor in resident's room at 3:55 AM. The resident had received Trazadone (antidepressant) as needed at 10:30 PM. Review of the resident's care plan revealed that a fall intervention was put into place to avoid giving the resident medications that would affect their ability to ambulate safely. Review of Nursing Progress Notes dated 11/18/24 at 7:08 AM revealed that the resident was on the floor in the resident's room leaning against the bed on their left side. The resident was incontinent of bowel. Review of the Internal Risk Note revealed that the pressure alarm was not sounding. Review of Nursing Progress Notes dated 11/18/24 at 11:55 AM revealed that the Trazadone had been decreased to 25 mg at bedtime as needed. Review of Nursing Progress Notes dated 1/4/25 at 11:05 PM revealed that the resident was laying on the floor on the right side in the hallway. The resident did not respond to staff initially. Review of the resident's care plan and Internal Risk Note revealed that no new interventions were put into place. During an interview on 1/13/25 at 9:00 AM, the DON verified that no new fall interventions were put into place for the falls on 1/4/25, 10/31/24, 10/7/24 and 9/28/24. During an interview on 1/13/25 at 9:15 AM, RN-B verified that the Charge Nurses were responsible for assessing the resident after a fall, completing the fall incident report, and updating the care plan with new fall interventions. During an interview on 1/14/25 at 9:22 AM, the DON confirmed the staff were to assess residents after a fall, were to determine causal factors, and revise the current interventions or develop new interventions at the time of the fall. Falls were reviewed with the next risk meeting and interventions were reviewed/revised if needed at that time.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 51391 Licensure Reference Number 175 NAC 12-006.09(J)(i)(1) Based on record review and interviews; the facility failed to revise nutritional interventions and/or develop new interventions to address ongoing weight loss for 1 (Resident 14) of 2 sampled residents. The facility census was 31. Findings are: A. Review of the facility policy Weight and Height with a revision date of 10/15/2024 revealed the following regarding weighing the residents and monitoring weight loss. The policy indicated the purpose of weighing the resident was to: -ensure the resident maintained acceptable parameters of nutritional status regarding weight. -report a significant weight change to the physician, family, and resident. -monitor weight loss in a resident. The policy indicated residents at nutritional risk were to be weighed weekly and the facility was to immediately inform the resident, consult with the resident's physician and notify the resident's legal representative when there was a significant change in the residents' weight. The following procedure was identified for weighing the resident: -weigh the resident at the same time of the day using the same type of scale -document the weight in the resident's medical record. -if weight varied by more than three percent (%), the staff were to reweigh the resident, document and report the weight to a licensed nurse. -the licensed nurse was to notify the director of food and nutrition within 24 hours regarding any significant weight change. Significant weight change was defined as 5% in 30 days, 7.5% in 90 days and 10% in 180 days. -the licensed nurse should immediately notify the medical provider regarding any significant weight change. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Review of Resident 14's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 12/25/24 revealed the resident was independent with eating and drinking. The resident's weight was 140 pounds (lbs.) with a loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The resident had a diagnosis of fractures, anxiety, and depression. Review of Resident 14's Care Plan (undated) revealed the resident ate independently and would usually request a room tray. The following nutritional interventions were identified: -the resident was to be weighed weekly. -the staff were to discuss with the resident positive coping behaviors, alternatives to undereating, feelings related to food and self-image concerns. The care plan identified repeatedly the resident would request something specific to eat then refuse. The facility was to accommodate the resident to the best of their ability. Review of the Weight and Vitals Summary Sheet (form used to document a resident's weights, blood pressure, respirations, temperature, and pulse) revealed the resident's weight on 9/25/24 was 158 lbs. Review of Nursing Progress Notes revealed the following: -9/27/24 at 4:58 PM the physician was notified the resident wanted a house supplement (nutritional drink with added calories and nutrients) daily due to poor appetite related to pain and that the resident had been refusing MiraLAX (laxative) and Colace (stool softener) every morning. -10/1/24 at 10:52 AM the facility received a physician's order to change the MiraLAX and the Colace to as needed (PRN) and to start a house supplement daily. Further review of the resident's medical record revealed no evidence as to the amount of supplement the resident was to receive. Review of the resident's Weight and Vitals Summary sheet revealed on 10/5/24 the resident's weight was 151lbs. (down 7 lbs. in 10 days). Review of a Nursing Progress Note dated 10/16/24 at 12:18 PM revealed the resident was seen by the pain physician with new orders to start Percocet (medication for pain) every 4 hours PRN pain. Review of a Nutritional Progress Note dated 10/21/24 at 9:54 AM by the Registered Dietician (RD) revealed the resident's weight was down 3% in less than 2 weeks and the resident's average meal intakes were 54%. No new nutritional interventions were identified. Review of a Nursing Progress Note dated 10/22/24 at 11:37 AM revealed the resident received an injection for pain. Review of the resident's Weight and Vitals Summary sheet revealed on 10/23/24 the resident's weight was 143 lbs. (down 15 lbs. in 1 month). Review of the resident's Nursing Progress Notes revealed the following: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/25/24 at 6:30 PM the facility received an order for an Enema (introducing fluid into the rectum to stimulate bowel movement) daily PRN. -10/30/24 at 2:34 PM the physician was notified the resident's admission weight was 158 lbs. and on 9/24/24 the resident had a weight of 143 lbs. (a 15 lb. weight loss since admission). The resident continued to receive the house supplement daily and had been eating 50% or less of meals. -10/31/24 at 11:02 AM new orders were received to increase the house supplement to 3 times daily, and the resident's physician indicated considering the use of Remeron (antidepressant with a side effect of stimulating the resident's appetite) if no improvement. Review of the October 2024 Medication Administration Record (MAR) revealed no documentation from 10/1/24 to 10/8/24 to indicate the amount of house supplement consumed when offered to the resident. Review of the resident's Weight and Vitals Summary sheet revealed the following: -11/3/24 weight was 140 lbs. -11/9/24 weight was 138 lbs. Review of Nursing Progress Notes revealed the following: -11/12/24 at 12:18 PM new orders were received for Buspar (antianxiety medication) 5 milligrams (mg) daily for depression and Speech Therapy was to evaluate and treat the resident due to difficulty with swallowing. -11/12/24 Speech Therapy evaluation was completed with no change in diet recommended. -11/14/24 at 11:57 PM a new order was received for Zofran (antinausea medication) 4 milligrams (mg) every 6 hours PRN nausea. Review of the resident's Weight and Vitals Summary sheet revealed on 11/17/24 the resident's weight was 141 lbs. Review of Nursing Progress Notes revealed the following: -11/20/24 at 10:07 AM a new order was received for a consult with a gastroenterologist (physician who specializes in the digestive system, diagnosing and treating disorders that affect it). -11/26/24 at 1:37 PM the resident and family refused to see the gastroenterologist. The resident was started on Omeprazole (medication which reduces acid in the stomach) 40 mg daily. Review of a Nutritional Progress Note dated 11/26/24 at 2:20 PM confirmed the residents weight loss and indicated the resident had a weight loss of 11% in less than 90 days. Further review revealed no changes were made regarding weight loss interventions. Review of the resident's Weight and Vitals Summary sheet revealed on 11/30/24 the resident's weight was 140 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the November 2024 MAR revealed the facility staff failed to document the resident's intakes of the house supplement from 11/1/24 to 11/21/24. Review of a Nursing Progress Note dated 12/3/24 at 10:48 am revealed the resident was seen by the physician. New orders were received to discontinue the Omeprazole, and the resident was referred to a surgeon for dysphagia (difficulty with swallowing) and abdominal pain. A recommendation was received for an EGD (medical procedure that involves inserting a tube with a camera down the esophagus and into the stomach to look at the organs for abnormalities). Review of the resident's Weight and Vitals Summary sheet revealed the following: -12/7/24 the resident's weight was 139 lbs. -12/15/24 the resident's weight was 140lbs. Further review of the resident's medical record revealed no evidence a weight was obtained and documented for the resident from 12/15/24 until 12/29/24. Review of Nursing Progress Notes revealed the following: -12/16/24 at 12:44 AM an order was received for Tums (antacid) 1-2 chewable tablets 2 times daily PRN upset stomach. -12/16/24 at 10:45 AM the EGD was completed and revealed a large hiatal hernia (a condition in which part of the stomach pushed up through the chest cavity), there were no change in orders. -12/18/24 at 2:36 PM the resident refused to travel out of town to see a physician for the hiatal hernia. Review of a Nutritional Progress Note dated 12/23/24 revealed the resident's current weight was 140 lbs. which was a severe weight loss of 11.4% in 90 days. There was no evidence the RD revised current nutritional interventions or developed additional interventions despite the resident's ongoing weight loss. Review of the resident's Weight and Vitals Summary sheet revealed the following: -12/29/24 weight was 135 lbs. -1/4/25 weight was 135lbs. (this weight was found on a bathing sheet the morning of 1/14/25). An interview on 1/13/25 at 12:45 PM with the Dietary Manager (DM) verified that resident was on the weight loss list and was being reviewed in the risk meetings. The resident continued to receive the house supplement 3 times per day. The DM verified that the amount of house supplement the resident drank should be documented each time administered. The resident's weight on 1/14/25 at 8:59 AM was 136 lbs. and was completed by Registered Nurse (RN)-G. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 1/14/25 at 1:30 PM verified the resident was not being weighed weekly. An interview with the DON, RN-J, and the DM on 1/14/25 at 2:55 PM verified there was not a specific amount of house supplement to administer on the house supplement order. The DM verified that the kitchen was sending 120 cubic centimeters (cc) of the house supplement with the resident meals. The DON verified that the Remeron suggested on 10/31/24 was never addressed despite the resident's weight loss. During an interview with the DON and DM on 1/14/25 at 3:15 PM verified the following: -the resident eats meals in their room and requests small portions for meals, -the resident had concerns with constipation, and medication changes had been made on 10/1/24 and 10/25/24, -the resident had complaints of pain, and medication changes had been made on 10/6/24 and resident received an injection for pain on 10/22/24, -house supplement was started on 10/1/24 1 time daily and the order did not state how much to administer, the house supplement was increased on 10/31/24 to 3 times daily and the order continued to not have an amount to administer, -the resident was started on an antidepressant on 11/12/24, -Speech Therapy evaluation was completed on 11/12/24 with no change in diet order, -the resident received an order for an antinausea medication as needed on 11/14/24, -the resident had an order to see a gastroenterologist and refused to go see the gastroenterologist, -the resident had an EGD on 12/16/24 but refused further treatment due to not wanting to go out of town, -the resident's weight and dietary intake was reviewed by the Dietician and the DM, and the only dietary interventions in place for the resident are house supplement 3 times per day.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 45739 Licensure Reference Number 175 NAC 12-006.04(G) Licensure Reference Number 175 NAC 12-006.04(D) Based on observation, record review, and interview; the facility failed to have sufficient staff to meet the daily living activities of Resident 20; the bathing needs of Resident's 3, 11, 16, and 24; and to ensure timely call light response times. This had the potential to affect all facility residents. The sample size was 20 and the facility census was 31. Findings are: A. Review of the Device Activity Report (record of call light activations and responses) from 1/9/25 through 1/13/25 revealed the following call light response times greater than 15 minutes: -1/12/25 at 9:28 PM answered at 36 minutes 19 seconds, -1/12/25 at 9:27 PM answered at 19 minutes and 12 seconds, -1/12/25 at 8:37 PM answered at 19 minutes 3 seconds, -1/12/25 at 5:51 PM answered at 66 minutes 39 seconds, -1/12/25 at 5:28 PM answered at 47 minutes 52 seconds, -1/12/25 at 5:12 PM answered at 38 minutes 2 seconds, -1/12/25 at 4:52 PM answered at 15 minutes 54 seconds, -1/12/25 at 6:36 AM answered at 26 minutes 52 seconds, -1/12/25 at 6:20 AM answered at 18 minutes 10 seconds, -1/11/25 at 7:21 PM answered at 18 minutes 55 seconds, -1/11/25 at 6:58 PM answered at 26 minutes 8 seconds, -1/11/25 at 6:50 PM answered at 28 minutes 0 seconds, -1/11/25 at 4:46 PM answered at 17 minutes 47 seconds, -1/11/25 at 12:30 PM answered at 29 minutes 23 seconds, -1/11/25 at 13:05 PM answered at 15 minutes 28 seconds, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1/11/25 at 12:01 PM answered at 28 minutes 29 seconds, -1/11/25 at 8:32 AM answered at 16 minutes 26 seconds, -1/11/25 at 8:23 AM answered at 33 minutes 47 seconds, -1/11/25 at 8:00 AM answered at 21 minutes 54 seconds, -1/11/25 at 7:49 AM answered at 33 minutes 47 seconds, -1/11/25 at 1:53 AM answered at 21 minutes 8 seconds, -1/10/25 at 3:13 PM answered at 16 minutes 57 seconds, -1/10/25 at 2:18 PM answered at 22 minutes 35 seconds, -1/10/25 at 9:55 AM answered at 16 minutes 43 seconds, -1/10/25 at 8:32 AM answered at 32 minutes 3 seconds, -1/10/25 at 6:38 AM answered at 15 minutes 48 seconds, and -1/9/25 at 7:39 PM answered at 16 minutes 4 seconds. Interview on 1/13/25 at 2:40 PM with the Director of Nursing (DON) revealed call lights were expected to be answered within 15 minutes. Further interview confirmed the facility did not have a policy related to answering call lights. Interview on 1/13/25 at 4:08 PM with the Administrator confirmed there were long call light time frames (longer than 15 minutes) on 1/9/25 through 1/13/25 and staff were expected to answer within 10-12 minutes. B. Review of Resident 11's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 10/16/24 revealed the resident had severe cognitive impairment; was dependent with toileting, showering, dressing, transfers, and hygiene; and had diagnoses of stroke, dementia, anxiety, weakness of one side of the body, and depression. Review of Resident 11's Care Plan last revised 1/1/25 revealed the resident was cognitively impaired, requested 1 bath per week, and required assistance with bathing, bed mobility, dressing, personal hygiene, toileting, and transfers. Review of Resident 11's Bathing Documentation for October, November, and December of 2024 and January 2025 revealed the resident received baths on: -10/5/24, 10/9/24, 10/17/24 (8 days between baths), 10/24/24, 11/7/24 (14 days between baths), 11/14/24, 11/21/24, 11/28/24, 12/5/24, 12/12/24, a sponge bath on 12/21/24 (9 days between baths), 12/28/24, and a bed bath on 1/3/25. There was no further documentation of a bath in January as of 1/15/25 (12 days since last bath). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/15/25 at 10:10 AM with Registered Nurse (RN)-G confirmed Resident 11 did not receive a bath at least weekly. 42360 C. Review of Resident 16's MDS dated [DATE] revealed the resident was cognitively impaired, had Diabetes, had a dementia diagnosis, and received substantial assistance with bathing. Review of Resident 16's Care Plan with a revision date of 12/27/24 revealed the resident had impaired cognitive function and confusion, self-care deficits and requested one bath weekly and needed staff assistance to bathe. Review of Resident 16's Bathing Records from December 1st, 2024, through January 15th, 2025, revealed the following: -Bathing occurred on the following days in December 2024: December 4th, 11th, and 18th. -Bathing occurred on the following days in January 2025: No documented baths as of January 2025. -There was no evidence of bathing from December 18th, 2024, and January 15th, 2025 (28 days). During an interview on 1/15/25 at 10:15 AM RN-G confirmed Resident 16 was not receiving baths at least weekly as care planned. D. Review of Resident 3's MDS dated [DATE] revealed the resident had severe cognitive impairment, had a dementia diagnosis, and was dependent for all Activities of Daily Living (ADL's) including bathing. Review of Resident 3's Care Plan with a revision date of 12/30/24 revealed the resident had self-care performance deficits including being unable to walk, and dependence on the staff for moving in bed, dressing and grooming, eating, oral care, hygiene, toilet use, and bathing. Review of Resident 3's Bathing Records from October 1st, 2024, through January 15th, 2025, revealed the following: -Bathing occurred on the following days in October 2024: October 6th, and October 17th. -Bathing occurred on the following days in November 2024: November 7th, 14th, 21st, and 28th. (20 days between the baths on October 17th and November 7th). -Bathing occurred on the following days in December 2024: [DATE]th, 12th, and 27th. (15 days between the baths on December 12th and December 27th). -Bathing occurred on the following days in January 2025: January 10th. (14 days between the baths on December 27th and January 10th). During an interview on 1/15/25 at 10:15 AM RN-G confirmed Resident 3 was not receiving baths at least weekly as care planned. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	E. Review of the facility Resident Council Meeting minutes 4/5/24 one concern from a resident about call light response times at the meeting; the resident was not named. The resident reported waiting for an hour. 7/12/24 a non-specific complaint about call lights and not knowing when to call- a resident was not named. In addition, the resident referred to staff on their cell phones during work shifts. 11/1/24 a concern about occasional longer wait times for call lights (no specifics). F. During the Resident Council meeting with the surveyor on 1/15/25 at 9:35 AM Resident 24 reported the facility had ongoing concerns with lack of bathing related to not having enough staff, despite this concern being discussed routinely at Resident Council. It's the one concern that never seem to have any permanent resolution. 51391 G. Review of Resident 20's MDS dated [DATE] revealed the resident received substantial to maximal assistance with toileting cares and transfers and was frequently incontinent of bowel and bladder. The resident had a diagnosis of non-traumatic brain dysfunction, Alzheimer's Dementia with short- and long-term memory loss with severely impaired decision-making skills. Review of Resident 20's Care Plan with a revision date of 11/27/24 revealed the resident required extensive assist to use the toilet, was dependent on staff for perineal hygiene and required extensive assist with transfers. The resident did not recognize the need to use the bathroom, was frequently incontinent of bowel and bladder and the staff were to check the resident for incontinence before and after each meal and as needed (PRN). During an observation of the provision of care for Resident 20 on 1/12/25 at 9:30 AM the resident was sitting in a wheelchair in the dining room, breakfast was completed, and staff then pushed the resident to the aviary area to watch the birds. At 11:30AM the resident continued to sit in the aviary area in the wheelchair. At 12:20 PM staff pushed the resident from the aviary area to the dining room for the noon meal. At 1:40 PM the resident was assisted out of the dining room to the resident's room to complete toileting cares. During an interview on 1/12/25 at 11:00 AM RN-B, verified Resident 20 had been sitting in the aviary area since after breakfast. During an interview on 1/12/24 at 2:00 PM Nursing Assistant (NA-L), verified that Resident 20 was to be assisted to the bathroom with morning cares, before and after meals, in the afternoon and at bedtime and the resident had not been assisted to the bathroom since before breakfast. H. During an interview with Resident 24 on 1/12/25 at 9:40 AM, the resident voiced that weekly baths were not being done by the facility all of the time. Review of Resident 24's MDS dated [DATE] revealed the resident received partial assistance with bathing and supervision with a tub transfer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 24's Care Plan with a revision date of 12/2/24 revealed the resident required extensive 1 assist with taking a whirlpool. Review of Resident 24's Bathing Records from December 16th, 2024, through January 10th, 2025, revealed the following: -Bathing occurred on the following days in December 2025: December 20th -Bathing occurred on the following days in January 2025: January 4th -There was no evidence of bathing on December 27th, 2024, or January 10th, 2025. -There was no evidence of bathing from the facility from 12/21/24 to 1/4/25. During an interview on 1/14/25 at 2:00 PM, NA-C and RN-H, verified that Resident 24 required assistance with bathing. During an interview on 1/14/25 at 2:45 PM, RN-G, verified that the resident had not received a bath weekly from the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45739 Licensure Reference Number 175 NAC 12-006.09(A) Based on record review and interview; the facility failed to ensure a documented rationale for the use of an anti-depressant for Resident 4. The sample size was 5 and the facility census was 31. Findings are: Review of the facility policy Psychotropic Medications with a revision date of 12/30/24 revealed the following: -the resident would be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms, -each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose or duration, without adequate monitoring or without adequate indications for use, in the presence of adverse consequences that indicated the dose should be reduced or discontinued, or any of the above combination of the reasons above, -after reviewing the mood and behavior documentation, the behavior committee and/or care plan team determines psychotropic medications may be necessary, the reduction team would be notified, -Gradual Dose Reduction's (GDR's) must be done according to federal regulations, -the reduction committee would review the need for the psychotropic medications every 3 months and document the rationale for continuing the medication, -the purpose of tapering medications was to find an optimal dose or to determine if the mediation benefited the resident, and -the GDR may be clinically contraindicated if the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or increase their behavior. Review of Resident 4's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 12/12/24 revealed the resident was cognitively intact; required partial assistance with toileting, dressing, and hygiene; had diagnoses of heart failure, diabetes, anxiety, and depression; and received antidepressants. Review of Resident 4's Care Plan last revised 12/27/24 revealed the resident received Sertraline (an antidepressant); had a mood disorder; and required assistance with bed mobility, dressing, and transfers. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's Active Orders as of 1/1/4/25 revealed the resident received Sertraline 25 milligrams every day for depression with an order start date of 3/23/23. Review of the facility facsimile (fax), a GDR request to Resident 4's provider dated 4/2/24 revealed the provider documented that the resident had a good response to the medication and to maintain the current dose. Further review revealed the provider was to add resident specific information to the physician progress notes. There was no resident specific rationale documented on the fax form. Interview on 1/14/25 at 10:45 AM with the Director of Nursing confirmed there was no documented rationale for the GDR contraindication for the sertraline dated 4/2/24.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45739 Licensure Reference Number 175 NAC 12-006.17 Based on observation, record review, and interview, the facility failed to implement hand hygiene at appropriate intervals and utilize Personal Protective Equipment (PPE) in a manner to prevent the potential spread of infection for Resident 15. The sample size was 16 and the facility census was 31. Findings are: A. Review of the facility policy Standard and Transmission-Based Precautions, last revised 4/2/24 revealed: -Enhanced Barrier Precautions (EBP) expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated ad refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing, -EBP is needed for resident with chronic wounds, and residents with indwelling medical devices (catheters, indwelling urinary catheters), -EBP are intended for the duration of the resident's stay, -EBP's are also needed for residents with CDC-targeted and MDRO infections and colonization's, -High-Contact Care Activities included: transfers, dressing, assisting during bathing, providing hygiene, changing briefs or toileting, close physical contact while assisting with transfer and mobility, changing linens, device care (urinary catheters), and wound care, -procedure: post clear signage and the required PPE (gown and gloves), signs should clearly indicate the high-contact resident care activities that require the use of gown and gloves, gowns and gloves should be readily available, ensure access to alcohol based hand rub, incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education, and provide education to residents and visitors on the importance of hand hygiene, especially when entering and exiting the resident's room and the facility. B. Review of the facility policy Hand Hygiene with a revision date of 3/29/22 revealed the following: -the purpose was to establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in the health care setting, -hand hygiene was that applied to hand washing or applying hand sanitizer, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-all employees were responsible for maintaining adequate hand hygiene by adhering to specific infection control practices including the 4 moments of Hand Hygiene (Entering Room, before a clean task, after bodily fluid/glove removal, and exiting a room) and the 2 zones of hand hygiene (Patient zone and Health Care zone), -the preferred method of hand hygiene for most patient care settings was the use of waterless alcohol-based hand sanitizer, -access to hand hygiene products were provided in all work units, -gloves are a protective barrier for health care workers and hand hygiene should be performed after glove removal, and -health care workers used alcohol-based hand sanitize or soap and water to clean their hands when entering patient rooms, before preparing or administering medication, before putting on sterile gloves, when moving from a contaminated body site to a clean body site during patient care, when entering a health care zone and after removing gloves regardless of the task completed, and when exiting a patient room. C. Review of Resident 15's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 11/21/24 revealed the following: the resident was dependent with toileting, dressing, and transfers; had an indwelling catheter; and had diagnoses of neurogenic bladder (urinary conditions caused by nerve problems), quadriplegia (paralysis of the arms, trunk, legs, and pelvic organs), anxiety, and depression. Review of Resident 15's Care Plan last revised 12/9/24 revealed the resident required assistance with bed mobility, toileting, dressing and transfers; the resident had an indwelling urinary catheter; and the resident was on EBP's with high-contact care activities including dressing, transfers, and changing linens. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/13/25 at 7:50 AM with Nursing Assistant (NA)-E revealed NA-E performed hand hygiene and applied a gown and gloves. NA-E uncovered Resident 15 and applied lotion then support hose to Resident 15's legs. The resident's urinary catheter became unhooked and the charge nurse was informed by the Registered Nurse Consultant (RN-G). NA-E placed an alcohol swab over the exposed catheter end, then removed their gloves and applied new gloves without performing hand hygiene. RN-F entered the room and applied a gown and gloves. No hand hygiene was observed to be completed. RN-F applied a new catheter bag and tubing to the resident's catheter. RN-F removed their gloves and put on a new pair of gloves without performing hand hygiene. NA-E applied the resident's pants, then removed their gloves and applied new gloves without performing hand hygiene. RN-F cleansed the residents catheter site and tubing and applied a gauze pad. RN-F removed their PPE and washed their hands in the resident bathroom prior to exiting the resident room. NA-E rolled Resident 15 to the side and the resident was incontinent of bowel. NA-E performed incontinent cares and changed their gloves 3 times without performing hand hygiene between glove changes. When finished with incontinent cares, NA-E applied a clean brief underneath the resident. NA-C entered the resident room, applied a gown and gloves, and hand hygiene was not observed to be completed. The NA's transferred the resident to the wheelchair using a full body lift. Once the resident was in the wheelchair safely and comfortable, both NA's removed their PPE and performed hand hygiene in the resident's bathroom. NA-E exited the resident's bathroom, without wearing PPE and had the residents hand towel draped on NA-E's shoulder. NA-E had a wet washcloth in their hand and was not wearing gloves. NA-E washed the residents face and dried it without wearing gloves. NA-E, still not wearing a gown or gloves, obtained a blanket from Resident 15's bed, folded the blanket in half against NA-E's clothing then placed it on Resident 15's lap. NA-E, still not wearing a gown or gloves, removed all the linens from the resident's bed and placed the linens into bags for the laundry. NA-C applied gloves then removed the full body lift from the room and cleansed it and performed hand hygiene. NA-E removed the linens from the room and placed them into the appropriate receptacle and performed hand hygiene. Interview on 1/13/25 at 8:40 AM with NA-E, NA-C, and RN-G confirmed hand hygiene was not performed between glove changes and PPE was not worn when changing bed linens. Further interview with RN-G confirmed PPE was to be worn when changing bed linens and hand hygiene should be performed between glove changes. Interview on 1/14/25 at 4:00 PM with the Administrator, Director of Nursing, and RN-G confirmed hand hygiene should be performed between glove changes and the PPE should be worn when removing bed linens.

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Good Samaritan Society - Atkinson	409 Neely Street 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.18(A) Based on record review and interview; the facility failed to offer Resident 16 the recommended Pneumococcal vaccines in accordance with facility policy and Center for Disease Control (CDC) guidelines. The sample size was 5 and the facility census was 31. Findings are: Review of the facility policy Immunization/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other with a revision date of 9/21/23 revealed the facility provided residents the opportunity to receive immunizations as they fit into their healthcare goals. -Upon admission, each resident and/or their representative received Vaccination Information Statements for influenza and pneumococcal vaccines. -The facility reviewed immunization records for all residents each year and residents' vaccine eligibility was reviewed on an ongoing basis as immunization recommendations changed. -Each time eligibility was determined education, consent, and screening were provided prior to each vaccine given. -All Residents received pneumococcal vaccination per CDC guidelines. Review of Resident 16's MDS (Minimum Data Set (MDS- federally required comprehensive assessment used in the development of resident Care Plans dated 10/9/24 revealed the resident was cognitively impaired, had Diabetes, had a dementia diagnosis. The Pneumococcal vaccine was not up to date and not offered. Review of Resident 16's undated Immunization Summary revealed no evidence the resident had received a pneumococcal vaccine. Review of Resident 16's EMR (Electronic Medical Record (EMR)-Fax received from the Medical Clinic dated 11/8/97 revealed the resident received a Pneumovax (Pneumococcal vaccine) on that date (over [AGE] years ago). During an interview on 1/14/25 at 7:01 AM Registered Nurse (RN)-G confirmed the Resident 16 had not been offered a pneumococcal vaccine since admission, and the last documented vaccine was administered on 8/11/97 (over [AGE] years ago). The resident was not current on the recommendation for the vaccine.