STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285187	A. Building B. Wing	07/10/2025

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

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to issue the required Advance Beneficiary Notices (ABN, a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case) to 2 (Residents 11 and 140) of 3 sampled residents. The facility census was 37. Findings are:A record review of a facility document titled Advance Beneficiary Notice of Non-Coverage and dated 09/12/2024 revealed the notice must be reviewed with and given to the beneficiary and or their representative far enough in advance that they have time to consider the options and make an informed choice. Once the form is completed and is signed a copy must be retained by the notifier or issuer of the notice.A.A record review of an admission Record revealed the facility re-admitted Resident 11 on 03/03/2025 after an acute hospitalization with diagnoses of generalized muscle weakness and fatigue.A record review of Resident 11's Census on 07/08/2025 revealed that Resident 11's payor source was Medicare Part A starting on 03/03/2025 and ending on 03/31/2025.In an interview completed on 07/08/2025 at 12:00 PM with the Facility Administrator (FA), the FA confirmed that the facility did not retain a copy of the notice providing evidence that the notice was issued to the resident and or their representative.B.A record review of an admission Record revealed the facility admitted Resident 140 on 01/31/2025.A record review of Resident 140's Census on 07/08/2025 revealed that Resident 140's payor source was Medicare Part A starting on 01/31/2025 and ending on 02/11/2025.In an interview completed on 07/08/2025 at 12:00 PM with the Facility Administrator (FA), the FA confirmed that the facility did not retain a copy of the notice providing evidence that the notice was issued to the resident and or their representative.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.05(G)Based on record review and interview the facility failed to ensure non-pharmacological interventions were attempted prior to giving 1 (Resident 19) of 5 sampled residents an as needed psychotropic medication. The facility census was 32.Findings are:A record review of a facility policy titled Psychotropic Medications and dated 05/12/2025 revealed the resident will be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Before administration of a psychotropic medication the following must be complete: Documentation of observations of mood, symptoms or behaviors that causes the resident distress and or endanger the resident or others and responses to interventions used prior to the administration of the medication. A record review of an admission Record revealed the facility admitted Resident 19 on 07/31/2020 with a diagnosis of 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).A record review of Resident 19's Care Plan on 07/09/2025 revealed:-A behavior listed of the resident making frequent trips to the nurse's station and becoming aggravated with staff when redirecting them. An intervention was listed to redirect the resident to their room if possible and one on one visit with the resident.-A behavior listed of pacing in the halls and becoming agitated due to confusion and being difficult to redirect to their room. An interventions were listed to take the resident to the dining room for a snack and to fold laundry as well as take the resident to the chapel area to sing along with music.-A behavior listed of delusional thinking, telling staff the resident needed to pick up their kids, thinking that their husband was in their room and seeing children in their room. An intervention listed to assist the resident to call their daughter and take the resident to the dining room for a snack and coffee.A record review of Resident 19's Physician Orders on 07/08/2025 revealed Resident 19 had an order for Quetiapine (a antipsychotic psychotropic medication used to manage mental health conditions like schizophrenia and bipolar disorder) Fumarate oral tablet 25 milligrams. The order contained directions to give 1/2 a tablet every 12 hours as needed for behaviors related to dementia and behavioral disturbances.A record review of Resident 19's Electronic Medical Health Record revealed:-On 06/08/2025 the Quetiapine was administered with documentation reflecting Resident 19 was confused and wandering hallways. The resident was looking for the elevator to get downstairs and to a party that they were supposed to be at. The documentation stated the staff were unable to redirect the residents. There was not documentation reflecting interventions used prior to the administration of the Quetiapine medication. There was no documentation reflecting the resident being in distress or causing distress to others.-On 06/09/2025 the Quetiapine was administered with documentation reflecting Resident 19 was disturbing other residents getting into their rooms and waking the residents up. There was no documentation reflecting interventions used prior to the administration of the Quetiapine medication.-On 06/10/2025 the Quetiapine was administered with documentation reflecting Resident 19 was in their room visibly upset and stating they were afraid they had lost their baby, and staff were unable to redirect. There was no documentation reflecting interventions used prior to the administration of the Quetiapine medication.-On 06/11/2025 the Quetiapine was administered with documentation reflecting Resident 19 had disturbed other residents during the night getting into their rooms and waking them up as well as Resident 19 was disoriented and confused. There was no documentation reflecting interventions used prior to the administration of the Quetiapine.-On 06/13/2025 the Quetiapine was administered with documentation reflecting Resident 19 was restless and having flight of thoughts going into other resident rooms and staff were unable to divert. There was no documentation reflecting interventions used prior to the administration of the Quetiapine.-On 06/17/2025 the Quetiapine was administered with documentation reflecting Resident 19 was wandering around the facility confused, asking staff if they had the correct walker. There was no documentation reflecting interventions used prior to the administration of the Quetiapine medication. There was no documentation reflecting the resident being in distress or causing distress to others.In an interview completed on 07/09/2025 at 3:00 PM with Registered Nurse (RN)-K, RN-K confirmed that prior to administering an as needed psychotropic medication, non-pharmacological interventions should be documented in the Progress Notes and if they were or were not effective.In an interview completed on 07/10/2025 at 8:00 AM with the Director of Nursing (DON), the DON confirmed that non-pharmacological interventions should be documented in the Progress Notes and their effectiveness prior to the administration of an as needed psychotropic medication. The DON confirmed the necessary documentation for the use of

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview the facility failed to investigate allegations of resident to resident abuse and failed to submit an investigation to the state agency within 5 working days as required for 2 (Residents 15 and 190) of 2 sampled residents. The facility census was 37.Findings are:Record review of the facility policy titled Abuse and Neglect dated 4/7/25 revealed that the purpose is to ensure that residents are not subjected to abuse by anyone; to ensure that all identified events of alleged or suspected abuse/neglect are promptly reported and investigated; and ensure a complete review by the investigation team to identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation. Alleged or suspected violations will be reported immediately to the administrator. Intervene in any situation in order to protect residents. \ Remove any individual from the location for the protection of residents. The facility will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress. Results of all investigations will be reported to the administrator and to other officials in accordance with state law, including the state survey and certification agency within 5 working days of the event. Record review of the facility report to Adult Protective Services dated 8/18/24 revealed that staff observed Resident 15 walking in the hallway. Resident 15 was behind Resident 190. Resident 15 told Resident 190 to move over. Resident 190 moved over for Resident 15 to pass. Resident 15 directed their walker into Resident 190 and caught the foot of Resident 190 with the walker. Staff redirected Residents 15 and 190 to prevent additional confrontation. Record review of the current Care Plan dated 7/7/25 for Resident 15 revealed that Resident 15 can become aggressive when told what to do by other residents. Care interventions include monitoring Resident 15 for aggressive behavior to protect the rights and safety of others. Resident 15 requires supervision in common public areas. Record review of the incident report titled #1296 Resident to Resident (physical contact made) dated 8/18/24 for Resident 15 revealed that it was for the resident to resident physical contact made between Resident 15 and Resident 190 on 8/18/24. The incident report described the incident and contained no investigation of the incident. Record review of the incident report titled #1297 dated 8/18/24 for Resident 190 revealed that it was for the resident to resident physical contact between Resident 15 and Resident 190 on 8/18/24. The incident report briefly described the incident and contained no investigation of the incident.Record review of the medical record for Resident 15 revealed no progress note for the resident to resident physical abuse on 8/18/25. The medical record did not contain an investigation of the 8/18/24 resident to resident abuse for Resident 15 against Resident 190.Record review of the medical record for Resident 190 revealed no progress note for the resident to resident physical abuse on 8/18/25. The medical record did not contain an investigation of the 8/18/24 resident to resident abuse for Resident 15 against Resident 190.Interview on 7/10/25 at 8:43 AM with the facility Director of Nursing (DON) confirmed that the facility did not have an investigation for the Resident 15 to Resident 190 abuse that occurred on 8/18/24. The DON confirmed that the facility had no documentation that an investigation of the incident was submitted to the state agency within the required 5 working days.

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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. Based on record review and interview the facility failed to obtain the resident/resident representative choice for bed hold (reserving a bed for a resident who has been temporarily transferred to a hospital. This ensures the resident can return to the same facility and bed upon their return if desired) as required for 1 of 1 residents reviewed (Resident 5); and the facility failed to provide the required Ombudsman (a state appointed advocate for residents of nursing homes) notification of a resident discharge for 1 of 1 residents (Resident 38). The facility census was 37.Findings are: A. Record review of the facility policy titled Bed Hold dated 12/19/24 revealed that the purpose is to ensure that the resident/resident representative is made aware of the facility's bed hold and reserve bed payment policy before and upon transfer to a hospital. At the time of transfer the facility will provide written information to the resident or resident representative that specifies the duration of the state bed hold policy during which a resident is permitted to return and resume residence. In case of emergency transfer the resident's copy of the Notice of Bed Hold Policy is sent with the other papers accompanying the resident to the hospital. The social worker or designated individual will contact the resident/resident representative to inquire regarding their decision to hold a bed. In cases where the facility was unable to notify the resident representative, the social worker will document multiple attempts to reach the resident's representative. Record review of the admission Record dated 7/8/25 for Resident 5 revealed that Resident 5 admitted into the facility on 3/4/20. The resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe) and heart failure. Record review of the Progress Note for Resident 5 dated 5/18/25 at 7:18 AM revealed that Resident 5 had a loose, moist cough. Resident 5 complained of chest pain. A call was placed to the Power of Attorney (POA, a resident representative) and the POA requested that Resident 5 be sent to the hospital. Resident 5 left the facility by ambulance at 7:15 AM on 5/18/25. The Bed Hold policy was sent with Resident 5. Record review of the progress note dated 5/18/25 at 8:54 AM revealed that the facility was notified that Resident 5 was being admitted to the hospital. Record review of the undated Notice of Bed-Hold Policy form for Resident 5 revealed that it contained the Resident Name (Resident 5) and the box was checked for copy sent to the hospital with the resident. The check boxes for documenting either “I do” or for “I do NOT” request that a bed be held during this leave of absence were both unchecked. The form did not contain the signature of the resident or responsible party. The form did not contain the signature of the facility representative. No other documentation was present on the form. Record review of the medical record for Resident 5 revealed no documentation that the resident/resident representative were contacted to inquire about their decision to hold a bed for Resident 5’s hospital stay from 5/18/25-5/20/25. The resident record revealed no documentation of any attempts to reach the resident/resident representative to obtain their choice for bed hold or no bed hold. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/10/25 at 8:23 AM with the Facility Administrator (FA) confirmed that the facility did not obtain the resident decision for bed hold or no bed hold for Resident 5's hospitalization 5/18/25-5/20/25. The FA confirmed that the resident/resident representative should have been contacted and had their decision documented. B. A record review of an “admission Record” revealed that the facility admitted Resident 38 on 03/04/2025 with diagnoses of COPD and hypertension (high blood pressure). A record review of Resident 38 “Progress Notes” revealed that Resident 38 was discharged from the facility on 04/09/2025. In an interview completed on 07/08/2025 at 12:00 PM with the FA, the FA confirmed that there was no documentation reflecting the facility notified the Ombudsman of Resident 38’s discharge from the facility. The FA confirmed that there should be documentation reflecting this notification and there was not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(B)Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) for 3 (Residents 6, 22, and 16) of 12 sample residents. The facility census was 32.Findings are:A record review of a facility policy titled MDS 3.0 revealed the MDS Coordinator will complete a validation verification of the entire MDS. The RN (Registered Nurse) MDS Coordinator or the Designee will sign and date the MDS signifying it as complete.A record review of a document titled Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual and dated 10/2024 revealed only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS in the Respiratory Therapy section. A.A record review of the Quarterly MDS dated [DATE] for Resident 6 revealed:-The resident had an original admission date to the facility of 01-22-2024.-Section O0400, letter D: Respiratory therapy was coded reflecting Resident 6 received respiratory therapy 2 days for at least 15 minutes during the look back period. In an interview on 07/09/2025 at 9:19 AM with the facility Minimum Data Set Coordinator (MDS), the MDS stated during the look back period the resident received respiratory therapy in the form of a nurse administering an ultra-sonic nebulizer (inhalation) breathing treatment twice.B.A record review of the Comprehensive MDS dated [DATE] for Resident 22 revealed:-The resident had an original admission date to the facility of 05/19/2025.-Section O0400, letter D: Respiratory therapy was coded reflecting Resident 22 received respiratory therapy 2 days for at least 15 minutes during the look back period. The total number of minutes therapy was received was documented as 75.In an interview on 07/09/2025 at 9:19 AM with the facility Minimum Data Set Coordinator (MDS), the MDS stated during the look back period the resident received respiratory therapy in the form of a nurse administering an ultra-sonic nebulizer (inhalation) breathing treatment twice with documented minutes of 75.In an interview on 07/09/2025 at 5:00PM with the facility Director of Nursing (DON), the DON stated the facility had nurses complete a 15 minute online course and this qualified them as a respiratory nurse so the minutes used to complete ultra-sonic nebulizer treatments were counted on the resident's MDS. The DON confirmed that the facility did not employee a respiratory therapist that administered the treatments. The DON confirmed that none of the nurses administering the treatment to Resident 6 held an American Nursing Association accreditation indicating formal training and certification as a respiratory nurse.C.A record review of the Comprehensive MDS dated [DATE] for Resident 16 revealed:-The resident had an original admission date to the facility of 12/18/2019. -Section N0350, Injections was coded reflecting Resident 16 received 1 insulin (an injectable medication used to help regulate blood sugar levels) injection during the look back period.A record review of Resident 16's electronic medical health record revealed:-05/07/2025 through 05/13/2025 Resident 16 had no physician orders for insulin injection.-05/07/2025 through 05/13/2025 Resident 16 had an physician's order for Ozempic (an injectable medication that is not insulin used to treat diabetes and assist in weight management) injection with directions to inject 2 milligrams subcutaneously once weekly on Fridays.In an interview on 07/09/2025 at 9:19 AM with the facility MDS, the MDS confirmed that Resident 16 did not have an order for and did not receive insulin during the look back period for completion of the MDS. The MDS confirmed that this was a coding error.In an interview on 07/09/2025 at 5:00 PM with the facility DON, the DON confirmed that Resident 16 did not receive an insulin injection and this should not have been coded on the resident's MDS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(ii)Based on observations, interviews and record reviews, the facility failed to update and implement objectives, goals, and interventions related to hospice care on the comprehensive care plan for one (Resident 33) of one sampled resident. The facility census was 37.Findings are:Record review of the facility policy and procedure for Hospice Provided Services dated 11/01/2024 revealed under Procedures paragraph 9;A coordinated comprehensive care plan of care shall be jointly developed by the location and hospice. Hospice participation in the care plan conference and input from the hospice representative is required.1. The plan of care must include directives for managing pain and other symptoms associated with hospice care and must be revised and updated as necessary to reflect the resident's current clinical, psychological, and spiritual condition.2. Location employees will address the discipline specific resident needs on the care plan.3. The hospice team and location employees must communicate with each other when any changes are made to the resident's plan of care.4. Location employees will assess nursing and the hospice in monitoring the resident's pain and reporting resident needs. For example, issues of pain may exacerbate mood and behavior, and all employees should help in monitoring and communicating the resident condition changes so appropriate interventions can be implemented.On the last two pages of the policy and procedure for Hospice care was an excel spreadsheet that outlined what was required by federal regulations, with the federal reference numbers, to be on the comprehensive care plans.Record review of the Resident Census printed and reviewed on 07/10/2025 revealed that Resident 33 was admitted to the facility on [DATE] and was later admitted to Hospice care on 05/20/2025.Record review of the Medical Diagnoses for Resident 33 revealed diagnoses of chronic pulmonary embolism, pressure induced deep tissue damage, malignant neoplasm of the lung, chronic kidney disease stage 3, dementia, and pain.Record review of the working comprehensive care plan (an ongoing and continuously updated plan that outlines the support needed for individuals who can no longer perform daily living activities independently due to chronic illness, disability, or aging.) for Resident 33 revealed there was a revision to the comprehensive care plan on 07/07/2025 there was a revision to the focused objectives of Resident 33 which stated Resident 33 had a terminal prognosis related to lung cancer and achalasia of the esophagus and the phone number for a Hospice nurse was listed. No specific care plan objectives, goals, or interventions related to Hospice care were identified for Resident 33 in the comprehensive care plan. Confirmation obtained in an interview with the Director of Nursing (DON) on 7/9/2025 at 11:42 AM that the comprehensive care plan was not updated with measurable goals and interventions related to Hospice care after Resident 33 was placed on Hospice.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.09 and 175 NAC 12-006.04(F)(i)(5)Based on record review and interview, the facility failed to notify the provider of pharmacist recommendations and an injury; and failed to monitor a resident's injury for 1 (Resident 19) of 2 sampled residents. The facility census was 32. Findings are:A record review of a facility policy titled Medication: Drug Regimen Review and dated 12/02/2024 revealed the pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed. The report will be given to the Director of Nursing (DON) and must be shared with the attending physician and these reports must be acted upon.A record review of an admission Record revealed the facility admitted Resident 19 on 07/31/2020 with diagnoses of 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) and constipation.A.A record review of Resident 19's Progress Notes revealed:-On 02/17/2025 the consulting pharmacist documented the resident had to use their as needed cathartic (a medication used to assist with bowel movements) twice during the look back period and if the usage persisted the pharmacist recommended to modify the resident's bowel regimen.-On 04/18/2025 the consulting pharmacist documented the resident had to use their as needed cathartic medication twice during the look back period and the bowel regimen should be modified if the usage persists.-On 05/29/2025 the consulting pharmacist documented the resident had used their as needed cathartic medication and recommended that the physician continue to monitor usage and adjust bowel regimen if needed.-On 06/21/2025 the consulting pharmacist documented the resident had used there as needed cathartic medication three times during the look back and the provider should evaluate whether the resident would benefit from initiation of a scheduled laxative.A record review of Resident 19's Physician Orders revealed that Resident 19 had orders for Senna S (a cathartic medication) Oral Tablet 8.6-50 milligrams (MG) to administer one tablet twice a day with a start date of 02/09/2024 and an order for Milk of Magnesia (a cathartic medication) 1200 MG per 15 milliliters (ML) and to administer 30 ML every 24 hours as needed. No new orders or order changes were noted in the resident's Physician Orders.A record review of Resident 19's Bowel Documentation conducted on 07/08/2025 for the prior 30 days revealed documentation that Resident 19 did not have a bowel movement between the following dates:-From 06/10/2025 through 06/12/2025, three days.-From 06/24/2025 through 06/26/2025, three days.-From 06/28/2025 through 07/02/2025, five days.-From 07/04/2025 through 07/07/2025, four days.In an interview completed on 07/09/2025 at 5:00 PM with the facility DON, the DON stated they review the recommendations of the pharmacy consultant each month and forward the information to the providers as requested by the pharmacy consultant. The DON was unable to provide documentation that the provider for Resident 19 had been notified of the consultant pharmacist's concern related to the resident's use of the as needed medication and bowel regimen needing reviewed. The DON confirmed that there should be documentation reflecting the provider review of the recommendations and notification of the recommendations and there was not.B.A record review of a facility policy titled Interact Change in Condition Evaluation revealed that a detailed progress note should accompany the completion of a change in condition evaluation in the resident's electronic medical health record.A record review of an untitled document that, per the DON, was the facility's investigation into an abuse allegation involving Resident 19 and dated 05/05/2025, revealed that on 04/30/2025 Resident 19 was involved in an incident where their right arm was bent behind their back with enough force to cause the resident to lose their balance.A record review of Resident 19's progress notes revealed no evidence of documentation of the incident or monitoring of the resident's arm and/or psychosocial state until 05/05/2025. On 05/06/2025 documentation reflected that the resident complained of right arm pain and was assessed to have a 4 centimeter by 2.2 centimeter swollen area to their right arm that was tender to the touch. On 05/07/2025 documentation reflected that bruising was starting on the right forearm with measurements included. The documentation stated there was swelling and the area was tender to touch. On 05/07/2025 documentation reflected that the resident was seen by a provider and the area was assessed by the provider and the resident's responsible party was notified.In an interview on 07/09/2025 at 5:00 PM with the facility DON, the DON stated that an investigation was not completed into the swelling and bruising to the resident's right arm. The DON stated the facility deemed the areas were a result of the incident that occurred on 04/30/2025. The DON confirmed there was no documentation of continued monitoring or assessment of the resident from the incident that occurred on 04/30/2025 between that date

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	285187	A. Building B. Wing	07/10/2025

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Good Samaritan Society - Superior	1710 Idaho Street Superior, NE 68978

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation and interviews, the facility failed to maintain the ice machine in a sanitary manner. This had the potential to affect all residents residing in the facility. The facility census was 32.Findings Are:In an observation completed on 07/08/2025 at 8:00 AM the facility ice machine was observed in the common dining area. A thick, yellow-white flakey buildup was observed on the front of the machine where ice is dispensed. This material was also visible to the black water dispensing area as well as the fluid drain area and black grate that covered the fluid drain area. In an interview completed on 07/09/2025 at 9:00 AM with the facility Dietary Manager (DM), the DM confirmed that the buildup on the ice machine made it an uncleanable and unsanitary surface. The DM also confirmed that it was the responsibility of the dietary department to clean these portions of the machine but there was not a process in place to ensure this was completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.04(A)(ii)Based on record review and interview the facility failed to ensure that pre-employment health assessments were completed prior to the first day of employment as required to prevent the potential for transmissible diseases for 2 of 5 sampled staff. The facility census was 37.Findings are:Record review of the facility policy titled Hiring and Screening dated 3/28/25 revealed that Human Resources will conduct background checks on all new employees and transfers prior to beginning employment or transferring to a new position. All offers of employment are contingent upon successful completion of the background check, state-specific background check, professional/personal reference check, health assessment, drug screen, and any other pre-employment requirements. A pre-employment health assessment will be conducted on all external job applicants who have accepted offers of employment. The health assessment is required prior to the first day of employment and employment is contingent upon successful completion of the health assessment. A.Record review of the untitled and undated list of facility employees revealed that Food Service Assistant-A (FSA-A) had a hire date of 6/16/25.Record review of the Supervisor Time Card Report Summary dated 7/9/25 for June 2025 for FSA-A revealed that FSA-A worked 6.3 hours on 6/17/25 (first day of work), 4.5 hours on 6/18/25, 0.67 hours on 6/19/25, 4.07 hours on 6/24/25, 3.83 hours on 6/26/25, 3.68 hours on 6/27/25, and 4.83 hours on 6/28/25. Record review of the Communicable Disease Screening form (the pre-employment health assessment) dated 6/25/25 for FSA-A revealed that it was signed by FSA-A on 6/25/25 and reviewed by the nurse on 6/25/25.Record review of the untitled Dietary Staff Schedule dated June 15-28, 2025 revealed that FSA-A was scheduled and worked the 4:00 PM to 7:45 PM shift on 6/24/25, 6/26/25, 6/27/25, and 6/28/25.Interview on 7/9/25 at 4:22 PM with FSA-A revealed that during the first week of employment at the facility FSA-A did online in-service training. FSA-A revealed that the first night in the dining room on the job was on 6/24/25. FSA-A revealed that they worked with the Dietary Manager doing on the job training in the dining room on 6/24/25.Interview on 7/9/25 at 2:32 PM with the Facility Administrator (FA) confirmed that new staff usually do two days of on-line orientation training and then do on the job training. The FA confirmed that the Communicable Disease Screening form for FSA-A was completed on 6/25/25. The FA confirmed that the pre-employment health assessment had not been completed prior to FSA-A beginning their job duties as required. B.Record review of the untitled and undated list of facility employees revealed that FSA-B had a hire date of 6/17/25.Record review of the Supervisor Time Card Report Summary dated 7/9/25 for June 2025 for FSA-B revealed that FSA-B worked 4.15 hours on 6/17/25 (first day of work), 1.35 hours on 6/18/25, 1.35 hours on 6/19/25, 2.92 hours on 6/23/25, 3.80 hours on 6/26/25, and 3.70 hours on 6/27/25.Record review of the Communicable Disease Screening form dated 6/25/25 for FSA-B revealed that it was signed by FSA-B on 6/26/25 and reviewed by the nurse on 6/26/25.Record review of the untitled Dietary Staff Schedule dated June 15-28, 2025 revealed that FSA-B was scheduled and worked the 4:00 PM to 7:45 PM shift on 6/24/25, 6/26/25, and 6/27/25.Interview on 7/9/25 at 2:32 PM with the Facility Administrator (FA) confirmed that the Communicable Disease Screening form for FSA-B was completed on 6/26/25. The FA confirmed that the pre-employment health assessment had not been completed prior to FSA-B beginning their job duties as required.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.19 Based on observations and interviews, the facility failed to ensure that fences on the outside perimeter were safe for residents who go outside, failed to ensure the weeds and grasses were mowed and removed from flower beds, failed to ensure that the water system electricity to the backyard pond was safe and the water in the pond was clean, failed to ensure that caulking in resident rooms was safe and sanitary in all resident rooms - this affected 3 residents (Residents 15, , and 36) of 37 sampled, and failed to ensure there were working light bulbs in the bathrooms of all resident rooms - this affected 2 residents (Resident 13 and Resident 5) of 37 residents sampled. The facility census was 37.Findings Are:A. Observation on 07/07/2025 at 9:15 AM upon arrival at the facility revealed the following: 1. The fence to the north side of the building had a vinyl fence that stretched the entire length of the building, but some parts of the fence leaned to the south. 2. A seating area to the north side of the building beside the sidewalk/walking path, was overcome with grass, weeds, and green vegetation.3. The sidewalk area had weeds and other vegetation growing amongst the flowers and shrubbery. B.Observation on 07/07/2025 at 11:48 AM in room [ROOM NUMBER] revealed the bathroom lighting was dark with the middle of 3 bulbs above the sink not working. Observation on 07/07/2025 at 11:51 AM in room [ROOM NUMBER] bathroom revealed there was caulking with gaps and dark soiling on top of sink and around base of toilet. There was also dark black/brown soiling and some light tan soiling on the top of the metal molding seam along the bathroom wall with the toilet paper and call light.Observation on 07/07/2025 at 1:33 PM in room [ROOM NUMBER] revealed caulking with gaps and dark soiling on top of the sink and around the base of the toilet. Observations on 07/08/2025 at 4:25 PM during a tour of the facility with the facility Maintenance Supervisor (MAINT) revealed the following: 1. Fans were located in the 100 hallway near the bath and storage area blowing air towards the northern part of the hall.2. The backyard fence was open in the middle of the eastern side and had one more opening on the south side. Gates were not closed or secure.3. A small pond with dimensions of approximately 10 feet by 20 feet sat just outside the window of the administrator's office in the northwest corner of the grassy area of the yard. The pond was surrounded by large decorative rocks and a short black fence that stood about 2 feet tall, had vegetation that needed trimmed, was filled with water that was green and opaque, and had a working rock waterfall. 4. A bench for outdoor seating near the administrator's window had three large hydrangeas sitting on the resident seating area in containers and three more large hydrangeas on the ground in containers. Residents could not sit on the bench.5. Small silver domes were observed above the resident rooms of the 100 hallway and MAINT stated that these were the single unit ventilation fans for each room that are currently not in working order. Interview on 07/08/2025 at 4:25 PM with the facility Maintenance Supervisor (MAINT) MAINT stated, The building has issues. The resident ventilation fans don't work. They squeal and the bearings are out of them. The Heating and Air Conditioning (HVAC) units also don't work the way they are supposed to work. The air coming out of the air conditioners should be around 45 degrees Fahrenheit (F). But the coolest air I can get out of the HVAC system is 74 degrees F. I have had the HVAC repairman in here multiple times. The repairman told me not to call him again because the unit that serves the 100 and 200 halls and the unit in the dining rooms are all the same - old, worn out, and can't be repaired anymore. They need replaced. These units are not pulling the humidity out of the air like they should for cooling. These are the same units that will heat the building this winter. The same units we will rely on to heat this place when the temperature is 20 degrees F below zero. That is why you have seen the fans in the halls of the 100 hall because staff are just trying to keep the temperature between the mandatory 71 to 81 degrees F in the building for the residents. Filters on the HVAC systems are changed monthly during the summertime and every other month in the winter. I don't change them every month. I don't have a manual that tells me how often I need to change the filters. I change them more often in the summer because of all of the cotton flying, dust, and pollen. The fences outside on the north side of the building are vinyl fences. but they didn't put anything sturdy in the middle of the post part and just stuck them in the ground with cement. So, in the wintertime, snow from the parking lot next door gets pushed up against the vinyl fence to the north. That has caused our fence to lean. The fences on the north side are still standing but they are all leaning. MAINT confirmed that this was a safety concern for any resident who is able to go outside and walk around or any resident who would elope and get outside and not be noticed. MAINT confirmed room [ROOM NUMBER] did need new caulking around the toilet. We have weeds in all the flower beds. There are places

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure ventilation in all resident rooms was in working order. This affected 27 (Residents 1, 2, 4, 5, 7, 8, 9, 10, 11, 13, 15, 18, 19, 21, 22, 23, 24, 26, 27, 28, 29, 31, 33, 34, 35 and 36) of 37 sampled residents. The census was 37.Findings are:Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 11:45 AM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 11:48 AM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 11:51 AM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 12:17 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 1:02 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 1:25 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 1:28 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 1:33 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Observation of the ventilation system in room [ROOM NUMBER] on 07/07/2025 at 2:34 PM revealed the bathroom exhaust ventilation fan would not pull up a 1-ply square of toilet paper. Staff had just finished assisting Resident 30 with toileting and the room was noted to have a foul odor.Observation on 07/08/2025 at 4:25 PM of the Maintenance Director (MAINT) who used a feather duster and 4 squares of toilet paper to check the ventilation system in room [ROOM NUMBER]. There was no movement and the vent did not pull up the toilet paper piece to the vent.Interview on 07/08/25 at 4:25 PM with MAINT whose date of hire was 05/10/2021, confirmed the ventilation fan in room [ROOM NUMBER] did not work. MAINT then revealed it was known the bathroom ventilation fans in the 100 and 200 halls did not work. MAINT stated, I have worked here for 3 years, and they have never worked. MAINT then stated that the 300 and 400 halls/rooms were on a different type of ventilation system and those fans should have no issues and should all work. Observation on 07/08/2025 at 4:30 PM as MAINT checked the fan in room [ROOM NUMBER] which did not work. Confirmation interview on 07/08/2025 at 8:40 AM with MAINT who confirmed the bathroom ventilation fans in the 100 and 200 halls do not work. MAINT further confirmed the fans in room [ROOM NUMBER], 403, and 406 do not work. MAINT stated that if the fans were to be turned on the squeal and the noise is overwhelming, the bearings were burned out and the fans did not work. Interview on 07/08/25 at 4:40 PM with the Interim Administrator (FA) whose hire date was 04/15/2025, revealed FA was unaware that the resident bathroom ventilation fans did not work in the 100 and 200 hall rooms and rooms in the 400 hallway. The FA confirmed that not having working fans in rooms of resident bathrooms could cause resident embarrassment if the rooms smelled.