STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - St Johns	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 1-009.01(B) Licensure Reference Number 175 NAC 12-006.19(A) Based on observation, interview, and record review; the facility failed to ensure that resident equipment was cleaned and maintained for 5 residents (Residents 15, 17, 29, 7, and 18) of 8 residents sampled. This affected the residents' right to a dignified existence. The facility census was 44. Findings are: A. A record review of the facility's Resident Handbook dated 06/2021 revealed in the section titled Maintenance Services that the facility is responsible for the maintenance and service of the building and all equipment owned by the center. The section titled Resident Mobilization Information revealed the facility strives to sustain and improve each resident's health with frequent mobilization. The resident's weight-bearing support needs will be determined and the appropriate equipment will be provided for bed mobility, transfers, and ambulation. Residents who are determined to need weight bearing assistance or hands on assistance by staff will receive mobility assistance specific to their needs. A record review of the facility document Resident's Rights for Skilled Nursing Facilities dated 01/2022, revealed that the resident has the right to a dignified existence. The facility must protect and promote the rights of each resident. The facility must treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life. The facility must protect and promote the rights of the resident. A record review of the facility's Admission Agreement dated 07/2020, revealed in the section titled Services and Charges that the facility agrees to furnish the resident with the following services included in the daily rate: nursing services, food and nutrition services, an activities program as defined by regulations, room/bed maintenance and housekeeping services, basic laundry services, medically related social services and other services required by law. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Admission Record dated 12/31/2024 for Resident 15 revealed that Resident 15 was admitted into the facility on [DATE]. A record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 10/24/2024 for Resident 15 revealed that Resident 15 used a manual wheelchair for mobility. An observation on 12/31/2024 at 7:22 AM in the room of Resident 15 revealed that Resident 15 was seated in a wheelchair next to the bed watching the tv. The floor in front of the resident was soiled with yellowish crumbs or food debris. The right wheelchair wheel was soiled with a large amount of tan crusty debris and grayish debris that was visible from the doorway. The wheelchair was soiled with visible tan and grayish crusty debris on the right wheelchair wheel and build up on the right brake. The edge of the wheelchair seat was soiled with a tan residue. [NAME] residue soiling was also visible on the wheelchair pedals. An observation on 12/31/2024 at 11:19 AM in the room of Resident 15 revealed that Resident 15 was seated in the recliner facing towards the tv. The resident's wheelchair was also in their room and the right wheelchair wheel was visibly soiled with a large amount of tan crusty debris and grayish debris. [NAME] crusty debris build up was piled on the right brake of the wheelchair. The seat and edge of the seat along the seat frame was soiled with tan residue. [NAME] residue soiling was also visible on the wheelchair pedals. An observation on 1/2/2025 at 8:27 AM in the facility dining room revealed that Resident 15 sat in the wheelchair at a table. The right wheelchair wheel was soiled with a large amount of tan crusty debris and grayish debris. [NAME] crusty debris build up was piled on the right brake of the wheelchair. The seat and edge of the seat along the seat frame was soiled with tan residue. The left wheelchair wheel was soiled with a brown substance on the left wheel. [NAME] residue soiling was visible on the wheelchair pedals. An observation on 01/06/2025 at 7:47 AM in the front tv room near the activity room revealed that Resident 15 sat in the wheelchair. The right wheelchair wheel remained soiled with a large amount of tan crusty debris and grayish debris. [NAME] crusty debris build up remained piled on the right brake of the wheelchair. The seat and edge of the seat along the seat frame remained soiled with tan and light yellow debris build up and chunks of food debris along the left and right edges of the wheelchair cushion. [NAME] residue soiling was also visible on the wheelchair pedals. An interview on 01/06/2025 at 11:20 AM with Nurse Aide (NA)-D revealed that resident wheelchairs were rarely cleaned and they were not on a regular cleaning schedule. An interview on 01/06/2025 at 11:56 AM with NA-E revealed that the night shift was supposed to clean wheelchairs weekly or biweekly and document the cleaning. An observation on 01/06/2025 at 12:01 PM in the facility dining room with the Facility Administrator (FA) revealed that Resident 15 sat in the wheelchair at a table. The wheelchair remained soiled with the dried white/tan, yellow, and gray debris on the wheelchair wheels, frame along the wheelchair seat cushion, and had a large crusty grayish-tan buildup on the top of the right brake. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/06/2025 at 12:01 PM with the FA confirmed that the wheelchair of Resident 15 was soiled with dried white, yellow, and gray debris on the wheelchair wheels, frame along the wheelchair seat cushion, and had a large crusty grayish buildup on the top of the right brake. The FA confirmed that the wheelchair needed to be cleaned. A record review of the Wheelchair/Walker Cleaning Schedules for 06/23/2024-08/31/2024 revealed no cleaning of resident wheelchairs and walkers was documented. A record review of the Wheelchair Cleaning Schedule dated 10/07/2024-10/12/2024 revealed no documented cleaning of wheelchairs for Resident 15. A record review of the Wheelchair Cleaning Schedule dated 10/20/2024 revealed documentation that the wheelchair of Resident 15 was cleaned on 10/20/2024. No Wheelchair cleaning schedules were completed for 10/27/2024-01/06/2025. An interview on 01/06/2025 at 12:08 PM with the FA confirmed that the night shift was to clean wheelchairs weekly. The FA confirmed that no cleaning of wheelchairs had been documented since October 2024. The FA confirmed that the wheelchair of Resident 15 had not been cleaned since October 2024. B. A record review of the Admission Record dated 12/31/2024 revealed that Resident 17 was admitted to the facility on [DATE]. A record review of the Care Plan for Resident 17 dated 12/30/2024 revealed that Resident 17 used a manual wheelchair for independent mobility. An observation on 12/31/2024 at 10:58 AM in the room of Resident 17 revealed that Resident 17 sat in the wheelchair in the middle of the room. Scattered tan debris soiling and debris were visible on the wheelchair wheels, hand propel wheels, rims, and frame. An observation on 01/02/2025 at 8:27 AM in the facility dining room revealed that Resident 17 sat in the wheelchair at a dining room table. Debris of various colors was stuck on the wheelchair on both rubber wheels, the hand propel bars, and rims. An approximately 2 centimeter x 1 centimeter whitish food chunk was visible on the right brake lever connection. An observation on 01/06/2025 at 7:47 AM outside the room door of Resident 17 revealed that Resident 17 sat in the wheelchair. Scattered tan and dark brown debris soiling remained on the wheels and frame of the wheelchair. An observation on 01/06/2025 at 12:04 PM in the facility dining room with the Facility Administrator (FA) revealed that Resident 17 sat in the wheelchair at a table. The wheelchair remained soiled with the dried white, yellow, and gray debris and residue on the wheelchair wheels, frame, along the wheelchair seat cushion, and had food debris on the top of the right brake lever connection. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 01/06/2025 at 12:01 PM with the FA confirmed that the wheelchair of Resident 17 was soiled with dried white, yellow, and gray debris on the wheelchair wheels, frame, along the wheelchair seat cushion, and had food debris on the top of the right brake connection. The FA confirmed that the wheelchair needed to be cleaned. A record review of the Wheelchair/Walker Cleaning Schedules for 6/23/2024-8/31/2024 revealed no cleaning of resident wheelchairs and walkers was documented. A record review of the Wheelchair Cleaning Schedule dated 10/07/2024-10/12/2024 revealed no documented cleaning of wheelchairs for Resident 17. A record review of the Wheelchair Cleaning Schedule dated 10/20/2024 revealed documentation that the wheelchair of Resident 17 was cleaned on 10/20/2024. No Wheelchair cleaning schedules were completed for 10/27/2024-01/06/2025. An interview on 01/06/25 at 12:08 PM with the FA confirmed that the night shift was to clean wheelchairs weekly. The FA confirmed that no cleaning of wheelchairs had been documented since October 2024. The FA confirmed that the wheelchair of Resident 17 had not been cleaned since October 2024. C. A record review of the Admission Record dated 12/31/2024 for Resident 29 revealed that Resident 29 was admitted into the facility on [DATE]. A record review of the Minimum Data Set (MDS) dated [DATE] for Resident 29 revealed that Resident 29 used a manual wheelchair for mobility. An observation on 12/31/2024 at 7:59 AM in the room of Resident 29 revealed that the wheelchair sat next to the resident's bed. Brown, tan, and gray debris was visible on both wheels, the wheel frames, and foot pedal peg platforms. An observation on 01/02/2025 at 10:20 AM in the room of Resident 29 revealed that Resident 29 sat in the wheelchair at the card table in the corner of the room at the foot of the bed. Food and trash debris was visible on the floor in front of the recliner and under the resident bed. The wheelchair of Resident 29 was soiled with brown, tan, and gray debris on both wheels, the foot pedal pegs, and wheelchair frame. An observation on 01/06/2025 at 9:43 AM at the room of Resident 29 revealed that Resident 29 propelled themselves out of the room in the wheelchair. [NAME] and other various colored dried debris remained visible on both wheels, foot pedal peg platforms, and frame of the wheelchair. An observation on 01/06/2024 at 11:56 AM in the room of Resident 29 with the FA confirmed that the wheelchair of Resident 29 was soiled with gray debris on the wheel spokes, brownish debris on the wheelchair frame, and other brown, tan, and gray debris on the wheelchair foot pedal platforms and the frame. A record review of the Wheelchair Cleaning Schedule dated 10/07/2024-10/12/2024 revealed no documented cleaning of wheelchairs for Resident 29. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Wheelchair Cleaning Schedule dated 10/20/2024 revealed no documentation that the wheelchair of Resident 29 was cleaned. No Wheelchair cleaning schedules were completed for 10/27/2024-01/06/2025. An interview on 01/06/2025 at 12:08 PM with the FA confirmed that the night shift was to clean wheelchairs weekly. The FA confirmed that no cleaning of any wheelchairs had been documented since October 2024. The FA confirmed that the wheelchair of Resident 29 had not been cleaned since sometime before October 2024. D. An observation on 12/30/2024 at 12:07 PM in the bathroom of Resident 7 revealed that the bathroom exhaust vent was soiled with a buildup of fluffy grayish debris. The base of the toilet had missing caulking and the base of the toilet was soiled with brown and yellow debris. An observation on 01/06/2025 at 11:58 AM with the Facility Administrator (FA) in the bathroom of Resident 7 revealed that the exhaust vent was soiled with fluffy grayish debris. The base of the toilet had missing caulking and was soiled with brown to yellow debris buildup. An interview on 01/06/2025 at 11:58 AM with the FA confirmed that the exhaust vent in the bathroom of Resident 7 was soiled and needed to be cleaned. The FA confirmed that the toilet in the bathroom of Resident 7 was soiled with brown to yellow debris buildup and needed to be cleaned. E. An observation on 12/30/2024 at 11:59 AM in the bathroom of Resident 29 revealed that the bathroom exhaust vent was soiled with a buildup of fluffy gray debris. An observation on 01/06/2025 at 11:56 AM with the FA in the bathroom of Resident 29 revealed that the exhaust vent was soiled with a buildup of fluffy gray debris. An interview on 01/06/2025 at 11:56 AM with the FA confirmed that the exhaust vent in the bathroom of Resident 29 was soiled and needed to be cleaned. F. An observation on 12/30/2024 at 11:56 AM in the bathroom of Resident 18 revealed that the hot water temperature was 110.3 degrees Fahrenheit per a thermometer with the hot water running. The water continued to rise up in the sink as the water ran. This surveyor shut the water off before it ran over the sink. The water drained slowly. An observation on 01/06/2025 at 11:58 AM in the bathroom of Resident 18 with the FA revealed that the water built up in the sink as the water was on. The water continued to rise in the sink until this surveyor shut the water off. An interview on 1/6/2025 at 11:58 AM with the FA confirmed that the drain in the bathroom sink of Resident 18 was not draining properly and needed to be fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. An observation on 12/30/2024 at 12:03 PM in the bathroom of Resident 15 revealed that the hot water temperature was 110.3 degrees Fahrenheit per a thermometer with the hot water running. The water continued to rise up in the sink as the water ran. This surveyor shut the water off before it ran over the sink. The water drained slowly. An observation on 01/06/2025 at 12:04 PM in the bathroom of Resident 15 with the FA revealed that the water built up in the sink as the water was on. The water continued to rise in the sink until this surveyor shut the water off. An interview on 01/06/2025 at 12:04 PM with the FA confirmed that the drain in the bathroom sink of Resident 15 was not draining properly and needed to be fixed.

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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** 41938 Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on record review and interview, the facility failed to ensure that the resident/resident representative were provided the opportunity to participate in quarterly care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) review as required for 1 resident (Resident 29) of 5 residents reviewed. The facility census was 44. Findings are: A. A record review of the facility policy titled Care Plan and dated 12/2/2024, revealed that each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables, directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent possible. The interdisciplinary team will review care plans at least quarterly. A record review of the facility policy titled Comprehensive Care Plan and Care Conferences and dated 12/4/2023, revealed that the purpose is to provide an ongoing method of evaluating and updating the resident's care plan to help maintain the resident's highest practicable level of function. The section titled Coordinating the Care Conference revealed that the social worker or designee will establish the time and place to hold the care conference and invite residents and their representative at least two weeks in advance of the care conference. Invitations may be sent to the resident representative using the Care Plan Invitation Letter. If the resident and/or resident representative is not invited to the care conference, an explanation must be included in the medical record. Inform residents and representatives of the right to request meetings, request revisions to the care plan and to be informed in advance of changes to the care plan. A record review of the Admission Record dated 12/31/2024 for Resident 29 revealed that Resident 29 was admitted into the facility on [DATE]. Resident 29 had a Power of Attorney (POA) for healthcare. The POA was a child of Resident 29. An interview on 12/30/2024 at 1:02 PM with the POA for Resident 29 revealed that they were concerned that they had not been invited to a care plan for Resident 29 since last spring or summer. A record review of the Progress Note for Resident 29 dated 8/6/2024 at 11:14 AM revealed that social services called the POA and notified them that they had a care plan conference on 8/08/2024 at 10:00 AM. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Progress Note for Resident 29 dated 8/06/2024 at 11:19 AM revealed that family stated that they would prefer to have the care plan meeting on 8/09/2024 at 9:30 AM to accommodate family schedule. A record review of the Care Plan Review note dated 8/07/2024 at 4:10 PM revealed that social services documented that Resident 29 had met goals and would continue the same course at that time. The note contained no documentation of resident or family presence or absence at the review. A record review of the Progress Notes in the medical record for Resident 29 dated from 8/08/2024 through 12/31/2024 revealed that it contained no documentation of the resident or family being invited to a care plan meeting or attending a care plan meeting. The medical record contained no documentation or explanation for the resident or family not being invited to a care plan meeting. A record review of the Care Plan Review note dated 12/19/2024 revealed it was a nursing note that the care plan was reviewed and reflected Resident 29's current Minimum Data Set assessment (a mandatory comprehensive assessment tool used for care planning). The note contained no documentation of resident or family participation in the review. An interview on 1/06/2025 at 2:25 PM with the facility Social Services Director (SSD) confirmed that a care plan meeting with each resident/family was to occur quarterly to review and discuss their care plan. SSD revealed that the facility had no documentation of Resident 29 or Resident 29's family participation or declination to participate in quarterly care plan meetings in the past year. The SSD confirmed that the SSD was unable to find any documentation that Resident 29 and Resident 29's family participated in quarterly care plan meetings in 2024 as required.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licensure Reference Number 175 NAC 12-006.09(H)(i)(3) Based on record review, interviews, and observations, the facility failed to ensure bathing was offered and completed for residents who needed assistance. This affected 4 (Residents 1, 20, 203, and 252) of 5 sampled residents. The facility census was 44. Findings are: A record review of the facility Policy and Procedure for Bathing reviewed and revised on 09/03/2024, stated that the purpose of the policy is; - To promote cleanliness and general hygiene, - Stimulate circulation of the skin, - Promote comfort, relaxation, and well-being, - Observe resident's condition, - Assist resident with personal cares, and - To promote safety for the resident in the bath. Procedures outlined in the policy included tub or shower bathing and bed baths. A. A record review of the Minimum Data Set (MDS, a mandated assessment tool used to evaluate the health and functional status of residents in nursing homes used for care planning) dated 12/10/2024 for Resident 1 indicated this resident was admitted to the facility on [DATE]. Resident 1 had a Brief Interview for Mental Status (BIMS, a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) score of 15/15 indicating the resident is cognitively intact. The MDS also revealed Resident 1 needed partial to moderate assistance with bathing. A record review of Resident 1's Care Plan (a detailed document outlining a person's health needs, current medical conditions, treatment plan, and specific goals for their care) printed and reviewed on 12/30/2024 revealed Resident 1 had a self-care deficit related to the fractured pelvis and needed assistance with bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 12/30/2024 at 3:38 PM with Resident 1 revealed that the resident wanted to take a bath or have a whirlpool bath. However, because of a pressure ulcer Resident 1 had obtained prior to admission to the facility and daily dressing changes to the sacral area, Resident 1 was not allowed to have a regular bath. When asked how long it had been since Resident 1 had been allowed to take a bath, the resident stated let's just say it's been awhile. A record review of Resident 1's 30-day look back period of their bathing record printed on 12/31/2024 revealed that the last recorded bath was on 12/03/2024 with no other baths recorded for the month. An interview on 1/02/25 at 10:40 AM with Resident 1 revealed Resident 1's family member had gotten very upset because Resident 1 was not getting any baths. Resident 1 stated their family member had gone to the staff and requested Resident 1 have a bath immediately. Resident 1 revealed they were then given a whirlpool bath on 1/1/2025. B. A record review the MDS, dated [DATE], for Resident 20 revealed the resident was admitted to the facility on [DATE]. Resident 20 had a BIMS score of 15/15 and was alert to person, place and time. The MDS data also revealed the resident was able to shower and bathe per self without assistance. A record review of the care plan for Resident 20 revealed Resident 20 had a self-care deficit related to chronic kidney disease and weakness and required the assistance of one person for bathing and personal hygiene. Resident 20 was at risk for skin breakdown due to morbid obesity and the care plan stated that skin was to be kept clean and dry. A record review of Resident 20's 30-day look back period on the bathing record printed on 12/30/2024 revealed Resident 20 had received a bath on 12/04/2024 and 12/26/2024. An observation on 12/30/24 at 3:35 PM of Resident 20 revealed the resident was seated in a personal recliner in their room and that the resident had a foul smelling body odor. An interview on 12/31/24 at 12:00 PM Resident 20 revealed they had been given a shower that day. An interview on 1/02/2025 at 7:45 AM with Resident 20 revealed the resident had an in-room shower the resident could use if there was someone who could assist with the shower. Resident 20 stated I am scared to shower by myself because the floor floods in my bathroom when I am in the shower and i have to use a shower chair. I just need to have someone in the room with me when I shower. An interview on 01/02/25 at 10:41 AM with Nursing Assistant (NA)-B confirmed NA-B had received no training on the use of the whirlpool bath but did assist residents with their showers once or twice a month. C. A record review of the MDS dated [DATE] for Resident 252 revealed this resident had an admitted [DATE] and was admitted to the facility as a Hospice care resident. Resident 252 had a BIMS score of 14/15 and was alert and oriented to person, place, and things. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 252's Care Plan, with a reviewed date of 12/30/2024 revealed the resident needed assistance with activities of daily living but did not specify what type of assistance was needed. A record review of Resident 252's Care Plan after it was updated on 1/2/2025, revealed Resident 252 required set-up assistance and oxygen management assistance while bathing. A record review of Resident 252's 30-day look back period for bathing on their Bathing Tasks printed on 1/2/2025 revealed there had been no baths recorded for the prior 30 days. An observation on 12/20/2024 at 11:23 AM of Resident 252 in their room revealed Resident 252's lower right leg had yellow, crusted exudate on it. The resident's lower left leg had a bandage wrapped around the resident's calf. An interview on 01/01/2025 at 9:55 AM with Resident 252 revealed the resident used shower wipes rather than bathe because the nursing staff completed dressing changes to both of the resident's legs so early in the day and did not want to wash the medication off while bathing. Resident 252 also revealed that Resident 252 needed assistance with showers because of their oxygen tubing and due to the resident getting tired while showering. An interview on 12/31/2024 at 1:30 PM with the Facility Administrator (FA) revealed that bathing was an issue in the facility as the bath aide had been terminatied at the beginning of December 2024. FA confirmed the residents, including Residents 1, 20, and 252 were not being assisted with bathing as required. 50105 D. A record review of an Admission Record indicated the facility admitted Resident 203 on 12/03/2015. A record review of Resident 203's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) updated on 12/30/2024 revealed that Resident 203 had an activity of daily living (ADL, basic everyday tasks including bathing, eating, dressing, getting in and out of bed, and toileting) self-care performance deficit. Interventions preferences for baths was 1 whirlpool bath per week. Other interventions for ADL care includes 1 assist for bathing/showering and dressing, while transferring and toilet use requires full lift assistance with 2 staff assisting. A record review of Resident 203's 30-day look back task record for bathing revealed documentation that the resident must have a shower, no tub bath related to suprapubic catheter (SPC, a tube that drains urine from the bladder by inserting through the abdominal wall and into the bladder). The look back period revealed no data found for any charting that a shower was offered or completed for the 30-days prior to 1/02/2025 for Resident 203. An observation of Resident 203 on 12/30/2024 at 11:20 AM revealed the resident lying in bed with their face unshaven. The resident had pink matter at both corners of their mouth and teeth. The resident was wearing a hospital gown with brown soiling on the shoulder and chest area of the gown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 12/30/24 at 11:20 AM with Resident 203 revealed that the brown matter was from a chocolate shake that was part of their breakfast. Resident 203 also stated they had received a shower but could not recall when it was. An interview on 12/31/2024 at 1:45 PM with the Facility Administrator (FA) revealed that the lack of charting for bathing residents was accurate, and there was no other charting to disclose bathing tasks being completed for facility residents, including Resident 203. The FA further revealed that bathing had not occurred because of staffing concerns.

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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 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. 50105 Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5) Based on record reviews and interviews, the facility failed to follow physician orders on bowel protocols for 1 resident (Resident 38) of 1 sampled resident. Facility census was 44. Findings are: A record review of a facility policy titled, Bowel Regimen and Standing Facility Orders dated 01/19/2024 revealed the following guidance for treating residents' bowel needs: -On Days 1 & 2 without bowel movement-do nothing. -On Day 3 without a bowel movement begin the following protocol: -On Day 3 in the AM: Administer 30 milliliters (ml) of Milk of Magnesia by mouth (PO) one time for constipation. Give 8 ounces of prune juice daily for 3 days. -If the resident does not have a bowel movement proceed to the next steps. -On Day 3 in the PM: Administer two Senna 8.6 tablets PO one time for constipation. Administer polyethylene glycol 17 grams/240 ml PO one time. -If the resident does not have a bowel movement proceed to the next steps. -On Day 4 in the AM: Administer 1 Dulcolax suppository 10 milligrams (mg) rectally for constipation. Administer polyethylene glycol 17 grams/240ml, PO one time. -On Day 5: If the resident has had no bowel movement, contact their primary physician for further clinical guidance. A record review of an Admission Record revealed the facility admitted Resident 38 on 09/18/2023 with diagnoses of constipation, communication deficit. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 38's annual Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning), with an assessment reference date (ARD) of 12/11/2024, revealed Resident 38 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairments) score of 00/15 which indicated the resident had severe cognitive impairment. The MDS also revealed that Resident 38 was wheelchair bound, unable to propel and required substantial and/or maximum assistance for activities of daily living (ADLs, basic everyday tasks including bathing, eating, dressing, getting in and out of bed and toileting). A record review of Resident 38's Physician Orders for the month of 12/2024 revealed the following orders related to bowel management: -An order dated 05/25/2024 for Senna (a stimulant laxative) 8.6 milligrams (MG), 2 tablets by mouth as needed for constipation, give in PM of day 3 without bowel movement (BM). -An order dated 05/25/2024 for Dulcolax (a stimulant laxative) 10 MG, 1 suppository rectally every 24 hours as needed for constipation. -An order dated 05/26/2024 for Prune Juice 8 ounces (oz) as needed for constipation, give in AM of day 3 without BM for 3 days. A record review of Resident 38's 30-day look back task record for toileting and charting BM's revealed that the resident had no BM from 12/13/2024-12/15/2024 (three days) and from 12/27/2024-12/31/2024 (5 days). A record review of Resident 38's Medication Administration Record for the month of December 2024 revealed the medications Senna, Dulcolax, and Prune juice had not been provided to Resident 38 at any time that month. A record review of Progress Notes and medical records for the month of December 2024 for Resident 38 revealed no communication to the physician for clinical guidance regarding the management or treatment for bowel protocols extending to day 5 of no bowel movement. During an interview on 12/31/2024 at 3:15 PM the Quality Assurance Coordinator (QAC) revealed that bowel protocols had not been initiated as ordered for Resident 38 during the month of December 2024.

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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 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50105

Licensure Reference Number 175NAC 12-006.09(J)(i)(1)

Based on record reviews, interviews, and observations; the facility failed to identify and monitor ongoing weight loss and implement new and/or revise interventions to prevent further weight loss for 1 (Resident 38) of 1 sampled resident. The facility census was 44.

Findings are:

A record review of a facility policy titled Height and Weight revised on 10/15/2024 revealed policy purposes:

-To ensure that that resident maintains acceptable parameters of nutritional status regarding weight.

-To report changes in a resident's clinical condition (significant weight change) to physician and family and/or resident.

-Residents at nutritional risk will be weighed weekly.

-The location will immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative when there is a significant change in the resident's weight, as defined by the RAI [NAME] (MDS).

-Based on a resident's comprehensive assessment, the location ensures that a resident maintains acceptable parameters of nutritional status, such as body weight, unless his/her clinical condition demonstrates that this is not possible.

A record review of Resident 38's Admission Record revealed the facility admitted the resident on 09/18/2023 with a principle/admitting diagnosis of unspecified dementia.

A record review of Resident 38's annual Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning), with an assessment reference date (ARD) of 12/11/2024, revealed Resident 38 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairments) score of 00/15 which indicated resident resident had severe cognitive impairment. The MDS also revealed that Resident 38 required substantial and/or maximum assistance for activities of daily living (ADLs, basic everyday tasks including eating, dressing, getting in and out of bed, bathing, and toileting). In the MDS section titled Swallowing/Nutritional Status it revealed Resident 38 was 66 inches in height and weighed 132 pounds (lbs). The MDS identified the resident as having lost weight and was not on a physician-prescribed weight loss or gain program. The nutritional approaches section revealed the resident was on a mechanically altered diet.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 38's care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) which had been updated on 12/12/2024 revealed the resident had a nutritional problem related to dementia, adult failure to thrive, type 2 diabetes, GERD, and dysphasia. The following interventions were identified: -An order for a texture modified diet which was initiated on 11/15/2023, -Weigh per policy. Notify registered dietician, primary care provider, and family of significant changes. Fortified foods added. A regular diet, puree texture, thin consistency, and 8 ounces (oz) of Boost three times a day (TID), with an initiation date of 09/18/2023 and a revision date of 11/13/2024. -An intervention dated 11/15/2023 with a revision date of 11/13/2024 for eating, use of adaptive equipment, needing a divided plate, 2 handled cup with a lid and straw. The care plan additionally revealed Resident 38 had an unplanned/unexpected weight loss related to decreased intake as evidenced by a 10% change over the past 6 months, initiated on 07/05/2024 and revised on 09/11/2024. The following interventions were identified: -Weigh weekly, which was initiated on 07/05/2024 and revised on 09/11/2024 and -Review overall meal plan with resident/family and adjust goals and interventions to meet resident's preferences and weight goals, which was initiated on 9/11/2024. A record review of Resident 38's weights documented in their medical records revealed the following: -On 6/25/2024 the resident weighed 150 lbs. -On 9/30/2024, the resident weighed 138 lbs. -On 11/27/2024, the resident weighed 132 lbs. -On 12/30/2024, the resident weighed 125 lbs. These weights revealed the resident had a significant weight loss of 8.7% in the three months from September 2024 through December 2024. The weights also revealed a significant weight loss of 16% in the six month from June 2024 through December 2024. A record review of Resident 38's Progress Note dated 12/19/2024 revealed a weight warning that stated the provider needed to be notified of the resident's significant weight loss. A record review of Resident 38's Mini-Nutritional Assessment (MNA) dated 12/09/2024 revealed that the resident had a moderate decrease in food intake and a weight loss of greater than 6.6 lbs which identified the resident to be at risk for malnutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/2024 at 12:17 PM, the Dietary Manager (DM) revealed the only fortified foods the facility offered was milk introduced into breakfast cereals or a stand-alone drink for breakfast service only. The Facility Administrator (FA) was interviewed on 12/31/2024 at 3:05 PM. The FA revealed that the interdisciplinary team (IDT, a group of healthcare professionals with various area of expertise who work together toward the goals of the resident) got together usually weekly; but most recently it had been monthly, but had not been reviewing Resident 38 because the IDT, including the RD, felt it was not necessary to continue to review because there was not anything else that could be done. An interview on 01/02/2025 at 1:44 PM with the DM revealed that communication on Resident 38's continued weight loss had not occurred between the facility and the physician despite the Progress Note from 12/19/24 that indicated the significant weight loss. An interview on 01/02/2025 at 1:50 PM with the Registered Dietician (RD) revealed the RD felt no new interventions or monitoring was needed for Resident 38 because there was nothing else that could be done. An observation on 01/02/2024 at 2:49 PM of Nurse Aide (NA)-H revealed NA-H was passing mid-day snacks to residents throughout the building. An interview on 01/02/2024 at 4:00 PM with NA-H revealed that the facility staff did not provide a mid-day snack to Resident 38 and that NA-H did not know the reason for this. A record review of Resident 38's 30-day look back task record for providing a nighttime snack for the month of December 2024 revealed the resident accepted a snack on one date, all other days reveal the resident was either sleeping, not available, refused, or the question was not applicable. An interview with Registered Nurse (RN)-C on 01/06/2024 at 1:40 PM revealed that Resident 38's intake of the Boost supplement varied, however with a little coaxing and time, Resident 38 would drink most of the nutritional supplement.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC 12-006.12(A)(i-vi) Based on record reviews and interviews, the facility failed to provide a clinical rationale and monitoring of psychotropic medication use for 1 Resident (Resident 27). The facility census was 44. Findings are: A record review of a facility policy titled Psychotropic Medications and dated 12/30/2024, reveals its purpose: To evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary psychotropic medications. The policy also revealed that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: -without adequate indications for its use, and -without adequate monitoring. The policy also revealed that based on a comprehensive assessment of a resident, the location must ensure that: -Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. A record review of Resident 27's Admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident 27's quarterly Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning), with an assessment reference date (ARD) of 11/20/2024, revealed Resident 27 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairments) score of 00/15 which indicated a severe cognitive impairment. A review of the Mood section of the MDS revealed the Patient Health Questionnaire (PHQ-2 to 9, A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder) was not completed due to no response from the resident. The MDS also revealed Resident 27 was taking the high-risk drug class; antidepressant. The medication was marked as currently taking, however the section denoting that there was an indication for the use of this medication was not marked. A record review of Resident 27's Physician Orders for the month of December 2024 revealed an order dated 7/2/2024 for Amitriptyline (an antidepressant medication) 25 milligrams (mg) by mouth one time a day for requesting diagnosis. There was no other information on the order regarding a diagnosis or indication for use. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 27's diagnosis list, dated 12/31/24, revealed the resident had no diagnoses related to depression. An interview on 12/31/2024 at 3:15 PM with the Quality Assurance Coordinator (QAC) confirmed Resident 27's Amitriptyline order had no indications for use. The QAC revealed that Resident 27 was originally prescribed the medication around November 2023 for pain associated with shingles (a painful rash caused by the varicella-zoster virus (VZV), the same virus that causes chickenpox). The QAC confirmed that pain associated with shingles is a short-term medical event that does not last more than a few weeks and the QAC was unaware of why the resident continued to take the medication. A record review of Resident 27's undated Care Plan revealed no evidence of the resident taking an antidepressant medication or of any interventions related to this medication. A record review of Resident 27's Treatment Administration Record (TAR) for December 2024 revealed Resident 27 had no order in place related to monitoring their use of an antidepressant medication. An interview on 01/02/2025 at 4:00 PM with MDS revealed that the medication Amitriptyline should be adequately monitored for the safety and efficacy of use.

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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 - Many

Provide and implement an infection prevention and control program.

50253

License Reference Number 175 NAC 12-006.04(A)(iii)

Based on record review and interview the facility failed to ensure that employee healthcare questionnaires were completed, reviewed, and maintained prior to the hire dates for 5 of 5 sampled employees. This had the potential to affect all residents in the facility. The facility census was 44.

Findings are:

An interview on 01/06/2025 at 1:30 PM with the Facility Administrator (FA) revealed that all new hires were given paperwork which was to be filled out prior to being hired. The FA provided a copy of the facility's General Orientation Packet, which contained the paperwork the new hires were to complete.

A record review of an undated copy of the facility's General Orientation Packet (GOP) revealed all paperwork in the packet must be completed by the new hire and returned to the Director of Nursing Services prior to starting work. The following documents were included in this section;

-Medical History Questionnaire (a 5-page document),

-Employee/Candidate Tuberculosis Screening Questionnaire (a 3-page document),

-Hepatitis B Consent and Immunization Form (1 page document), and

-Hepatitis B Vaccination Declination (1 page document).

A.

A record review of the Minimum Data Set (MDS) Nurse's employment file revealed MDS was hired by the facility on 9/17/2024. The file contained a single paged paper entitled Communicable Disease Screening (a 1-page document) which was dated and signed by MDS on 09/27/2024. There were no other documents from the GOP in the file and the Communicable Disease Screening sheet contained no evidence that it had been reviewed by facility staff.

An interview on 01/06/2025 at 5:00 PM with FA confirmed this was all of the healthcare information in the personnel file for MDS.

B.

A record review of Facility Driver (DR)-F's employment file revealed DR-F was hired by the facility on 9/17/2024. The file contained the Employee/Candidate Tuberculosis Screening Questionnaire (a 3 page document) which was dated and signed by DR-F on 09/17/2024. This document revealed that the Infection Control Preventionist (IP) had reviewed the information.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 01/06/2025 at 5:00 PM with FA confirmed this was all of the healthcare information in the personnel file for DR-F. C. A record review of Cook-K's employment file revealed Cook-K was hired on 4/29/2024. The file contained the Medical History Questionnaire, the Hepatitis B Consent and Immunization Form, and the Hepatitis B Vaccination Declination. The Hepatitis B Vaccination Declination form was signed and dated 04/29/2024 and the Hepatitis consent and immunization form was blank (because the hepatitis vaccination was declined). The first 4 pages of the Medical History Questionnaire was completed by the new hire. Page 5 of the Medical History Questionnaire was blank. This page was to be completed by the Human Resources Representative or designee, indicate that the information has been reviewed, and then signed and dated by the person reviewing. An interview on 01/06/2025 at 5:00 PM with FA confirmed this was all of the healthcare information in the personnel file for Cook-K. D. A record review of Nurse Aide (NA)-L's employment file revealed NA-L was hired by the facility on 3/4/2024. The file contained the Medical History Questionnaire signed and dated by NA-L on 03/04/2024, the Hepatitis B Consent and Immunization Form with NA-L's name on it but no other section was completed, and a blank Hepatitis B Vaccination Declination form. There was no Employee/Candidate Tuberculosis Screening Questionnaire. The first 4 pages of the Medical History Questionnaire was completed by the new hire. Page 5 of the Medical History Questionnaire was blank. This page was to be completed by the Human Resources Representative or designee, indicate that the information has been reviewed, and then signed and dated by the person reviewing. An interview on 01/06/2025 at 5:00 PM with FA confirmed this was all of the healthcare information in the personnel file for NA-L. E. A record review of Maintenance Technician (MAINT)-G's employment file revealed MAINT-G was hired on 10/9/2024. The file contained a one page Communicable Disease Screening document dated 10/09/2024. There was an untitled document that stated Completed by Location - RN Required in some states at the top and contained sections to indicate the Communicable Disease Review had been completed and Immunizations reviewed and then signed by a facility staff member, this document had not been filled out. An interview on 01/06/2025 at 5:00 PM with FA confirmed this was all of the healthcare information in the personnel file for MAINT-G.

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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.

50253

License Reference Number 175 NAC 12-007.01(B)(ii)

Based on observations and interviews, the facility failed to provide a sanitary environment in the laundry area (three specific areas which are ante room, storage room, and dirty laundry) for staff. This had the potential to affect all laundry staff and all residents. The current facility census was 44.

Findings are:

During the initial observation tour of the facility laundry department on 01/02/2025 at 8:43 AM, revealed the following:

-The ante room to the clean laundry area. There were 3 shelves to the left which contained blankets and other various items folded. Under the shelf on the left side there was one metal mouse trap, a step stool, and cardboard boxes filled with items. The floor in that area was dusty, had dirt debris, brownish gray fuzzy matter, and paper trash on the floor. On the right side of the ante room, were hooks which held staff winter wear. At the floor level was a long wooden shelving approximately 5 feet long that lifted things off the floor approximately one inch. On that shelving piece were cardboard boxes and plastic totes stacked upon each other, one metal mouse trap, and a small trashcan. This area was also had fuzzy debris and dirt, and had not been swept. One could not see underneath the shelving piece that lifted these items directly off the floor.

-In the storage room in the laundry area. There was a large framed print covered in grey fuzzy substance between the wall and one of the small tables. There was grey fuzy substance, debris, pieces of paper, a pen, a straw, and fuzz as well as two more large cardboard boxes overflowing with clothing on the floor

-The dirty laundry area was inspected. Soiled clothing had been sorted into different containers and ready to be washed. There were two cardboard boxes on the floor that had at one point been wet and then dried sitting on the floor. The stainless-steel sink was covered in what looked to be soap scum and mineral deposits and was not clean. The linen scale was covered in grey fuzzy substance and debris. The vent was covered in gray fuzzy substance.

A second observation tour occurred on 01/02/25 at 2:51 PM with Facility Administrator (FA) and Infection Control Preventionist (IP) in the laundry area. The Housekeeping/Laundry Supervisor (EVS) was in the storage room sorting, discarding, and organizing.

Interview on 01/02/2025 at 3:00 PM with IP who revealed the laundry area was rarely inspected or observed by the IP. All of the items on the floor, including the boxes in the dirty area that had water damage, and generalized lack of cleanliness in the laundry department was discussed. IP agreed that this area had been overlooked as an area of concern for cleanliness as well as infection control.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285189	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - St Johns	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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/02/2025 at 3:00 PM with FA revealed that EVS had been told many times to clean up that area and didn't do it and had started on it today. Staff are going to sort items and discarding what they able to eliminate and keep only what is needed.