STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285192	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - St Luke's Village	2201 East 32nd Street 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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number: 175 NAC 12-006.09 Based on record reviews and interviews, the facility failed to follow physician orders for 1 of 4 sampled residents (Resident 1). The facility census was 42. The facility Administrator was notified on 4/16/25 at 7:48 PM of an Immediate Jeopardy (IJ) which began on 3/18/25. The IJ was removed on 4/16/25, as confirmed by surveyor onsite verification. Findings are: Review of Resident 1's Baseline Care Plan (BCP, a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission) last updated on 04/16/2025 revealed the resident was admitted to the facility on [DATE] from another facility for long term care. Further review of the BCP revealed Resident 1 has a communication problem related to Down's Syndrome (a disorder causing distinct facial appearance, intellectual disability, developmental delays), is non-verbal, takes an anticonvulsant, dependent for all care needs, and has a nutritional problem related to full reliance on Gastric tube feedings (PEG-Tube; a feeding tube inserted through the skin and into the stomach, bypassing the mouth and esophagus, for food and medicine). A review of Resident 1's Physician Orders for the month of 03/2025 revealed: -Dilantin Oral Suspension 125 mg/5 ml (used to treat certain type of seizures) Give 8 ml via PEG-Tube two times a day. Start Date: 02/25/2025 -Phenytoin Oral Tablet Chewable 50 mg (used to control certain type of seizures) Give 3.5 tablet via PEG-Tube every 12 hours PRN, if we run out of liquid Dilantin. Start Date: 02/25/2025 A record review of the Medication Administration Record (MAR) from March 1st through March 31, 2025 for Resident 1 revealed that the liquid Medication Dilantin was documented as see nurse notes for the 4 PM dose on 3/18/25 and 3/19/25. On 3/20/25 and 3/21/25 both 8 AM dose and 4 PM dose was documented as drug not available. On 3/23/25 for 4 PM dose and 3/25/25 for 8 AM dose was documented as drug not available. The MAR further revealed the Phenytoin Oral Tablet had no documentation from 3/18/25 through 3/20/25, and on 3/21/25 and 3/23/25 was documented as unknown and 3/25/25 Phenytoin was documented as effective. There was no other documentation for the month of March on the MAR. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the MAR from April 1st through April 30, 2025 for Resident 1 revealed no documentation that Dilantin was administered for 8 AM on 4/8/2025, and the noon dose on 4/12/2025 and 4/13/2025. MAR further revealed no documentation that Phenytoin was administered for the Month of April 2025 A review of Resident 1's progress note dated 03/20/2025 revealed that Licensed Practical Nurse-B (LPN-B) sent a communication to the pharmacy stating, call placed to pharmacy and asked about resident's Dilantin refill. Medication is back ordered and should be delivered tomorrow. Review of Resident 1's progress notes for the month of March 2025 did not reveal any further documentation for Dilantin or Phenytoin. A record review of progress notes dated 04/16/2025 revealed that Resident 1 went to the hospital on 04/04/2025 in the early am due to a seizure. The hospital notes reveal the residents' Dilantin levels were low, a new order was placed to increase the Dilantin. An interview with the pharmacy on 04/16/2025 at 4:50 PM confirmed the pharmacy did not have Dilantin or Phenytoin available to deliver to the facility from 3/18/25 through 3/21/2025. A review of Resident 1's communication form titled, Doctor of Medicine (MD)/Nursing Communications dated 03/28/2025 revealed on 03/23/2025 Phenytoin Oral Tablet Chewable 50 milligram (mg) give 3.5 tablet via PEG-Tube every 12 hours as needed for epilepsy use if we run out of liquid Dilantin administered due to liquid not available. The communication was signed by the physician on 03/31/2025. No other communication to the physician was found on notification that the medication was not available or provided. An interview with the DON and the Administrator (ADM) on 04/16/2025 at 5:10 PM confirmed there was no further documentation on the MAR or progress notes for providing the medication Dilantin on dates 3/18/2025-3/21/2025, 3/21/25, 3/23/25, and 3/25/25. The DON and the Administrator also confirmed that there was no documentation on the MAR to show that the medication Dilantin or Phenytoin Oral Tablet had been administered for the listed dates. DON and ADM further confirmed there was no documentation of administration of the medications on 04/08/2025 for the AM dose, 04/12/2025 noon dose, and 4/13/2025 noon dose. The DON and the ADM confirmed that the physician was not directly notified within 24 hours of the missing medication, and that the medication was not provided and should have been. A review of a facility policy titled, Medication: Administration Including Scheduling and Medication Aides dated 04/08/2025 revealed: -If a medication is given but not signed for, the person who administered the medication has 24 hours to sign, provided there is definitive evidence that the medication was administered. If not signed for within 24 hours, it is considered a medication error, and a SAFE Event Report must be completed. -Medication Errors: A SAFE Event Report will be completed for all medication errors. If medication is not available for 24 hours, the provider must be notified that the medication is not available and must give directions for how to proceed. The facility removed the immediate jeopardy with the following Abatement Statement: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 1's primary care provider was notified by the ADM and DON on 4/16/25 at 7:36 PM of the missing does of Dilantin. Resident 1 is currently in the hospital. All licensed nursing staff were immediately educated on the Policy Local Pharmacy Medication Ordering-R/S, LTC that were on shift 4/16/25. All licensed nursing staff will be educated prior to the next schedule shift. If a medication is not available, we will notify the physican immediately to get further direction and work with the pharmacy to get medication from another pharmacy. DON or designee with implement an end of shift checklist to monitor an potential missed medication and educate licensed nursing staff on checklist. DON or designee with audit for any unavailable or missed medications daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months until 100% compliance reached and brought to QAPI for further review and recommendations. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number: 175 NAC 12-006.12 Based on record reviews and interviews, the facility failed to ensure pharmacy provided medications for 1 of 4 sampled residents (Resident 1). The facility census was 42. The facility Administrator was notified on 4/16/25 at 7:48 PM of an Immediate Jeopardy (IJ) which began on 3/18/25. The IJ was removed on 4/16/25, as confirmed by surveyor onsite verification. Findings are: Review of Resident 1's Baseline Care Plan (BCP, a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission) last updated on 04/16/2025 revealed the resident was admitted to the facility on [DATE] from another facility for long term care. Further review of the BCP revealed Resident 1 has a communication problem related to Down's Syndrome (a disorder causing distinct facial appearance, intellectual disability, developmental delays), is non-verbal, takes an anticonvulsant, dependent for all care needs, and has a nutritional problem related to full reliance on Gastric tube feedings (PEG-Tube; a feeding tube inserted through the skin and into the stomach, bypassing the mouth and esophagus, for food and medicine). A review of Resident 1's Physician Orders for the month of 03/2025 revealed: -Dilantin Oral Suspension 125 mg/5 ml (used to treat certain type of seizures) Give 8 ml via PEG-Tube two times a day. Start Date: 02/25/2025 -Phenytoin Oral Tablet Chewable 50 mg (used to control certain type of seizures) Give 3.5 tablet via PEG-Tube every 12 hours PRN, if we run out of liquid Dilantin. Start Date: 02/25/2025. A review of Resident 1's Medication Administration Record (MAR) dated 03/01/2025-03/31/2025 revealed that the resident was admitted to the facility on [DATE] from another facility for long term care. MAR for Resident 1 further revealed that the liquid Medication Dilantin was documented as see nurse notes for the 4 PM dose on 3/18/25 and 3/19/25. On 3/20/25 and 3/21/25 both 8 AM dose and 4 PM dose was documented as drug not available. On 3/23/25 for 4 PM dose and 3/25/25 for 8 AM dose was documented as drug not available. The MAR further revealed the Phenytoin Oral Tablet had no documentation from 3/18/25 through 3/20/25, and on 3/21/25 and 3/23/25 was documented as unknown and 3/25/25 Phenytoin was documented as effective. There was no other documentation for the month of March on the MAR. A record review of the MAR from April 1st through April 30, 2025 for Resident 1 revealed no documentation that Dilantin was administered for 8 AM on 4/8/2025, and the noon dose on 4/12/2025 and 4/13/2025. MAR further revealed no documentation that Phenytoin was administered for the Month of April 2025 (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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's progress note dated 03/20/2025 revealed that Licensed Practical Nurse-B (LPN-B) sent a communication to the pharmacy stating, call placed to pharmacy and asked about resident's Dilantin refill. Medication is back ordered and should be delivered tomorrow. Review of Resident 1's progress notes for the month of March 2025 did not reveal any further documentation for Dilantin or Phenytoin. A record review of progress notes dated 04/16/2025 revealed that Resident 1 went to the hospital on 04/04/2025 in the early am due to a seizure. The hospital notes reveal the residents' Dilantin levels were low, a new order was placed to increase the Dilantin. An interview with the pharmacy on 04/16/2025 at 4:50 PM confirmed the pharmacy did not have Dilantin or Phenytoin available to deliver to the facility from 3/18/25 through 3/21/2025. A review of Resident 1's communication form titled, Doctor of Medicine (MD)/Nursing Communications dated 03/28/2025 revealed on 03/23/2025 Phenytoin Oral Tablet Chewable 50 milligram (mg) give 3.5 tablet via PEG-Tube every 12 hours as needed for epilepsy use if we run out of liquid Dilantin administered due to liquid not available. The communication was signed by the physician on 03/31/2025. No other communication to the physician was found on notification that the medication was not available or provided. An interview with the DON and the Administrator (ADM) on 04/16/2025 at 5:10 PM confirmed there was no further documentation on the MAR or progress notes for providing the medication Dilantin on dates 3/18/2025-3/21/2025, 3/21/25, 3/23/25, and 3/25/25. The DON and the Administrator also confirmed that there was no documentation on the MAR to show that the medication Dilantin or Phenytoin Oral Tablet had been administered for the listed dates. DON and ADM further confirmed there was no documentation of administration of the medications on 04/08/2025 for the AM dose, 04/12/2025 noon dose, and 4/13/2025 noon dose. The DON and the ADM confirmed that the physician was not directly notified within 24 hours of the missing medication, and that the medication was not provided and should have been. The DON provided a facility checklist titled Nurse Shift Change Checklist dated 7/7/15 revealing: Purpose: Includes a list of items that need to be completed during the shift. 1. Verify all medications and treatments have been administered on either the clinical dashboard or eMAR (Electronic Medication Administration Record). A review of a facility policy titled, Medication: Administration Including Scheduling and Medication Aides dated 04/08/2025 revealed: -If a medication is given but not signed for, the person who administered the medication has 24 hours to sign, provided there is definitive evidence that the medication was administered. If not signed for within 24 hours, it is considered a medication error, and a SAFE Event Report must be completed. -Medication Errors: A SAFE Event Report will be completed for all medication errors. If medication is not available for 24 hours, the provider must be notified that the medication is not available and must give directions for how to proceed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility policy titled, Local Pharmacy Medication Ordering dated 09/03/2024 revealed: -Purpose: To assist in resolving issues in receiving medications from a pharmacy. -If the medication is not available, notify the ordering physician immediately to determine whether the order should be changed tor starting the medication can wait until the medication is available from the pharmacy. Document in Progress Notes. The facility removed the immediate jeopardy with the following Abatement Statement: Resident 1's primary care provider was notified by the ADM and DON on 4/16/25 at 7:36 PM of the missing does of Dilantin. Resident 1 is currently in the hospital. All licensed nursing staff were immediately educated on the Policy Local Pharmacy Medication Orderins-R/S, LTC that were on shift 4/16/25. All licensed nursing staff will be educated prior to the next schedule shift. If a medication is not available, we will notify the physican immediately to get further direction and work with the pharmacy to get medication from another pharmacy. DON or designee with implement an end of shift checklist to monitor an potential missed medication and educate licensed nursing staff on checklist. DON or designee with audit for any unavailable or missed medications daily for 2 weeks, weekly for 2 weeks, and then monthly for 2 months until 100% compliance reached and brought to QAPI for further review and recommendations. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.