STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Superior	1710 Idaho Street Superior, NE 68978

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12.006.09(G)(ii) Based on record review and interview, the facility failed to provide written notice of transfer to residents or their representatives upon transfer to the hospital for 2 Residents (8 and 21) of 5 residents The facility claimed a census of 38. Findings are: A review of Resident 8's Clinical Census dated 07/16/2024 revealed Resident 8 was admitted on [DATE]. A review of Resident 8's Admission Record dated 01/08/2024 revealed Resident 8 had diagnoses of a history of transient ischemic attack (TIA-a brief period of stroke-like symptoms) and cerebral infarction (stroke-a loss of blood flow to part of the brain. Brain cells cannot get the oxygen and nutrients they need and start to die within a few minutes. This can cause lasting brain damage, long-term disability, or even death.) with hemiparesis (weakness on one side of the body), and hemiplegia (paralysis on one side of the body.) A review of Resident 8's Progress Notes from 06/29/2023 to 07/16/2024 revealed that on 04/30/2024, Resident 8 was sent to the emergency room with shortness of breath and was admitted to the hospital. The resident returned to the facility on [DATE]. There was no documentation of a written notice of transfer being provided to the resident or the resident's representative for this transfer. The facility provided a copy of a Transfer or Discharge Notice for Resident 8 with Date of Discharge 04/30/2024. An interview on 07/17/2024 at 12:28 PM with the Social Services Designee (SSD) revealed that the SSD was not documenting discussions of notifications of transfers. The SSD confirmed that the resident and/or resident representatives were getting notified verbally of transfers, but were not being provided with a copy of Transfer or Discharge Notice form. B. A review of Resident 21's Admission Record dated 07/16/2024 revealed Resident 21 was admitted on [DATE] and had diagnoses of a history of TIA and cerebral infarction, high blood pressure, and dementia. (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: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 Idaho Street Superior, NE 68978	

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 21's Progress Notes from 06/29/2023 to 07/16/2024 revealed that on 01/05/2024, Resident 21 was sent to the emergency room for diarrhea, weakness, and low blood pressure, and was admitted to the hospital. The resident returned to the facility on [DATE]. There was no documentation of a written notice of transfer being provided to the resident or the resident's representative for this transfer. The facility provided a copy of a Transfer or Discharge Notice for Resident 21 with Date of Discharge 01/05/2024. An interview on 07/17/2024 at 12:28 PM with the Social Services Designee (SSD) revealed that the SSD was not documenting discussions of notifications of transfers. The SSD confirmed that the resident and/or resident representatives were getting notified verbally of transfers, but were not being provided with a copy of Transfer or Discharge Notice form. C. A review of the Discharge and Transfer-Rehab/Skilled, Therapy & Rehab policy, with Date Reviewed/Revised of 01/03/2024 revealed: Before a location transfers or discharges a resident, the location must: 1. Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand. The Notification of Transfer or Discharge (GSS#223A), or other state required form will serve as the written notice to be given to the resident and/or resident representative. Note: When a resident is temporarily transferred on an emergency basis to an acute care center, this type of transfer is considered to be a facility-initiated transfer and a notice of transfer must be provided to the resident and resident representative as soon as practicable before the transfer. 3. The resident must also be given information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Superior	1710 Idaho Street Superior, NE 68978

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.05(B) Based on record review and interview, the facility failed to provide a notice of bed hold policy to Resident 8 and Resident 21 upon transfer to the hospital. This affected 2 of 5 residents sampled for hospitalization s. The facility census was 38. Findings are: A. A review of the Discharge and Transfer-Rehab/Skilled, Therapy & Rehab policy, with Date Reviewed/Revised of 01/03/2024 revealed: Transfer to Hospital 3. The Social Worker or designated individual will: a. Complete and provide the Notice of Bed-Hold Policy (GSS, Good Samaritan Society) #273 or state specific form) to the resident and/or responsible party. (See Bed Hold-Rehab/Skilled) b. Complete the Notification of Transfer or Discharge (GSS #223A or state-specific form). Note: The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time social services is not at the location. B. A review of the Bed-Hold-Rehab/Skilled policy with Date Reviewed/Revised of 12/07/2023 revealed: At the Time of Transfer: 1. The Social Worker or designated individual will provide the Notice of Bed-Hold Policy (GSS #273 or state specific form) to the resident and/or resident representative, which specifies the duration of the bed-hold policy under the state plan and the facility policy regarding bed-holds. 2. The social worker or designated individual will review the Notice of Bed-Hold Policy and explain that future admission is based on bed availability and the criteria listed in the Notice of Bed-Hold Policy. In Case of Emergency Transfer: 1. The resident's copy of the Notice of Bed-Hold Policy is sent with the other papers accompanying the resident to the hospital. The family member or resident representative, if any, is provided with the Notice of Bed-Hold Policy within 24 hours of the transfer. a. The Notice of Bed-Hold Policy should be mailed if family or the resident representative does not come to the facility to receive a copy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Superior	1710 Idaho Street Superior, NE 68978

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The charge nurse is responsible for completion of notification procedures if the transfer occurs at a time the social worker is not at the location. 2. The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision for holding a bed. 3. In cases where the facility was unable to notify the resident representative, the social worker or designated individual will document multiple attempts to reach the resident's representative. C. A review of the undated Hospital Transfer Checklist: revealed the following: Bed hold paper, send with transfer packet. Document everything accordingly in progress notes Document time that resident left facility in van or ambulance. Document that transfer packet was sent along with resident. Also chart that the bed hold paper was sent. D. A review of Resident 8's Clinical Census dated 07/16/2024 revealed Resident 8 was admitted on [DATE]. A review of Resident 8's Admission Record dated 01/08/2024 revealed Resident 8 had diagnoses of a history of transient ischemic attack (TIA-a brief period of stroke-like symptoms) and cerebral infarction (stroke-a loss of blood flow to part of the brain. Brain cells cannot get the oxygen and nutrients they need and start to die within a few minutes. This can cause lasting brain damage, long-term disability, or even death.) with hemiparesis (weakness on one side of the body), and hemiplegia (paralysis on one side of the body.) A review of Resident 8's Progress Notes from 06/29/2023 to 07/16/2024 revealed that on 04/30/2024, Resident 8 was sent to the emergency room with shortness of breath and was admitted to the hospital. The resident returned to the facility on [DATE]. There was no documentation of a notice of bed-hold policy being provided to the resident or the resident's representative for this transfer. An interview on 07/17/2024 at 12:28 PM with the Social Services Designee (SSD) revealed that the SSD was not documenting discussions of the bed hold policy. The SSD further confirmed that there was no documentation that Resident 8 or Resident 8's representative was informed of the Bed Hold Policy upon transfer to the hospital. E. A review of Resident 21's Admission Record dated 07/16/2024 revealed Resident 21 was admitted on [DATE] and had diagnoses of a history of TIA and cerebral infarction, high blood pressure, and dementia. A review of Resident 21's Progress Notes from 06/29/2023 to 07/16/2024 revealed that on 01/05/2024, Resident 21 was sent to the emergency room for diarrhea, weakness, and low blood pressure, and was admitted to the hospital. The resident returned to the facility on [DATE]. There was no documentation of a notice of bed-hold policy 7 being provided to the resident or the resident's representative for this transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 Idaho Street Superior, NE 68978	

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 07/17/2024 at 12:28 PM with the Social Services Designee (SSD) revealed that the SSD was not documenting discussions of the bed hold policy. The SSD further confirmed that there was no documentation that Resident 21 or Resident 21's representative was informed of the Bed Hold Policy upon transfer to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE: 1710 Idaho Street Superior, NE 68978	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC ,d+[DATE].17 Based on record review and interview, the facility failed to ensure medical records for 1 resident (Resident 38) of 3 residents surveyed were accurate and contained specific information of significant events. The facility claimed a census of 38. Findings are: A record review of Resident 38's electronic health record revealed the following diagnoses: Expressive language disorder, developmental disorder of scholastic skills, Dysphagia (difficulty swallowing), history of falling, Essential Hypertension (High Blood Pressure), Mild intellectual disabilities, Pain, Fever, Complete loss of teeth, Xerosis Cutis (Dry Skin), An unspecified cataract (clouding of the normally clear lens of the eye). A record review of Resident 38's Medication Administration Record (MAR) dated [DATE] revealed Resident 38 was a DNR (Do not Resuscitate). A record review of Resident 38's Minimum Data Set (MDS - a federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes) dated [DATE], revealed Resident 38 had a Brief Interview for Mental Status (BIMS - a federally mandated tool to measure cognitive ability in residents) of 9, which indicated Resident 38 was moderately impaired. A record review of Resident 38's Progress Note (PN) dated [DATE] revealed the facility staff documented Death. Further review of Resident 38's PN dated [DATE] revealed there were no futher information on what was going on wth the residents prior, who had found the resident and what condition/ position the resident was in. An interview on [DATE] at 2:20 PM with the Director of Nursing (DON) confirmed there is no other documentation relating to Resident 38's death. An interview on [DATE] at 2:35 PM with Medication Aide (MA) D revealed MA-D was the person who found the resident deceased . Resident 38 did not answer MA-D when they knocked at the door. MA-D entered the room and found Resident 38 lying in bed, dressed in nightclothes and cold to the touch. MA-D used their walkie-talkie to contact the charge nurse and request assistance. Registered Nurse (RN)-B entered the room and assessed the patient for vital signs. RN-B was unable to find signs of life. RN-B instructed MA-D to prepare the body for transfer to the funeral home. MA-D reported RN-B took care of the notifications. MA-D reported Resident 38 was a DNR so no attempts to resuscitate were made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 Idaho Street Superior, NE 68978	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on [DATE] at 3:16 PM with RN-B confirmed they were the nurse who assessed the Resident 38 after their death. RN-B reported they were called to the room by MA-D who reported Resident 38 was deceased . RN-B stated Resident 38 was lying in bed, wearing nightclothes with their eyes half open. RN-B assessed the resident for pulse, respirations, temperature, and blood pressure. The vitals were negative. RN-B directed MA-D to prepare the body and RN-B notified the physician, DON, Administrator, family, and funeral home. RN-B stated the assessment and vital signs were not charted in the progress notes for Resident 38.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Superior	1710 Idaho Street Superior, NE 68978

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45484 Licensure Reference Number 175 NC 12-006.18 (D) Based on observations, record reviews, and interviews, the facility failed to ensure hand hygiene was performed in a manner to prevent cross-contamination during medication administration for Resident 8 and Resident 29. This affected 2 of 7 residents observed for medication administration. The facility census was 38. Findings are: A. A review of the facility Hand Hygiene-Enterprise policy with Date Reviewed/Revised of 03/29/2022 revealed the following instructions: -In the section labeled Procedure: HCW (Health Care Worker) will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: After removing gloves regardless of task completed In the section labeled Washing with soap and water/liquid antiseptic and water: Rub hands together briskly for at least 15-20 seconds covering all surfaces of the hands, fingers, and wrists (CDC). -In the section labeled Lotion Use, glove use, and fingernail care are important aspects of hand hygiene. Change gloves when moving from a dirty to a clean or sterile activity performing hand hygiene in between changing gloves. B. An observation on 07/17/2024 at 11:56 AM of Licensed Practical Nurse (LPN) A administering an injection to Resident 29 revealed the LPN prepared the injection, took the supplies to Resident 29's room, performed hand sanitization, and put on gloves. LPN A administered the injection, discarded the syringe in a sharps box, removed and discarded their gloves, then washed their hands with soap and water for ten seconds. C. An observation on 07/17/2024 at 2:10 PM of LPN A administering a nebulizer (drug delivery device used to administer medication in the form of a mist inhaled into the lungs) treatment to Resident 8 revealed the LPN listened to the resident's lungs and obtained the required vital signs (VS). LPN A then washed their hands with soap and water for eight seconds and put on gloves. The LPN moved the resident's wheelchair and overbed table, put the nebulizer machine on the overbed table and plugged it in, set up the medication in the nebulizer kit, assisted Resident 8 to put the mask on, and started the machine. LPN A took the resident's urinal to the bathroom and emptied it, then removed their gloves and washed their hands with soap and water for seven seconds. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER: Good Samaritan Society - Superior		STREET ADDRESS, CITY, STATE, ZIP CODE: 1710 Idaho Street Superior, NE 68978	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. An observation on 07/17/2024 at 2:27 PM revealed LPN A turned off the nebulizer machine, sanitized their hands and put on gloves. The LPN then assisted Resident 8 with removing the nebulizer mask, checked the required VS, and listened to the resident's lungs. LPN A then brought the urinal into he room and put it on the overbed table. LPN A then changed their gloves without performing hand hygiene, disassembled the nebulizer kit, washed it with soapy water, and put in a plastic container to air dry. LPN A covered the kit with a washcloth and had Resident 8 rinse their mouth and spit the water into a pan. The LPN rinsed out the pan, then removed their gloves and washed their hands with soap and water for nine seconds. E. An interview on 07/17/2024 at 2:35 PM with LPN A confirmed that handwashing should be done for 20 seconds, and that eight to ten seconds was not long enough. The LPN further confirmed they should have sanitized their hands between glove changes. F. An interview on 07/18/2024 at 12:50 PM the Director of Nursing (DON) confirmed handwashing with soap and water should be done for 20 seconds, and that hand sanitizing should be performed between changing gloves.