STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285185	A. Building B. Wing	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Colonial Villa	719 North Brown Street Alma, NE 68920

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Licensure Reference Number 175NAC 1-005.06(D)Licensure Reference Number 175NAC 12-006.18(B) Based on observation, record review, and interview the facility failed to ensure that hand hygiene (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) occurred between residents while administering medications to prevent the potential for cross-contamination. This affected 3 of 4 residents sampled (Residents 19, 2, and 8); the facility failed to ensure that staff performed hand hygiene as required before and after glove use during the provision of resident cares and failed to ensure that staff performed hand washing for the required length of time during resident cares. This affected 1 of 1 sampled residents (Resident 21). The facility census was 32. Findings are:A. Record Review of the Medication Administration policy dated 4/8/2025 revealed one purpose to be to provide direction regarding medication aides. Furthermore, it revealed that medications are administered to the residents according to the Six Rights. All employees passing medications are familiar with action and adverse reactions of medications. Page 5 of the 8-page policy revealed that medication administration is a nursing task. The procedure stated: -Wash your hands prior to beginning med pass and following the administration of medication for each resident. If hands are visibly soiled, wash hands with soap and water. If hands are not visibly soiled, the use of an alcohol-based hand sanitizer (ABHS) is acceptable. -Review the Medication Administration Record for medications due. -Check for allergies prior to administering any medications -Follow the Six Rights: right medication, right dose, right resident, right route, right time, and right documentation. -Administer medications on each side of ordered time, except for STAT (immediate need) medications which must be given immediately or other time sensitive medications. Page 8 of the Medication Administration policy was the medication aide clinical skill checklist. The first sentence of the clinical checklist stated: Wash your hands prior to beginning the medication pass and following the administration of medication for each resident. Record review of the Hand Hygiene Policy dated 3/29/2022 revealed hand hygiene is the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings. Hand hygiene was either to be by handwashing (washing hands with soap and water) or applying hand sanitizer. The policy further revealed that Health Care workers would use (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	waterless alcohol-based hand sanitizer (ABHS) or soap and water to clean their hands before preparing or administering medications. Record review of the Facility Education Report of Medication Aide A Revealed that MA-A had received the following education on the these dates: -Hand Hygiene and Infection Prevention on 01/02/2024, -Infection Control; Enhanced Barriers on 05/27/2024, -Infection Prevention and Medication Administration on 06/06/2024, -Medication Administration overall process on 09/09/2024, -Infection Prevention 1 and 2 on 10/02/2024. Observation of Medication Aide (MA) A on 09/15/2025 between 8:33 AM to 8:55 AM revealed that MA-A did not use hand sanitization prior preparing the medications. MA-A took the medications to Resident 19 and took the empty medication cup and water glass to the trash. At 8:47 AM, MA-A completed the documentation of the medications for Resident 19. MA-A then prepared medications for administration for Resident 8. MA-A did not use ABHS prior to preparing medications for administration. MA-A administered Resident 8's medications, then took the used glass to the trash and did not use ABHS afterwards. MA-A did not use ABHS. At 8:55 AM, MA-A then started preparing the medications for Resident 2. The medications were prepared and administered with a glass of supplement to Resident 2. When Resident 2 finished, MA-A took the used glass and disposed of this in the trash. MA-A did not use ABHS and then began to prepare medications for another resident. At no time did MA-A use any type of handwashing or ABHS to do hand sanitization while medications were prepared and administered to Residents 19, 2, and 8. Interview on 09/15/2025 at 9:05 AM with MA-A revealed that staff were to use ABHS or wash hands with soap and water between Residents while administering medications. MA-A did reveal the ABHS carried in MA-A's in pocket and did state that there was ABHS at the doors of the residents' rooms. MA-A confirmed hand hygiene had not been performed between the Residents 19, 2, and 8 while medications were prepared and administered. B. Record review of the facility policy titled Hand Hygiene dated 3/29/22 revealed that hand hygiene is the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings. Hand hygiene is a general term that applies to either handwashing or applying hand sanitizer. All employees will adhere to the 4 moments of hand hygiene and 2 zones of hand hygiene. The 4 moments of hand hygiene are: 1. Entering room. 2. Before Clean Task. 3. After Bodily Fluid/Glove Removal. 4. Exiting room. The 2 zones of hand hygiene are: Patient zone and Health-care zone. Gloves are a protective barrier for the healthcare worker. Hand Hygiene should be performed after glove removal. If gloves are used to perform a clean/aseptic procedure hand hygiene must be completed before putting on gloves. Hand hygiene must be done after removing gloves regardless of the task completed. Hand hygiene will be done when moving from a contaminated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	body site to a clean body site during patient care. The procedure for washing hands with soap and water revealed that staff must wet the hands and apply soap to the hands. Rub hands together briskly for at least 15-20 seconds covering all surfaces of the hands, fingers, and wrists. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 7/9/25 for Resident 21 revealed that Resident 21 admitted into the facility on 7/3/25. Resident 21 was dependent on staff for toileting hygiene and dependent on staff for transfers and repositioning (roll to left and right, chair to bed transfers, and toilet transfers). The MDS revealed that Resident 21 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 3 (BIMS scoring: 13–15: Cognitively intact; 8–12: Moderately impaired; 0–7: Severely impaired) indicating that Resident 21 had severely impaired cognition. Record review of the current care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) for Resident 21 dated 9/10/25 revealed that Resident 21 has limited physical mobility and requires 2 staff to assist with bed mobility and transfers. The care plan revealed that Resident 21 has an activities of daily living (basic everyday tasks including bathing, eating, dressing, getting in and out of bed, and toileting) performance deficit and requires staff assistance with personal hygiene. Observation on 09/11/25 at 1:25 PM at the resident commons tv area revealed that Nurse Aide-K (NA-K) transported Resident 21 per wheelchair from the commons area into the resident room. Medication Aide-J (MA-J) brought the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own) into the resident's room. NA-K and MA-J did not perform hand hygiene on entering the resident's room as required. NA-K removed the lap blanket from Resident 21 with the bare hands. NA-K and MA-J both put on gloves. NA-K and MA-J did not perform hand hygiene prior to putting on the gloves as required. MA-J revealed that Resident 21 has sores on the heels and gets daily dressing changes. MA-J and NA-K adjusted the loops on the lift sling (a fabric device with straps that is placed underneath a resident when a mechanical assistive device is used to transfer a resident with difficulty or the inability to stand up on their own from a seated or lying position) from underneath Resident 21. NA-K and MA-J connected the loops of the lift sling to the hooks of the mechanical total body lift using the gloved hands. NA-K operated the lift and lifted Resident 21 from the wheelchair and positioned Resident 21 over the bed. NA-K lowered Resident 21 onto the bed. MA-J reached over Resident 21 with the bare forearm of MA-J touching the bare right thigh of the resident to disconnect the sling loops from the lift. MA-J placed a gloved hand between the resident's legs to steady themself with the gloved hand touching the left heel boot (a cloth padded device to protect areas from pressure) as MA-J reached across the resident to unhook the far sling loop from the lift hook. NA-K and MA-J adjusted the position of Resident 21 on the bed with the bare forearms and gloved hands of NA-K touching the bare calves of Resident 21. The bare forearms and gloved hands of NA-K touched the bare left thigh of Resident 21 as NA-K and MA-J repositioned Resident 21 onto their right side. NA-K and MA-J used the gloved hands to reposition Resident 21 onto their left side. NA-K and MA-J used the gloved hands to remove the lift sling from underneath Resident 21. NA-K removed and discarded the gloves. NA-K did not perform hand hygiene as required. NA-K exited the room to get a package of wipes. NA-K did not perform hand hygiene on exiting the resident room as required. MA-J removed and discarded their gloves and went into the resident bathroom. MA-J performed hand washing with soap and water and scrubbed the hands for 10 seconds and rinsed and dried the hands (MA-J did not scrub the hands for 15-20 seconds as required). MA-J put on new gloves. NA-K returned to the room with a package of wipes. NA-K did not perform (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand hygiene upon entering the room. NA-K put on a pair of gloves. NA-K did not perform hand hygiene prior to putting on the gloves as required. MA-J positioned themself on the left side of the resident's bed. NA-K positioned themself on right side of the resident's bed. NA-K and MA-J unhooked the brief of Resident 21 using the gloved hands. NA-K used wipes to wipe the front private area (a contaminated body site) of Resident 21. NA-K and MA-J rolled Resident 21 onto their left side using the gloved hands. NA-K used wipes to wipe the anal area (a contaminated body site) of Resident 21 with the gloved right hand. NA-K removed and discarded the gloves. NA-K went into the resident's bathroom and performed hand washing for a total of 5 seconds (scrubbing, rinsing, and drying the hands). NA-K put on new gloves. NA-K and MA-J positioned a new brief underneath Resident 21 with their gloved hands. NA-K and MA-J repositioned Resident 21 with their bare forearms and gloved hands touching the bare thighs of Resident 21. NA-K and MA-J removed and discarded the gloves. NA-K and MA-J did not perform hand hygiene after removing the gloves as required. NA-K used the bare hand to operate the bed control. NA-K lowered the resident bed to the low position. NA-K removed the trash bag from the trash can and exited the resident room. NA-K performed hand hygiene with alcohol based hand rub (ABHR) on exit from the room. MA-J positioned the over bed table next to Resident 21's bed using the bare hands. MA-J put on gloves. MA-J did not perform hand hygiene prior to putting on the gloves as required. MA-J removed the mechanical total body lift from the room of Resident 21 and began to disinfect the lift with disinfecting wipes. Interview on 9/15/25 at 12:48 PM with the facility Infection Preventionist (IP) confirmed that facility staff are expected to follow the facility Hand Hygiene policy. The IP confirmed that staff are expected to follow the hand hygiene policy during resident care and revealed that the IP does monthly audits of hand hygiene for all facility staff. Interview on 9/16/25 at 12:07 PM Interview with Medication Aide-J (MA-J) confirmed that hand hygiene is to be performed prior to putting on gloves and again after removing gloves. MA-J confirmed that staff are expected to scrub the hands for 20 seconds during handwashing. MA-J confirmed that hand hygiene and hand washing were not completed as required during the care of Resident 21.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175NAC 12-00 6.09(7)Based on record review and interview the facility failed to ensure that a recapitulation (A concise summary of the resident's stay and course of treatment in the facility) was completed as required for 1 of 1 sampled residents (Resident 36); and the facility failed to notify the state ombudsman (a state appointed advocate for residents of nursing homes) of resident discharge for 1 of 1 sampled residents (Resident 36). The facility census was 32. Findings are: A.Record review of the facility policy titled Discharge and Transfer dated 3/28/25 revealed that when a transfer or discharge occurs the location (facility) must ensure that the transfer or discharge is documented in the medical record. With a transfer or discharge the location must send a copy of the facility or other state required form to a representative of the Office of the State Long-Term Care Ombudsman. The section titled Home revealed that the charge nurse or other designated individual will complete the progress note Discharge Home, obtain an order from the physician for discharge to home with medications, complete the Discharge or Therapeutic Leave Medication List assessment, complete the Miscellaneous section of the admission Record, complete and review any relevant portions of the progress note Teaching Resident/Family, and complete the Discharge Summary.Record review of the admission Record dated 9/15/25 for Resident 36 revealed that Resident 36 admitted into the facility on 5/8/25 and discharged to home from the facility on 6/23/25.Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 6/23/25 for Resident 36 revealed that the assessment was for discharge reporting. Active diagnoses included diabetes, malnutrition, and anxiety. Record review of the Discharge summary dated [DATE] for Resident 36 revealed that the section titled admission Diagnoses was left blank. The sections titled Hearing/Speech/Vision; Cognitive Patterns; Mood and Behavior; Preferences for Customary Routines and Activities; Functional Status; Bladder and Bowel; Active Disease Diagnoses; Health Conditions; Swallowing/Nutritional Status; Oral/Dental Status; Skin Conditions; Medications; Special Treatments and Procedures; Restraints; and Strengths and Goals were all left blank with no information documented. Record review of the Discharge admission Record dated 6/26/25 for Resident 36 revealed that the section titled Miscellaneous was not completed and contained no documented information.Record review of the progress note dated 6/23/25 at 6:49 PM for Resident 36 revealed that Resident 36 went home with all of their personal belongings. A friend came and picked up the resident. PICC Line was pulled prior to Resident 36 leaving. Record review of the progress notes for Resident 36 revealed no recapitulation of stay.Record review of the medical record for Resident 36 revealed no recapitulation of stay.Interview on 9/16/25 at 10:16 AM with the facility Director of Nursing (DON) confirmed that the discharge summary for Resident 36 did not contain all of the required information and much of the summary was left blank by the nurse. The DON confirmed that the facility did not have a recapitulation of stay for Resident 36.B.Record review of the facility policy titled Discharge and Transfer dated 3/28/25 revealed that when a transfer or discharge occurs the location (facility) must ensure that the transfer or discharge is documented in the medical record. With a transfer or discharge the location must send a copy of the facility or other state required form to a representative of the Office of the State Long-Term Care Ombudsman.Record review of the admission Record dated 9/15/25 for Resident 36 revealed that Resident 36 admitted into the facility on 5/8/25 and discharged to home from the facility on 6/23/25.Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 6/23/25 for Resident 36 revealed that the assessment was for discharge reporting. Active diagnoses included diabetes, malnutrition, and anxiety. Interview on 9/15/25 at 2:15 PM with the facility Social Services Director (SSD) revealed that the SSD sends the Emergency Transfers from Facility form to the state ombudsman monthly by email to notify the ombudsman of resident transfers. This surveyor (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested the ombudsman notification for June 2025.Record review of the Emergency Transfers from Facility form for the month of June 2025 provided by the SSD revealed that it did not contain the discharge of Resident 36. Interview on 9/16/25 at 9:28 AM with the facility SSD confirmed that Ombudsman notification of the discharge of Resident 36 did not occur.