STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285189	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - St John's	3410 Central Avenue Kearney, NE 68847

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 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. Licensure Reference Number 175 NAC 12-006.09(I)(i)(1) Based on record review and interview, the facility failed to identify the causative factors in falls as they related to one of 3 sampled residents (Resident 3). The facility census was 40.Record review of the facility policy dated 6/2/26 Falls Resource Packet - Rehab /Skilled revealed that the facility requires that all locations have a fall reduction program the provides organized and sustained processes that are monitored by designated employees and understood and followed by all employees. A successful fall reduction program is the responsibility of all employees. Employees are required to complete fall prevention and fall management training with a purpose to provide an evidence-based collection of information and tools for an effective fall reduction program that results in well-being for residents and employees. Medical documentation included completion of the SAFE Event Incident report and the Fall Risk Evaluation Report. Definition of a fall was the unintentional change in position coming to rest on the ground or onto the next lower surface or the result of an overwhelming external force (resident pushes another resident for example). The following examples constitute a fall; found on the floor, witnessed fall, slip or trip or resident reports slip trip or fall, eased to the floor assisted or unassisted, rolls or slides off bed or chair onto the floor, and falls off or out of any equipment.Further record review of facility policy's related to falls revealed staff were to use the post fall huddle evaluation to determine the cause of the fall and the appropriate interventions to prevent another fall. A Post Fall Huddle Worksheet was to guide efforts to gather information about possible causes, resident and employee actions and help with trending. The Post Fall Huddle Worksheet is not a part of the medical record, not a comprehensive evaluation, and not an incident report. While the cause will not be the same for each fall, tracking falls, and analyzing the data related to falls will help to identify any common elements and/or trends such as days of the week, certain shifts, certain locations, that may require changes in facility practices. Review of the SAFE Resident Event details for Resident 3 which had a documented date of fall on 5/6/26 revealed the description of the event to be found on floor by (wheelchair) on left side in his room. There was no documented injury but had an immediate intervention put into place to bring the resident to common area after getting up in the morning. Review of the Safe Resident Event details for Resident 3 which had a documented date of fall on 5/28/26 revealed Resident 3 was found with safety alarm on as nurse aide just left room, (Resident 3) was lying in front of wheelchair as pedals were on also. No injury was noted at that time with an immediate intervention put into place to remove the pedals from wheelchair when resident is not being pushed.Record review of the progress notes for Resident 3 revealed The both falls were documented however, there was no causative factors listed for either of the falls in the progress notes.Interview on 6/8/26 at 12:30 PM with Minimum Data Set (MDS) (a standardized, federally mandated clinical assessment tool used in all Medicare and Medicaid-certified nursing homes and skilled nursing facilities used to evaluate the health status, functional capabilities, and care needs of every resident) Coordinator (MDSC) revealed that the staff member that finds the resident who fell on the shift fills out the safety event. There is also a risk event that needs to be completed and they should do the SAFE fall event and vitals and pain assessment. There are several pieces to complete (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	with each fall. Each person filling out the information is expected to put into the reports what happened, the root case if they know what it is and hopefully they can figure that out. Sometimes if it someone that falls all the time they may be non-compliant or unable to learn and so that needs to be included in the cause of the fall. The staff should obtain the vitals. The vitals go into the charting. If there is an unwitnessed fall or they hit their head they will do neuro checks and monitoring for a period of about 3 days. Notes from the interdisciplinary team (IDT) meeting in which facility leaders discuss risk management will be included on the chart if needed. We try to do IDT meetings weekly. Sometimes it is every other week. We discuss every morning the falls in clinical handoffs at shift to shift reports so that all staff are aware of any falls that have taken place and the immediate actions that were taken to avoid more. Finally, the care plan (a personalized document created by healthcare professionals, patients, and caregivers that outlines a specific medical condition, care goals, and the actionable steps needed to achieve them) has to be updated. In a confirmation interview on 6/8/26 at 1:05, the MDSC revealed that on 5/6/26 Resident 3 had a fall. There is no causative factor listed and there is nothing noted in the chart or follow up investigation that reveals the cause of the fall. The chart states that the resident was found on the floor by the wheelchair on left side in the resident's room. This does not tell anyone what caused the fall, it just states that there was a fall. Our staff know why the resident fell, but as an outsider, nobody else would know. I think we become complacent in our charting as nurses and forget to write what needs to be there all the time. On 5/28/26, Resident 3 had another fall and there is nothing that tells us what occurred. The description of the event says the resident was found with safety alarm on as Nurse Aide just left room, (Resident 3) was lying in front of wheelchair as pedals were on also. This does not tell anyone what the cause of the fall was either. There is nothing in the chart note. We don't know if Resident 3 was competent or what Resident 3 was doing. We have a new person that is now doing the quality assurance and performance improvement now to make certain that we are improving on different aspects of the cares we give at the facility. Our new staff member is using spread sheets and fills things out a lot better than has been done in the past. I guess sometimes you don't know what you are missing until you actually have it. I guess there is not really good area that e cause of the falls are charted. We want nursing staff to find the root cause to prevent it from happening again.