

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 04/02/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - St John's		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D) Based on record review and interview the facility failed to ensure medication errors with the potential to negatively impact a resident's health or safety did not occur and the potential for negative effects were monitored for 2 (Residents 17 and 54) of 3 sampled residents. The facility census was 46. Findings are:Record review of a facility policy titled Medication Errors and dated 03/02/2026 revealed the definition of a significant medication error is one which causes the resident discomfort or jeopardized their health or safety. A.Record review of an admission Record dated 04/01/2026 revealed that the facility admitted Resident 17 on 04/18/2025 with diagnoses of mixed incontinence (the inability to control both bowel and bladder) and other disorder of the bladder. Record review of a facility document titled SAFE Resident Event and dated 01/19/2026 revealed on that date at 12:00 PM the facility identified a medication error for Resident 17. The resident's provider had written an order for the resident to extend their antibiotic therapy being used to treat their urinary tract infection for an additional 7 days. This order was dated 01/05/2026. The provider's order was received by the facility but was never entered in the resident's orders, therefore the resident's antibiotic therapy was not extended as ordered by the provider. The resident was admitted to the hospital on [DATE] for a urinary tract infection and required intravenous antibiotic therapy for the infection. In an interview completed on 04/02/2026 at 9:50 AM with the facility Director of Nursing (DON), the DON confirmed that the provider's order to extend the resident's antibiotic therapy was not transcribed, resulting in the resident not receiving the full course of antibiotic therapy as prescribed by the provider. The DON confirmed that the antibiotic therapy was being used to treat a urinary tract infection and the resident was subsequently hospitalized to treat the urinary tract infection with intravenous antibiotic therapy. The DON confirmed that the medication error for Resident 17 met the criteria of a significant medication error. B.Record review of an admission Record dated 04/01/2026 revealed the facility admitted Resident 54 on 02/19/2026 with diagnoses of generalized weakness and pain. The resident had a listed medical allergy to the medication Oxycontin (a narcotic pain medication). Record review of a facility document titled SAFE Resident Event and dated 12/21/2025 revealed on that date at 8:45 PM, Resident 54 was administered Oxycontin, which was not prescribed to them. The provider was notified of this error, and instructions were received to monitor the resident for symptoms of an allergic reaction. Record review of Resident 54's Electronic Medical Health Record (EMHR) revealed documentation in the resident's progress notes on 12/22/2025 at 8:22 AM of the incident occurring, the provider and responsible party being notified, and the instructions to monitor the resident for symptoms of an allergic reaction. The progress note documented that the resident's vital signs were within normal limits for the resident and the resident was showing no symptoms of an allergic reaction. There was also documentation of Resident 54's vital signs being obtained on 12/21/2025 at 10:28 PM. Further record review of Resident 54's EMHR revealed no evidence of continued monitoring of the resident for signs or symptoms of an allergic reaction following being administered a medication they were allergic to. There were also no further vital signs documented in the resident's EMHR to demonstrate continued monitoring of the resident for symptoms of an allergic reaction. In an interview completed (continued on next page)</p>

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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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>on 04/02/2026 at 9:50 AM with the facility DON, the DON confirmed that Resident 54 received a medication they were not prescribed and were allergic to and this medication error had the potential to negatively affect the resident's health. The DON confirmed that Resident 54's EMHR did not contain documentation beyond the initial assessment of the resident that the resident had received continued monitoring for symptoms of an allergic reaction and should have.</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(D)&(E) Based on record review and interview the facility failed to inform the resident or their representative in advance of treatment risks and benefits, options, and alternatives prior to administering psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) for 3 of 5 residents reviewed (Residents 17, 2, and 6). The facility census was 46. Findings are:Record review of the facility policy titled Psychotropic Medications dated 12/9/25 revealed that the purpose is to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary psychotropic medications. The family/legal representative will be notified before the administration of non-emergency psychotropic medications. The consent form must be signed for the use of psychotropic medications. The Permission for Use of Psychotropic Medications form will be used to obtain consent and must be signed for the use of psychotropic medications. If a resident is admitted on psychotropic medications or returns from hospitalization on new psychotropic medications, the Permission for Use of Psychotropic Medications form must be completed.</p> <p>A.</p> <p>Record review of the admission Record dated 3/30/26 for Resident 17 revealed that Resident 17 admitted into the facility on 4/18/25.</p> <p>Record review of the Order Recap Report (a listing of all physician orders for a specified period of time that includes order dates and discontinued dates of medications) for Resident 17 dated 4/2/26 revealed all physician orders between 4/1/25 and 4/30/26 including the following psychotropic medications:</p> <p>-An admission order for Bupropion 150 milligrams (mg) daily (a psychotropic medication used to treat major depressive disorder) with an order date of 4/18/25.</p> <p>-A new order for Paroxetine 40 mg daily (a psychotropic medication used to treat major depressive disorder) with an order date of 4/18/25.</p> <p>-An admission order for Venlafaxine 37.5 mg daily (a psychotropic medication used to treat major depressive disorder, anxiety disorder, panic disorder, and social anxiety disorder) with an order date of 3/30/26.</p> <p>Record review of the Care Plan dated 3/30/26 for Resident 17 revealed Resident 17 took antidepressant medications and side effects for these included increased risk for suicidal thoughts, increased drowsiness, changes in mood, and changes in condition.</p> <p>Record review of the medical record for Resident 17 revealed that it contained no consent for use of the psychoactive medications.</p> <p>Interview on 4/2/26 at 9:45 AM with the facility Director of Nursing (DON) confirmed that the facility did not provide education on the psychotropic medications Bupropion, Paroxetine, or Venlafaxine to Resident 17 or their representative. The DON confirmed that the facility did not obtain consent prior to the use of psychotropic medications for Resident 17 as required. (continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B.</p> <p>Record review of a admission Record dated 03/31/2026 revealed the facility admitted Resident 6 on 07/02/2019 with a diagnosis of anxiety (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it).</p> <p>Record review of Resident 6's Quarterly 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), dated 03/11/2026 revealed Resident 6 received an antidepressant medication routinely.</p> <p>Record review of Resident 6's Physician Orders on 03/31/2026 revealed Resident 6 had physician orders for Venlafaxine 150 mg (milligrams) to be administered every day for a diagnosis of anxiety and Trazodone (an antidepressant psychotropic medication) 50 mg to be given at bedtime for sleep.</p> <p>Record review of a document titled Permission for Use of Psychotropic Medication and dated 07/2025 revealed Resident 6's name at the top of the document. The document did not list the resident's use of the Venlafaxine or Trazadone medications. The document did not list the risks, benefits, or non-pharmacological alternatives to be used for the resident. The document was signed and dated by the resident on 01/28/2026.</p> <p>An interview completed on 04/02/2026 at 9:45 AM with the facility DON confirmed the document did not list the risks, benefits, non-pharmacological alternatives to uses of these medications for Resident 6 indicating the resident or their responsible party was educated on these things prior to the resident receiving the medications.</p> <p>C.</p> <p>A record review of Resident 2's Facesheet dated 04/02/2026 revealed an admission date of 08/10/2016.</p> <p>A record review of Resident 2's MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14, indicating the resident was cognitively intact. The MDS also revealed the resident was taking antipsychotic and antidepressant medications.</p> <p>A record review of Resident 2's Medication Administration Report (MAR) dated 04/02/2026 revealed the resident was taking Rexulti (an antipsychotic used to treat schizophrenia, agitation in Alzheimer's dementia, and as an add-on treatment for major depressive disorder) 0.5 mg for a diagnosis of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a cognitive decline where individuals require assistance with daily tasks (dressing, bathing, toileting) but do not display agitation, hallucinations, or significant mood shifts.</p> <p>A record review of Resident 2's Permission for Use of Psychotropic Medications for the antipsychotic medication Rexulti 0.5 mg revealed no signatures or dates of completion.</p> <p>An interview on 04/02/2026 at 9:45 AM with the facility DON confirmed that the facility did not provide education on the psychotropic medication Rexulti to Resident 2 or their representative. The (continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>DON confirmed that the facility did not obtain consent prior to the use of antipsychotic medication for Resident 2 as required.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Licensure Reference Number 175 NAC 12-006.09(H) Based on record reviews and interviews, the facility failed to monitor for adverse drug reactions related to antipsychotic medication use for 1 (Resident 2) of 5 residents sampled. The facility census was 46. Findings are: A record review of facility policy titled, Psychotropic Medications dated 12/09/2025 revealed: The resident will be free from any chemical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:-without adequate monitoring Procedure: 1. Before administration of non-emergency psychotropic medication, the following must be completed: 4. The reduction committee will ensure that the family/legal representative and resident are notified of this change in treatment. 5. If the physician prescribed an antipsychotic for the resident, a registered nurse must complete the Antipsychotic Medication Assessment and the Abnormal Involuntary Movement Scale in the Electronic Medical Record (EMR). 6. A consent form must be signed for the use of psychotropic medications. The Permission for Use of Psychotropic Medications will be used to obtain consent. 9. Throughout the administration of the psychotropic medication, the following must be completed: a. Mood and behavior documentation must continue in order to monitor the effect the medication has on the behavior. b. Monitor the side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the Psychopharmacological Med/Physical Restraint in the EMR and notify the physician and family/legal representative of this change in condition. c. If the resident is on an antipsychotic, a registered nurse must complete the Abnormal Involuntary Movement Scale in EMR every six months. A record review of Resident 2's face sheet dated 04/02/2026 revealed an admission date of 08/10/2016. A record review of Resident 2's 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) dated 02/11/2026 revealed under Section C for cognitive patterns a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14, which indicated the resident was cognitively intact. A record review of Resident 2's Medication Administration Report (MAR) dated 04/02/2026 revealed the resident was taking Rexulti (an antipsychotic medication used to treat schizophrenia, agitation in Alzheimer's dementia, and as an add-on treatment for major depressive disorder) 0.5 milligram (mg) for a diagnosis of unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (a cognitive decline where individuals require assistance with daily tasks (dressing, bathing, toileting) but do not display agitation, hallucinations, or significant mood shifts. A review of Resident 2's MAR revealed no missed doses during the month of March 2026. The MAR also revealed no orders to monitor for adverse effects related to taking the antipsychotic medication. A record review of Resident 2's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) dated 03/30/2026 revealed no plan of care related to Resident 2 taking an antipsychotic medication or monitoring for adverse effects related to taking an antipsychotic. A record review of Resident 2's Abnormal Involuntary Movement Scale assessments revealed being completed on 04/15/2025 and then on 01/26/2026. An interview on 04/02/2026 at 9:45 AM with the facility Director of Nursing (DON) confirmed that the facility did not complete monitoring for adverse effects for Resident 2 while taking an antipsychotic as required according to their policy.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(G)(i) Based on record review and interview, the facility failed to complete a discharge summary for 2 (Residents 60 and 62) of 2 sampled residents who had been discharged from the facility. The facility census was 46. Findings are:Record review of a facility policy titled Discharge and Transfer dated 01/15/2026 revealed when a transfer or discharge occurs, the location must ensure that the transfer or discharge is documented in the medical record. A.Record review of an admission Record dated 03/31/2026 revealed the facility admitted Resident 60 on 09/22/2020 and discharged or transferred the resident to the hospital on [DATE]. Record review of Resident 60's Progress Notes revealed on 01/06/2026 at 2:45 AM the resident complained of intolerable abdominal pain and wished to go the emergency department. At 7:06 AM the facility received a telephone call from the emergency department that the resident was being admitted to the hospital. Review of Resident 60's Electronic Medical Health Record (EMR) revealed no evidence of a discharge summary being completed for Resident 60. In an interview completed on 04/01/2026 at 10:25 AM with the Director of Nursing (DON), the DON confirmed that Resident 60 was admitted to the hospital on [DATE] and did not return to the facility. In an interview completed on 04/02/2026 at 9:20 AM with the DON, the DON confirmed that a discharge summary was not completed for Resident 60 and should have been. B.Record review of an admission Record dated 03/31/2026 revealed the facility admitted Resident 62 on 01/06/2026 and discharged the resident to home with home care services on 02/05/2026. Record review of Resident 62's Electronic Medical Health Record (EMR) revealed no evidence of a discharge summary being completed for Resident 60. In an interview completed on 04/02/2026 at 9:20 AM with the DON, the DON confirmed that Resident 62 was discharged from the facility on 02/05/2026 to their home. The DON confirmed that there was no discharge summary completed for Resident 62 and there should have been.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Licensure Reference Number 175 NAC 12-006.09(D) Based on observation, record review, and interview the facility failed to ensure that the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) identified dialysis services (a life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when kidneys have failed) as required for 1 (Resident 7) of 1 sampled resident. The facility census was 46. Findings are: Record review of the facility policy titled Dialysis Services dated 9/30/25 revealed that facilities caring for residents receiving dialysis services must have an agreement with the provider of the service. The facility will be responsible for arranging transportation to and from dialysis services. Care plan dialysis care specific to the resident: for example, unique nutritional needs or fluid restriction, avoid taking blood pressure in the arm with the fistula (a surgical connection between an artery and a vein, usually in the arm, created to make dialysis possible for kidney failure patients), and any other restrictions per the provider. Record review of the facility policy titled Care Plan dated 12/1/25 revealed that the purpose is to provide guidance to the interdisciplinary team in developing the initial care plan and develop a comprehensive care plan using an interdisciplinary team approach. Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment (the MDS). Interview on 4/1/26 at 11:20 AM with the Patient Transportation Driver (PTD) revealed that Resident 7 was out of the facility for dialysis treatment and PTD was preparing to pick Resident 7 up from the dialysis center. Observation on 4/1/26 at 11:45 AM at the facility driveway at the front entrance revealed that Patient Transportation Driver (PTD) was unloading Resident 7 from the facility bus. Observation 4/1/26 at 11:48 AM in the facility activity hallway revealed that the facility PTD transported Resident 7 per wheelchair directly from the front entry to the facility dining room where PTD positioned Resident 7 at a table in the dining room. Resident 7 had a dressing on their right forearm. Interview on 4/1/26 at 11:50 AM with Resident 7 confirmed that the dressing on their right forearm was from the dialysis center. Record review of the MDS assessment for Resident 7 dated 1/12/26 revealed that Resident 17 had a diagnosis of renal insufficiency (the kidneys stop working). The section of the MDS for special treatments revealed Dialysis was not marked as a treatment needed by Resident 7. Interview on 4/2/26 at 9:51 AM with the facility Director of Nursing (DON) confirmed that Resident 7 received dialysis outside of the facility 3 times per week. The DON confirmed that the current MDS assessment did not identify the need for dialysis for Resident 7 and that it should have been identified on the MDS.</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record review and interview the facility failed to complete a baseline care plan (a written plan required to be developed within 24 hours of admission detailing the instructions needed for staff to provide initial effective and person-centered quality care for a resident) for 2 of 3 residents reviewed (Residents 4 and 23) to identify immediate care needs of the resident. The facility census was 46. Findings are: Record review of the facility policy titled Care Plan dated 12/1/25 revealed that the purpose is to provide guidance to the interdisciplinary team in developing the initial care plan and develop a comprehensive care plan using an interdisciplinary team approach. The definition of Baseline care plan revealed that it includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of care. A baseline care plan will be developed upon admission according to federal and state regulations. The location must provide the resident and resident representative with a written summary of the baseline care plan. Staff were to use the Progress Note-Care Conference Note to document that the meeting occurred with the resident and resident representative and any significant discussion that occurred. A. Record review of the admission Record dated 3/30/26 for Resident 4 revealed that Resident 4 admitted into the facility on 8/11/25 with diagnoses of Parkinson's Disease, sleep apnea, and dysphagia (difficulty swallowing). Record review of the medical record for Resident 4 revealed no evidence of a baseline care plan being developed for Resident 4. Record review of the Progress Notes for Resident 4 revealed that it contained no care conference note for a baseline care plan for Resident 4. Interview on 4/1/26 at 2:27 PM with the facility Minimum Data Set Coordinator (MDSC, a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) confirmed that the facility did not complete a baseline care plan for Resident 4 upon admission as required. B. Record review of the admission Record dated 3/30/26 for Resident 23 revealed that Resident 23 admitted into the facility on 2/24/26 with diagnoses of dysphagia, cancer of the esophagus (the hollow, muscular tube that passes food and liquid from your throat to your stomach), and sepsis (a potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues). Record review of the medical record for Resident 23 revealed no evidence of a baseline care plan being developed for Resident 23. Record review of the Progress Notes for Resident 23 revealed that it contained no care conference note for a baseline care plan for Resident 23. Interview on 4/1/26 at 2:27 PM with the facility MDSC confirmed that the facility did not complete a baseline care plan for Resident 23 upon admission as required.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview the facility failed to maintain a comprehensive care plan for 1 of 5 residents reviewed (Resident 11) to provide direction to staff for care required for resident diabetes (a disease characterized by high blood sugar levels when the body does not produce enough insulin to regulate blood sugar levels). The facility census was 46. Findings are:Record review of the facility policy titled Care Plan dated 12/1/25 revealed the Comprehensive Care Plan is a plan of care that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. 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. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument and review of physician's orders. The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services. The resident/family or legal representative will have the opportunity to participate in the planning of his or her care to the extent practicable. The interdisciplinary team will review care plans at least quarterly. Care plans also will be reviewed, evaluated, and updated when there is a significant change in the resident's condition. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 1/14/26 for Resident 11 revealed that Resident 11 admitted into the facility on [DATE]. The MDS identified that Resident 11 had a diagnosis of diabetes mellitus. The MDS identified that Resident 11 received insulin (a medication use to control the amount of sugar in the blood) all 7 days of the assessment 7-day lookback period. Record review of the Comprehensive Care Plan for Resident 11 dated 3/31/26 revealed that it did not contain a focus area for the care of the resident's diabetes mellitus. The care plan did not identify care required for Resident 11's diabetes, including monitoring for symptoms of high or low blood sugar levels. Interview on 4/2/26 at 9:47 AM with the facility Director of Nursing (DON) confirmed that Resident 11 has a diagnosis of diabetes mellitus. The DON confirmed that the comprehensive care plan for Resident 11 did not identify care for the resident's diabetes mellitus as required.</p>		

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 04/02/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - St John's		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5) Based on record review and interview, the facility failed to follow practitioner orders to prevent constipation for 1 (Resident 2) of 1 sampled resident. The facility census was 46. Findings are: A.A record review of Resident 2's Facesheet dated 04/02/2026 revealed an admission date of 08/10/2016. A record review of Resident 2's 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) dated 02/11/2026 revealed under Section C for cognitive patterns a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14, indicating the resident was cognitively intact. The resident was dependent on staff for toilet transfers and for toileting hygiene and was always incontinent of bowels. A record review of Resident 2's undated Care Plan revealed the resident had a diagnosis of constipation. A record review of Resident 2's Medication Administration Report (MAR) for March 2026 revealed the following available medications for constipation ordered as needed:- Dulcolax Rectal Suppository 10 milligram (MG) Insert 1 suppository rectally as needed for constipation give in AM of day 4 without bowel movement (BM), start date 04/22/2025- Milk of Magnesia Suspension 400MG/5millileters (ML) give 30 ml by mouth every 24hours as needed for constipation give daily as needed, start date 05/28/2021- Prune Juice 8 ounces (oz) as needed for constipation give in AM of day 3 without BM x3 days, start date 04/22/2024- Senna Oral Tablet 8.6 MG(Sennosides) give 2 tablet by mouth as needed for in PM if 3 days without BM related to constipation, start date 11/10/2025 Record review of Resident 2's toileting tasks in the EMR revealed the resident went the following date ranges with no bowel movements:-From 03/07/2026 through 03/10/2026, a total of 4 days, and-From 03/14/2026 through 03/20/2026, a total of 7 days. An interview on 04/02/2026 at 9:00 AM with Nurse Aide (NA)-D revealed the staff only document bowel movements on Tasks in the EMR. Record review of the MAR for all days in March 2026 revealed the as needed medications for constipation were not provided on any dates. Record review of Progress Notes for Resident 2 from 03/03/2026 through 04/01/2026 revealed no evidence of the resident being assessed, or as needed medications being provided, for their constipation. An interview on 04/02/2026 at 9:45 AM with the facility Director of Nursing (DON) confirmed that the facility did not offer or provide the as needed medication for constipation as ordered.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Licensure Reference Number 175 NAC 12-006.09(l)Based on observation, record review, and interview the facility failed to ensure that fall prevention interventions were implemented for 1 of 1 resident reviewed (Resident 17). The facility census was 46. Findings are: Record review of the facility policy titled Fall Prevention and Management dated 3/31/26 revealed the purpose was to develop and implement a fall prevention and management program, identify risk factors and implement interventions before a fall occurs, to give prompt treatment after a fall occurs, and to provide guidance for documentation. The facility was to communicate fall risks and interventions to prevent a fall before it occurs, review and update the care plan with any changes/new interventions, and continue to monitor the condition and the effectiveness of the interventions. Record review of the admission Record for Resident 17 dated 3/30/26 revealed that Resident 17 admitted into the facility on 4/18/25 and had a diagnosis of repeated falls. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 1/22/26 for Resident 17 revealed that Resident 17 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 9 which indicated that Resident 17 had moderate cognitive impairment. Resident 17 required verbal cues or intermittent touching/steadying staff contact when standing from a chair, wheelchair, or side of the bed. Record review of the undated facility Survey Report (a listing of resident falls in the facility) revealed that Resident 17 had 13 falls since admission into the facility. Resident 17 had a fall on 5/21/25, 6/25/25, 7/12/25, 9/23/25, 10/5/25, 10/18/25, 10/27/25, 11/13/25, 12/8/25, 12/28/25, 2/14/26, 2/20/26, and 3/24/26. Record review of the Care Plan dated 3/30/26 for Resident 17 revealed a focus area for care for falls and fall prevention. A fall intervention dated 4/18/25 with a revision date of 3/4/26 revealed that Resident 17's wheelchair was to have anti rollback brakes (a safety device mechanism that automatically locks the rear wheels of the wheelchair to prevent the chair from moving backward when a user stands up to prevent falls) to prevent the wheelchair from moving if Resident 17 stood up. Interview on 4/2/26 at 9:28 AM with Nurse Aide-F (NA-F) revealed that Resident 17 transferred from the bed to the wheelchair with minimal assistance for standing and pivoting into the wheelchair. NA-F revealed that Resident 17 did try to self-transfer (moving self between bed, wheelchair, and chair without staff presence or assistance). NA-F revealed they were not aware whether Resident 17's wheelchair was to have anti-rollback brakes. Observation on 4/1/26 at 2:41 PM in the room of Resident 17 revealed that Resident 17's wheelchair had no anti rollback device on it. The wheelchair rolled backwards without resistance when pushed backwards. Interview on 4/1/26 at 2:52 PM with the facility Minimum Data Set Coordinator (MDSC, a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) confirmed that a fall prevention intervention on the care plan for Resident 17 was for an anti rollback brake device on the resident's wheelchair. Observation on 4/1/26 at 2:55 PM in the resident room with the facility MDSC confirmed that the wheelchair of Resident 17 did not have an anti rollback brake installed as care planned. The wheelchair pushed backwards with no resistance. Interview on 4/1/26 at 2:55 PM with the facility MDSC confirmed that the care planned fall intervention for anti rollback brake on the wheelchair of Resident 17 was not in place. The MDSC was not aware if the intervention was ever implemented on the resident wheelchair to prevent falls.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews ,and record review; the facility failed to ensure a physician's order for resident dialysis, ensure that pre-dialysis assessment and communication was completed, and failed to assess and monitor resident post dialysis as required for 1 (Resident 7) of 1 sampled resident. The facility census was 46. Findings Are: Record review of the facility policy titled Dialysis Services dated 9/30/25 revealed that facilities caring for residents receiving dialysis services must have an agreement with the provider of the service. Record review of the facility's Outpatient Dialysis Services Agreement dated 9/10/19 revealed that the company will provide outpatient renal dialysis services to the facility. The agreement revealed that renal dialysis services shall include items and services when ordered by the physician. The need for referral of a resident to the dialysis unit shall be determined by the resident's attending physician. Record review of the admission Record dated 3/31/26 for Resident 7 revealed that Resident 7 admitted into the facility on [DATE]. The admission Record revealed that Resident 7 had a diagnosis of chronic kidney disease (a condition where the kidneys are damaged or cannot filter blood properly, causing waste and fluid to build up in the body). Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 1/12/26 for Resident 7 revealed that Resident 7 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 15, which indicated the resident was cognitively intact. Interview on 3/30/26 at 3:58 PM with Resident 7 revealed that Resident 7 went out of the facility for dialysis on Mondays, Wednesdays, and Fridays. A.Observation on 4/1/26 at 11:45 AM at the facility driveway at the front entrance revealed that Patient Transportation Driver (PTD) was unloading Resident 7 from the facility bus. Observation 4/1/26 at 11:48 AM in the facility activity hallway revealed that the facility PTD transported Resident 7 per wheelchair directly from the front entry to the facility dining room. PTD positioned Resident 7 at a table in the dining room. Resident 7 had a dressing on their right forearm. Interview on 4/1/26 at 11:50 AM with Resident 7 confirmed that the dressing on their right forearm was from the dialysis center. Record review of the medical record for Resident 7 revealed that it did not contain a physician's order for dialysis for Resident 7. Record review of the Order Recap Report (a listing of all physician orders for a specified period of time that includes order dates and discontinued dates of medications and treatments) for Resident 7 dated 4/2/26 revealed all physician orders between 11/1/24 and 4/30/26 (all physician orders for Resident 7 from admission on [DATE] to present day). The report revealed no order for dialysis for Resident 7. Interview on 4/2/26 at 9:51 AM with the facility Director of Nursing (DON) confirmed that Resident 7 received dialysis outside of the facility 3 times per week. The DON confirmed that the medical record for Resident 7 did not contain a physician's order for dialysis. The DON confirmed that a physician's order for dialysis was required and that it should include the type of dialysis being received and the frequency. B.Record review of the facility's Outpatient Dialysis Services Agreement dated 9/10/19 revealed that the company will provide outpatient renal dialysis services to residents of the facility. The facility will ensure that all appropriate medical and administrative information accompanies all dialysis residents at the time of referral to the dialysis unit. The facility will be responsible for ensuring that the resident is medically stable to receive treatment at the dialysis center. The section titled Mutual Obligations revealed that both parties (the facility and the dialysis center) will ensure that there is documented evidence of care and communication between the facility and the dialysis center. Interview on 4/1/26 at 4:16 PM with Registered Nurse-A (RN-A) revealed that the nurse was to complete the top portion of the Dialysis Communication/Referral form for Resident 7 on dialysis days. RN-A revealed that the dialysis center normally put information in the bottom section of the form and that the facility received the form back from the dialysis center when the resident returned to the facility after each dialysis treatment. Record review of the medical record for Resident 7 revealed that a dialysis (continued on next page)</p>		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Communication/ Referral (for visits to dialysis) form was initiated for dialysis on 3/18/26. The form was marked No for significant change since last dialysis treatment. The section for Vital Signs which was to contain documentation of the resident's temperature, blood pressure, pulse rate, and respirations were all left blank. The section for Resident Status revealed that Resident 7 was oriented and had edema. The section was signed by an unidentified facility staff. The section of the form titled Dialysis to Complete the Following Section revealed pre-dialysis and post dialysis temperatures, blood pressures, pulse rates, respirations, and weights. The resident was marked as oriented and the section was signed by dialysis staff. Further record review of the medical records for Resident 7 revealed no evidence of Communication/ Referral (for visits to dialysis) forms being completed for Resident 7's dialysis treatment. Record review of the Communication/Referral (for visits to dialysis) forms received following a request by this surveyor for the date range of 12/1/25 through 4/2/26 revealed that the facility provided Communication/ Referral (for visits to dialysis) forms dated 12/4/24, 12/6/24, 12/9/24, 12/11/24, 12/13/24, 12/16/24, 12/18/24, and 12/20/24. The facility provided no forms for the requested date range. Interview on 4/2/26 at 9:10 AM with the facility's Minimum Data Set Coordinator (MDSC, a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) confirmed that the facility could not find any dialysis Communication/Referral forms after December 2024 for Resident 7. The MDSC revealed that they were not sure if the forms were not getting scanned into the resident medical record or if they had some new nurses that were not completing them. Interview on 4/2/26 at 9:51 AM with the facility's Director of Nursing (DON) confirmed that Resident 7 received dialysis outside of the facility 3 times per week. The DON revealed that the expectation was for the nurse on duty to complete the facility's dialysis Communication/Referral form prior to each dialysis appointment. The DON confirmed that the nurse should assess the resident's vital signs, any acute changes, and presence of fistula thrill (a palpable, buzzing vibration felt over a surgical connection between an artery and a vein, usually in the arm, created to make dialysis possible for kidney failure patients). The DON revealed that the dialysis Communication/Referral form was to be sent with the resident to each dialysis appointment. The DON revealed that the form was to be returned to the facility by the dialysis center. The DON confirmed that each dialysis Communication/Referral form was to be scanned into the resident's permanent medical record. The DON confirmed that the forms were either not being completed or scanned into the resident's permanent medical record as required for Resident 7. C.Record review of the facility policy titled Dialysis Services dated 9/30/25 revealed that the Clinical Monitoring Dialysis assessment is available for use in monitoring the resident receiving dialysis. Record review of the facility's Outpatient Dialysis Services Agreement dated 9/10/19 revealed in the section titled Mutual Obligations that both parties (the facility and the dialysis center) will ensure that there is documented evidence of care and communication between the facility and the dialysis center. Interview on 3/30/26 at 3:58 PM with Resident 7 revealed that Resident 7 went out of the facility for dialysis on Mondays, Wednesdays, and Fridays. Resident 7 revealed that the facility staff did not check the dressing on their fistula (a surgical connection between an artery and a vein, usually in the arm, created to make dialysis possible for kidney failure patients) after the resident returned to the facility from their dialysis treatments. Resident 7 revealed that the resident removed the dressing on their own. Interview on 4/1/26 at 11:20 AM with the Patient Transportation Driver (PTD) revealed that Resident 7 was currently out of the facility for dialysis and that PTD was preparing to go pick Resident 7 up from the dialysis center. Observation on 4/1/26 at 11:45 AM at the facility driveway at the front entrance revealed that Patient Transportation Driver (PTD) was unloading Resident 7 from the facility bus. Observation 4/1/26 at 11:48 AM in the facility activity hallway revealed that the facility PTD transported Resident 7 per wheelchair directly from the front entry to the facility dining room and positioned Resident 7 at a table in the dining room. Resident 7 had a dressing on their right forearm. Registered Nurse-A (RN-A) pushed a medication cart into the hall outside of the dining room and did not go into the dining room to assess Resident 7. Interview on 4/1/26 at 11:50 AM with (continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 7 confirmed that the dressing on their right forearm was from the dialysis center. Observation on 4/1/26 at 12:31 PM in the dining room revealed that RN-A entered the dining room and went to the beverage counter. RN-A grabbed a cup and exited the dining room without assessing Resident 7. Record review of the March 2026 calendar revealed that the dates of Mondays, Wednesdays, and Fridays (days of the week Resident 7 receives dialysis) in March were 3/2/26, 3/4/26, 3/6/26, 3/9/26, 3/11/26, 3/13/26, 3/16/26, 3/18/26, 3/20/26, 3/23/26, 3/25/26, 3/27/26, and 3/20/26. There were 13 total dialysis dates. Record review of the Progress Notes for Resident 7 between the dates of 3/1/26 and 3/31/26 revealed 5 progress notes that the resident returned from dialysis. The progress notes contained no evidence of an assessment being conducted for Resident 7 upon their return from dialysis on those dates. Record review of the Progress Note for Resident 7 dated 3/16/26 at 5:45 PM revealed that Resident 7 had returned from dialysis around noon with no new orders. Record review of the Progress Note for Resident 7 dated 3/18/26 at 11:41 AM revealed that Resident 7 had returned from dialysis with no new orders. Record review of the Progress Note for Resident 7 dated 3/23/26 at 12:16 PM revealed that Resident 7 had returned from dialysis without their paperwork. Dialysis was called and they were to fax papers over. Record review of the Progress Note for Resident 7 dated 3/27/26 at 1:06 PM revealed that Resident 7 had dialysis done today and they had no complaints. Resident 7 had gone to the dining room to eat. Record review of the Progress Note for Resident 7 dated 3/30/26 at 12:46 PM revealed that Resident 7 had returned from dialysis with no problems or new orders. Record review of the medical record for Resident 7 revealed that the Clinical Monitoring Dialysis assessment had been completed 4 times in March 2026. Record review of the Clinical Monitoring Dialysis assessment dated [DATE] revealed that it was completed at 2:17 AM. Record review of the Clinical Monitoring Dialysis assessment dated [DATE] revealed that it was completed at 12:38 PM. Record review of the Clinical Monitoring Dialysis assessment dated [DATE] revealed that it was completed at 5:25 AM. Record review of the Clinical Monitoring Dialysis assessment dated [DATE] revealed that it was completed at 6:43 AM. Interview on 4/1/26 at 4:16 PM with RN-A revealed that RN-A did not do any specific assessment of Resident 7 on return to the facility from dialysis treatments. RN-A confirmed that RN-A did not perform any physical assessment of the resident's dressing after dialysis treatments. RN-A revealed that RN-A did try to palpate the fistula for thrill (a palpable, buzzing vibration felt over a surgical connection between an artery and a vein, usually in the arm, created to make dialysis possible for kidney failure patients) each day. RN-A revealed that dialysis wanted the facility to leave the dressing on the fistula overnight after each dialysis treatment. Observation on 4/1/26 at 4:20 PM in the resident room revealed Resident 7 in the recliner. The dressing on the right forearm of Resident 7 was clean and dry. Resident 7 revealed that the facility staff did not remove the dressing following each dialysis treatment, Resident 7 did this on their own. Resident 7 removed the dressing from their forearm, and a small amount of bleeding was observed on the fistula that stopped without intervention. Interview on 4/2/26 at 9:51 AM with the facility Director of Nursing (DON) confirmed that Resident 7 received dialysis outside of the facility 3 times per week. The DON confirmed that the Clinical Monitoring-Dialysis assessment was to be completed each date the resident had dialysis. The DON revealed that the facility discovered sometime in the prior 2 weeks that this assessment was not being completed so the facility had been doing staff education. The DON confirmed that the Clinical Monitoring-Dialysis assessment should be completed on return of the resident from their dialysis treatments. The DON confirmed that the nurse was expected to assess and monitor the dressing on the resident's fistula on return from their dialysis treatments. The DON confirmed that the nurse should be the one removing the dressing and assessing the fistula site rather than the resident. The DON confirmed that the facility had not been assessing Resident 7 after dialysis treatments as required.</p>		