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	04/14/2026

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

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Licensure Reference Number 175 NAC 12-006.11Based on record review, observation, and interview the facility failed to ensure the amount of protein served at a meal was in the amount stated on the facility supplied menu for 32 residents (1, 3, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 23, 25, 26, 27, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 46, and 47) of 36 residents. The facility census was 36.Findings are:Record review of a facility supplied document titled Dining Manager BBQ Chicken Thigh dated 2026 revealed a portion description to reflect 3 ounces of chicken thigh boneless.A.In an observation of meal service on 04/09/2026 from 11:40 AM through 12:15 PM Dietary [NAME] D (Cook-D) used red handled tongues to place a single piece of cooked chicken on to Resident 1, 5, 6, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20, 21, 23, 25, 27, 29, 30, 31, 32, 35, 37, 38, 46, and 47's plates. The plate was then served to each resident with the piece of chicken on it. The [NAME] did not weigh each piece of the chicken to ensure that each resident received the recipe stated 3-ounce portion.In an interview completed at 12:10 PM with Cook-D, Cook-D confirmed that not all of the pieces of chicken were the same size. The cook confirmed that they did not weigh the pieces of chicken to ensure each resident received the recipe stated 3-ounce portion, so they had no idea how much chicken/protein menu item the resident was provided.B.In an observation of meal service on 04/09/2026 from 11:40 AM through 12:15 PM Cook-D used red handled tongues to scoop up pieces of cut up chicken onto Resident3, 7, 26, 34, 36, and 39's plates. The plates were then served to each of the residents with the unmeasured amount of chicken on them. The cook did not use a measured scoop to place a portioned amount of the cut-up chicken on to the residents' plates.In an interview completed at 12:10 PM with Cook-D, Cook-D confirmed that they did not use a measured scoop to place a portioned amount of the cut-up chicken onto the resident's plate. The cook confirmed that by not using a measured scoop they did not know the portion size that was served to each of the residents of the chicken/protein meal item.In an interview completed on 04/09/2026 at 12:30 PM with the facility Dietary Manager (DM), the DM confirmed that Cook-D did not weigh or measure the chicken/protein that was served to the residents and should ensure each resident received the recipe stated 3 ounce portion of chicken/protein.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D)Based on record review, observations, and interviews, the facility failed to ensure that the medication error rate was less than 5% with an actual medication error rate of 20% based on 25 observations. The facility census was 36.Record review of the facility policy Medication Errors dated 03/02/2026 revealed the purpose of the of the policy was to provide guidance in documenting and auditing medication errors. The location will have medication error rates of 5% or less and those residents are free of significant medication errors. Medication errors were defined as the observed of identified preparation of administration of medications or biologicals which are not in accordance with the prescriber's order, manufacture's specifications (not recommendations) regarding the preparation and administration of the medication or biological or accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the carious practice regulation in each state, and current commonly accepted health standards established by national organizations. Significant medication errors were defined as those which cause the resident discomfort or jeopardizes his or her health and safety. Significance may be subjective or relative depending on the individual situation and duration.Record review of the facility policy Medication Administration Including Scheduling and Medication Aides dated 3/30/2026 revealed that the purpose of the policy was to promote understanding of medication therapy, to administer medications correctly and in a timely manner, to provide direction regarding medication aides. Medications are to be administered according to the Six Rights. All employees passing medications are familiar with action and adverse reactions of medications. The procedure was to:Wash hands prior to beginning a med pass and follow the administration of medication for each resident. If hands are visibly soiled wash hands with soap and water, if hands are not visibly soiled use of an alcohol-based hand rub (ABHS) is acceptable.Review the Medication administration record (EMAR) for medications due.Check for allergies.Follow the 6 Rights: right medication, right dose, right resident, right route, right time, and right documentation.Perform three checks: read the label on the medication container and compare to the EMAR, look at the medication when placing in the med cup, and look at the meds just before administration. Do not touch the medication with ungloved hands, and if a medication falls on the floor, discard it and use a new med.Record review of the document Nursing Rights of Medication Administration dated 01/2025 by the National Library of Medicine stated the five rights of medication are the right patient (ensuring the medication is administered to the person it is prescribed for), the right drug (ensuring the medication being administered is identical to what is prescribed), the right route (ensuring the medication is administered in the correct way as prescribed), the right time (ensuring the medication is administered at the correct time intervals), and the right dose (ensuring the medication is administered at the prescribed dose).A.Review of the April 2026 Electronic Medication Administration Record (EMAR) for Resident 23 revealed orders for:Humalog Kwikpen subcutaneous (under the skin into the fatty tissue and not the muscle) insulin injection 10 units subcutaneously with meals andHumalog Kwikpen subcutaneous insulin per sliding scale (a dose that is dependent upon the actual blood sugar reading) to give 9 units for a blood sugar for blood sugar readings between 251 and 300. Record review of the Instructions for Use of the Humalog Kwikpen with copyright date of 2023 revealed the following:Attach the new needlePrime the needle before each injection to remove air from the needle and cartridge that may collect during normal use and to ensure the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.Prime the needle with 2 units of insulin.Select the required dose on the dose nob.Insert the needle into the skin and hold the dose knob in and slowly count to 5.Remove the needle from the injection site and discard in a sharps container. Record review of the facility policy Medication: Insulin Administration, Insulin Pens, Insulin Pumps dated 10/31/2025 revealed the purpose of the policy was to administer insulin injections correctly. The procedure for the use of the insulin pen was to cleanse (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the skin site with alcohol, wipe the tip of the needle hub with alcohol, attach the needle and screw it until it is snug, turn the dosage knob to 2 units to prime the pen, point the needle upwards and depress the injection button. The dial the ordered dose of the insulin and then inject the insulin, make sure to wait about 10 seconds until the full dose of insulin has been delivered.Observation on 4/13/2026 at 11:32 AM of RN-B, who administered insulin to Resident 23 with a Humalog Kwik-pen. RN-B took Resident 23's blood sugar with results of 295. RN-B reviewed the order for Resident 23 who had two orders for the insulin. RN-B took the insulin pen, attached a new needle to the pen, and walked with Resident 23 to their room. RN-B then dialed in the amount of insulin that was needed for both the regular order and the sliding scale doses (19 units total) into the insulin pen and injected the insulin into Resident 23's left lower quadrant of the abdomen, pushed the injection button, and immediately removed the insulin pen after pressing the injection button. Then left the room of the resident. Interview with RN-B on 4/13/2026 at 11:40 who confirmed the needle was not primed with 2 units of insulin prior to the administration of the insulin. RN-B also confirmed that the needle had not been held in place for 6 seconds after the administration of the insulin. I had no idea that the insulin pen needed to be left in place for that length of time. I will be holding it for 10 seconds from now on though.B.Record review of the April 2026 EMAR for Resident 30 revealed that this resident had orders for two different eye drops;Refresh tears ophthalmic solution (an eye drop for extremely dry eyes). Instill one drop in both eyes twice a day for severe dry eyes. Artificial Tears solution 1.4% (an eye drop for dry eyes). Instill one drop in both eyes before meals and at bedtime for dry eyes.Record review of the undated quick sheet provided by the facility. This revealed that a quick sheet is a synopsis of the procedure without rationales or citations and is intended to be a review of how to perform a procedure and not for the first time or novice user. There was an ALERT that stated avoid touching the eye with the tip of the applicator to prevent contamination. Ask the patient to lie supine or to sit back in the chair with the neck slightly hyperextended.When administering the eye drops:Ask the patient to look at the ceiling before administering the eye drops.Hold a tissue in the non-dominant hand on the patient's cheekbone just below the lower eyelid,While holding the tissue, gently press downward with the thumb or forefinger against the bony orbit to expose the lower conjunctival sacWith the dominant gloved hand resting on the patient's forehead, hold the filled medication eye drops perpendicular to the eye just above the lower conjunctival sac. Do not allow the tip of the dropper to touch the eye. Ophthalmic medications should be sterile.Instill the drops into the conjunctival sac that is exposed. Do not touch the eye or any other surface.If more than one eye drop or medication is prescribed, allow 5 minutes between the medications.IF the eye drop falls on the outer lid margins or the resident blinks, repeat the procedure.Then ask the resident to close their eye for at least one minute.Record review of the facility Job Description for Medication Aide Long Term Care Float staff revealed that the Medication Aide (MA) serves as caregiver who provides resident-centered nursing care and daily living assistance to assigned residents under the supervision of a charge nurse and included administering prescribed medications as delegated by a licensed nurse and with their scope of practice as defined by state regulations. Individuals must complete yearly competency testing. Individuals must administer medications as prescribed by physicians.Record review of the Transcript Report for Medication Aide (MA)-F printed on 4/14/2026 revealed that this was an interagency training report and whose position listed was Medication Assistant, Certified, long-term care, float. MA-F had taken the following courses with the completion dates listed:Hazardous Drugs - 12/2/2025Medication Administration - 12/17/2025Record review of the Certified Medication Aide preceptor records dated 12/9/2025 revealed that MA-F had to do a self-assessment and then a preceptor had to initial. The self-assessment scale was as follows: 1.) Unfamiliar with skill. 2.) Uncomfortable performing skill. 3.) Able to perform without supervision. 4.) Able to teach skills to new employees.Listed were the following competencies and skills with MA-F's self-assessment score.Demonstrates appropriate delivery of oral medications - 4Demonstrates or verbalizes how to use a metered dose inhaler - 4Demonstrates the appropriate delivery of eardrops (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and eye drops - 4These self-assessments were signed off by SW who was determined to be another Medication Aide at the regional level.In an interview with the Infection Control Preventionist (IP) on 4/13/2025 at 9:30 AM revealed the staff who float to all the regional facilities, interagency staff, are given training during the orientation and competencies are completed at that time as well before they are allowed to go to other facilities. Audits are performed monthly to address any issues that are seen within the facility.Interview with MA-F on 4/13/2026 at 3:25 PM revealed that they completed the Medication Aide course in January 2026. At that time MA-F had passed all required courses for the MA licensure as well as competencies so they could pass medications. After Medication Aide and Med Administration courses and tests are passed, then float staff are allowed to sign up for around 13 or 14 different facilities and can float or travel between all of them and work in each facility. Observation on 4/14/2026 at 3:20 PM of Medication Aide (MA) F who prepared and administered 2 eye medications for Resident 30, who was seated upright in a chair in their room. MA-F told Resident 30 that it was time for their eye drops. MA-F put one finger on the outer edge of the upper lid and pulled the eye up and out and asked Resident 30 to open the left eye, then dropped the eye drop in the eye while touching the eye lashes. Then MA-F touched the outer edge of the upper lid of the right eye, pulled up and outward and told the resident to open the right eye and dropped the eye drop in the eye and touched the eye lashes. MA-F then handed Resident 30 a Kleenex to wipe both cheeks. MA-F capped the first bottle of eye drops and immediately picked up the second bottle of eye drops, pulled the upper lid of the left eye up and out and dropped the second drop into the eye and touched the eye lashes of the left eye. MA-F then tried to put the eye drop in the right eye as the upper eye lid was pulled out and upward and the eyelashes were again touched. Resident 30 then asked if MA-F would put the eye drop in the resident's eye. MA-F stated to the resident that the eye drop was in the right eye and handed the resident another Kleenex to wipe the eyes and right cheek. MA-F did not try to insert another eye drop.Interview on 4/13/2026 at 4:20 PM revealed that MA-F did not know that eye drops are supposed to be given 5 minutes apart. MA-F confirmed that the eye drops were given about 1 minute apart. MA-F revealed not knowing that one was not supposed to touch the eye drop bottle on the eye lashes and that this could and would contaminate the bottle of eyedrops. Confirmed that the bottle of eye drops did touch the eye lashes. Confirmed that no pocket of the lower eyelid was formed when inserting the eye drops to assist with the instillation of the eye drops. C.Record review of the April 2026 EMAR of Resident 47 revealed there was an order for Budesonide-Formoterol (an inhaled corticosteroid used for long-term maintenance treatment of asthma) inhalation aerosol 160-4.5 micrograms to inhale 2 puffs orally twice a day related to dyspnea (trouble breathing).Observation on 4/13/2026 at 3:56 PM of MA-F gave Resident 47 the oral Budesonide, who inhaled two puffs, then returned the medication to MA-F. Resident 47 was ambulating in the hallway with a therapy aide at the time.Interview on 4/13/2026 at 4:20 PM with MA-F who revealed that it would have been better to have Resident 47 take the medication once that resident had returned to their room. MA-F confirmed that Resident 47 did not rinse and spit after the administration of the med because the medication was given while Resident 47 was ambulating in the hallway with therapy. MA-F confirmed they did not know why it was important to rinse and spit even though the order stated that this was to be completed. MA-F confirmed the order did state that the resident was to rinse mouth and spit this out.D.Record review of the April 2026 EMAR for Resident 26 revealed an order for Tamsulosin (a medication for urine retention) 0.4 mg once daily after meal in the evening.Observation on 4/13/2026 at 4:06, MA-F prepared and administered 4 medications for Resident 26 while reviewing medications at the med cart and double checking with the electronic medication record on the computer screen. MA-F gathered all 4 mediations and then went to the room of Resident 26 and administered the medications. MA-F went back to the med cart and logged the medications as given.Interview on 4/13/2026 at 4:20 with MA-F it was revealed that MA-F did not know what error had occurred with the administration of the medications for Resident 26. The 4 medications were pulled back out of the medication cart and MA-F reviewed each medication with the computer screen to be certain that the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct medications had been given. Then MA-F stated that the medication was supposed to be given after the meal and not before the meal. MA-F confirmed that they look at all the medications but doesn't always read the entire order for the medications. MA-F confirmed that the medication was given at the wrong time.Interview with the Regional Educator (RE) on 414/2026 at 3:45 confirmed that the staff members who are allowed to float between different facilities with the organization are competency tested prior to being allowed to float or travel to other facilities. The RE:Confirmed that insulin pens must be primed before dialing the amount of insulin to be injectedConfirmed that insulin pens must be held in place for at least 6 seconds while injecting the insulin.Confirmed that bottles of eye drops cannot be touched to any surfaces including eye lashes because then the bottle becomes contaminated. TheConfirmed when giving eye drops that there is a specific method for giving eye dropsConfirmed that when administering eye drops, that one must wait 5 minutes between each eye dropConfirmed that physician orders must be followed as writtenConfirmed that Budesonide administration requires the resident to rinse and spit after oral inhalation of the medication to prevent further medical concerns such as oral thrush (a fungal infection), hoarseness, throat irritation, or dental issues.Confirmed that the Medication Aides are supposed to follow the Five Rights of Medication Administration and this includes giving the medications at the right time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 1-005.06(D)Licensure Reference Number 175 NAC 12-006.18(D)Based on record review, observations, and interviews, the facility failed to ensure that hand hygiene was completed during the administration of medications between each resident who received medications. This affected 8 of 8 sampled residents (Residents 30, 34, 3, 46, 47, 15, 26 and 39). The facility census was 36.Findings were:.Record review of the facility policy Hand Hygiene - Enterprise dated 11/13/2025 revealed that the purpose of the policy was;To define terms related to hand hygieneTo guide compliance for hand hygiene with the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) Moments of Hand Hygiene recommendations.To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settingsTo provide guidance regarding lotion use, glove use, and fingernail careThe definition of hand hygiene: a general term that applies to either handwashing or applying hand sanitizer. Handwashing includes washing hands with soap and water. Hand sanitizer involves using a waterless antiseptic agent. Antiseptic hand sanitizer was defined as applying a waterless alcohol based antiseptic agent to all surfaces of the hands to reduce the number of organisms present. Waterless agents do not require water. Hand sanitizer should be at least 60% alcohol.This policy also stated:All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices.The preferred method of hand hygiene for most patient care settings was the use of an alcohol-based hand sanitizer (ABHS).Access to hand hygiene products was provided in all work units (wall mounted, attached to carts or positioned on counters).Gloves are a protective barrier for healthcare workers (HCW) according to standards precautions.Gloves should never be reused or sanitizedHand hygiene should be performed after glove removal.The procedure stated: HCW will use waterless ABHS or soap and water to clean their hands when:Entering the patient roomBefore preparing or administering medications.If gloves are used, hand hygiene must be completed before donning gloves and after removing gloves regardless of the task completed.Record review of the Regional Organization's check off Hand Hygiene Clinical Skill Checklist for Medication Aide (MA) F which was completed during the training courses for Certified Nursing Assistant and Medication Aide training revealed that on 12/09/2025 The RN Educator had signed off the skills checklist stating that MA-F had met and passed all the procedural and skills steps about hand hygiene and hand washing and knew when this was to be completed. Step one stated that hand hygiene is performed at the Moments of Hand Hygiene including but not limited to; 1) Before entering a room, 2) before performing a clean task, 3) After bodily fluid or glove removal, and 4) after exiting a room. Hand Hygiene is performed before touching anything in a healthcare zone and when leaving a patient zone.In an interview with the Infection Control Preventionist (IP) on 4/13/2025 at 9:30 AM revealed that as the IP, all staff were given training on hand hygiene (HH) on an annual basis. The staff that float to all of the regional facilities are given the training during orientation and receive the infection control training prior to coming into the facility as a traveler or float person. These traveler/float personnel are trained with the same information that the regular staff receive and then work within the same medical system just in different buildings throughout the state. The IP also revealed that HH is important to reduce the incidents of infections. Audits are performed monthly to address any issues that are seen within the facility.Observations on 4/13/2026 during the time period from 3:20 PM to 4:20 PM revealed the following:At 3:20 PM Medication Aide (MA) F opened the computer screen to prepare medications for Resident 30. The medication (med) cart was unlocked, opened, and medications were retrieved from the cart drawer for Resident 30. MA-F popped one med from the bubble pack (A specialized packing for meds taken daily in which only one dose of a med is in each bubble) and placed the med in a med cup. MA-F also removed two bottles of eye drops from another drawer. MA-F went to the room of Resident 30, obtained the resident's blood pressure and administered the pill in the med cup. MA-F (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered both eye drops, one drop in each eye, handed the resident a Kleenex to wipe eyes, left the room, charted the med on the computer administration record, then clicked on the name of the next resident. MA-F did not perform hand hygiene (HH) before or after the administration of the meds to Resident 30.At 3:29 PM MA-F unlocked and opened the cart and removed meds for Resident 34 and put two meds into the med cup. MA-F then took one med out of the med cup and laid it on the surface of the med cart, then took the other med and put into a plastic pouch to crush the med. MA-F then filled the med cup with pudding, poured the contents of the pouch into the med cup, stirred, opened the capsule of the second med and poured that into the med cup, and reviewed the med list on the computer screen. MA-F found two more meds that needed to be given to the resident, opened the cart drawer once again, removed the two meds from the drawer and bubble pack, put each of these meds into another pouch to crush, then added these to the pudding and stirred. MA-F then handed the meds to Resident 34 who was seated next to the med cart. Once the meds were administered, MA-F charted the meds on the computer record. MA-F did not do hand hygiene before or after the med administration. MA-F then clicked on the next resident on the computer screen.At 3:35 PM MA-F walked down the hall to see if Resident 3 was ready for the evening administration of meds. Resident 3 requested to wait until mealtime instead of having the meals at that time. MA-F did not use HH after entering or exiting Resident 3's room.At 3:38 PM MA-F unlocked and opened the med cart, clicked on the resident's name on the computer, pulled the meds out of the cart drawer and popped the meds out of the bubble pack for Resident 46, put the meds in a med cup, and then tried to give the meds to the Resident 46. MA-F walked to Resident 46's room. Resident 46 was not in the room. MA-F was told that Resident 46 was outside seated in a chair, so MA-F walked to the facility exit, opened the door and went outdoors, looked outside for the resident while carrying the medications and a small 3 ounce cup of water, then reached out and opened the door to go back into the facility carrying the meds and the water. MA-F asked the charge nurse about the meds and handed the medication to the charge nurse after labeling the meds. MA-F did not use HH to sanitize hands prior to the start of the medication pass, after going outside, and prior to preparing to administer the medications to the next resident.At 3:46 PM MA-F returned to the med cart, clicked on the next resident's name on the computer screen, unlocked and opened the med cart. Resident 3 was sitting in a wheelchair beside the med cart and asked for a pain pill. MA-F asked Resident 3 what was hurting. MA-F removed the sock from the right foot of Resident 3 to find that the small band aide on the top of Resident 3's foot was curled up, MA-F called for the charge nurse to assist in an assessment and asked Resident 3 how much pain the foot wound was causing. MA-F used ABHS at this time to do HH. MA-F then unlocked and opened the narcotic box and retrieved a bubble pack, obtained one pain pill, gave the pain pill to Resident 3 with a small glass of water, and then charted the medication in the narcotic record book and in the computer on the medication record. MA-F did not use ABHS at this time to do HH prior to starting the next medication administration.An unknown resident was seated near the med cart to the north side and across the hall nearest the nurses' station and asked for help with the foot pedals of the wheelchair. MA-F bent down and assisted the unknown resident with the foot pedal of the wheelchair, and returned to the med cart, and did not perform HH.At 3:56 MA-F selected the next resident from the computer screen to prepare the next resident's meds. MA-F unlocked the cart, opened the drawer and pulled out the bubble pack needed, put the single med in a med cup and then opened another drawer and retrieved an oral inhaler. Both medications and a 3-ounce glass of water were taken to Resident 47, who was, at the time, ambulating down the 300 hallway with a therapy aide. The resident took the med from MA-F and gave med cup back to MA-F. Then the resident took the glass of water from MA-F, drank the water and handed the empty cup to MA-F. MA-F returned to the med cart, discarded the med cup and glass, and charted the medications on the computer administration record. MA-F did not use HH.At 4:01 MA-F unlocked and opened the med cart and removed one med for Resident 15. MA-F added the med to a med cup, put applesauce in the med cup for the resident, poured a 3-ounce glass of water, locked the cart, and walked down the hall to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room of Resident 15. MA-F gave Resident 15 the med, took the empty med cup back to the med cart, and discarded the med cup in the med cart trash. MA-F did not use HH.At 4:06 MA-F unlocked and opened the med cart and removed 4 medications for Resident 26. MA-F removed all 4 medications and put them in a med cup, locked the med cart, then walked down the hall to the room of Resident 4. MA-F assisted Resident 26 while they took their meds, put a new plastic bag into the trash can in the room of Resident 26, threw the empty med cup in the trash can, then went back to the med cart. Med-F did not use HH after the medication administration or after handling the trashcan. MA-F then charted the medications on the chart.At 4:12 MA-F unlocked and opened the med cart, retrieved one medication from the cart for Resident 39, then returned the medication to the drawer. MA-F stated that Resident 39 has a hard time swallowing sometimes and took the large pill from the med cup with both hands, broke the pill in half, then went to the resident's room to give Resident 39 the med. No HH was used before entering the room or after leaving the room or after returning to the med cart. End of observations at 4:20Interview with MA-F on 4/13/2026 at 3:25 PM revealed that MA-F had just completed the Medication Aide course in January 2026. At that time MA-F had passed all required courses for the MA licensure as well as competencies that included Medication Passes and Infection Control at a facility near Omaha. MA-F revealed that as a Float staff employee there are several facilities that float staff can sign up to work in.Interview with MA-F on 4/13/2026 at 4:20 PM revealed that throughout the medication pass MA-F remembered only using HH only one time which was after removing the sock of Resident 3 and then putting the sock back on. MA-F confirmed that HH is supposed to occur each time one starts a resident's med pass and when that med pass is completed. MA-F confirmed not using ABHS or soap and water to cleanse hands. MA-F confirmed this was an infection control issue.Interview with Regional Educator (RE) at 3:45 PM on 4/14/2026 confirmed that hand hygiene is taught too all of the float staff before they are allowed to float to other facilities within the company. Hand Hygiene is an important aspect of keeping the residents safe within the facility and for this individual to not perform hand hygiene only once during the med pass was a real concern and could pose a threat for infection control in the facility.Interview with the facility Director of Nursing (DON) on 4/14/2026 at 3:55 PM confirmed that float staff are expected to use HH just like full time and part time staff in the facility.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Licensure Reference Number 175 NAC 12-006.05(G)Based on record review and interview, the facility failed to complete documentation of non pharmalogical interventions used prior to the administration of an as needed psychotropic medication for 1 resident (Resident 19) of 2 sampled residents. The facility census was 36.Findings are:Record review of a facility policy titled Psychotropic Medications and dated 12/09/2025 revealed before administration of a non-emergency psychotropic medication documentation in Point Click Care (PCC) the residents electronic medical health record) or POC (Point of Care) observations of mood, symptoms or behaviors that cause the resident distress and or endanger the resident or others and responses to interventions used.Record review of an admission Record revealed the facility admitted Resident 19 on 02/11/2026 with diagnosis of Cerebral Infarction (a loss of blood flow to an area of the brain causing tissue death resulting in sudden weakness, speech difficulties, and vision loss) and generalized muscle weakness.The comprehensive 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 03/27/2026 revealed that Resident 19 had short- and long-term memory problems and severely impaired cognitive skills for daily decision making. The resident required partial to moderate assistance with eating and was dependent on staff assistance for transfers and toilet use.Record review of Resident 19's Physician Orders revealed Resident 19 had orders for the following:-Lorazepam (an anti-anxiety psychotropic medication) Oral Concentrate 2milligrams per 1 milliliter with directions to give 0.5 milliliters every 4 hours as needed for anxiety with a start date of 04/03/2026 and revised on 04/07/2026.-Ativan (an anti-anxiety psychotropic medication) Oral Tablet 0.5 milligrams with directions to give 1 tabled by mouth every 4 hours as needed for anxiety or restlessness dated 04/02/2026.-The resident took Ativan for restlessness and anxiety. Target behaviors are increased restlessness, calling out for help despite needs being met. Attempt non pharmalogical interventions of 1) reposition, 2) offer toileting, 3) offer snack/drink, 4) provide one on one with the resident offering to hold their hand, 5) take the resident for a wheel chair ride outside if the weather was permitting.Record review of Resident 19's Electronic Medical Health Record (EMHR) for the month of April 2026 revealed:-On 04/08/2026 at 11:12 AM Resident 19 was administered the Lorazepam medication. There was no documentation in PCC or POC of observations of mood, symptoms, or behaviors that caused the resident distress and or endanger the resident or others and responses to and interventions used prior to the administration of the medication.-On 04/09/2026 at 9:10 AM Resident 19 was administered the Ativan medication with documentation stating the charge nurse requested the medication to be administered due to the resident appearing restless. There was no documentation in PCC or POC of the responses to and interventions used prior to the administration of the medication.-On 04/13/2026 at 10:08 AM Resident 19 was administered the Lorazepam medication with documentation stating the medication was administered per the charge nurse request and the resident appeared anxious. There was no documentation in PCC or POC of the responses to and interventions used prior to the administration of the medication.In an interview completed on 04/14/2026 at 11:30 AM with the facility Director of Nursing (DON), the DON confirmed that documentation in PCC or POC of the responses to and interventions used prior to the administration of the as needed psychotropic medication were not present for the medication administrations on 04/08/2026, 04/09/2026, and 04/13/2026 and should have been.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review and interview the facility failed to complete Care Area Assessments (a core component of the Resident Assessment Instrument(RAI), used in Medicare/Medicaid-certified nursing homes to evaluate a resident's functional status, identify potential care problems, and develop an individualized care plan (CAA's)) for 2 residents (Resident 9 and Resident 19) of 2 sampled residents. The facility census was 36.Findings are:Record review of a facility policy titled Minimum Data Set 3.0 Resident Assessment Instrument and dated 10/27/2025 revealed completion of the CAA includes direction for completion to include in the analysis of findings area the employee to describe in narrative format the relationship that the risk factors/complications and confounding problems have on the residents triggered CAA. In the section titled Care Plan Considerations yes or no should be chosen if the care area will be addressed in the care plan with a rational for the decision to be included.A.Review of the comprehensive 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 03/18/2026 for Resident 9 revealed the resident triggered for the CAA areas of Visual Function, Functional Abilities, Urinary Incontinence, Psychosocial Well-Being, Falls, Nutritional Status, Dental Care, Pressure Ulcer/Injury, and Psychotropic Drug Use.Review of Resident 9's CAA Worksheet for the comprehensive MDS dated [DATE] revealed the following:-The Visual Function CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDS Coordinator (MDSC) on 03/20/2026.-The Functional Abilities CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Urinary Incontinence CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Psychosocial Well-Being CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Falls CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Nutritional Status CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the Dietary Manager on 03/18/2026.-The Dental Care CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Pressure Ulcer/Injury CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.-The Psychotropic Drug Use CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.In an interview completed on 04/13/2026 at 1:52 PM with the facility MDSC, the MDSC confirmed that Resident 9's CAA's for the comprehensive assessment dated [DATE] were not completed as outlined in the facility policy and should have been.B.Review of the comprehensive MDS dated [DATE] for Resident 19 revealed the resident triggered for the CAA areas of Cognitive Loss/Dementia, Visual Function, Communication, Functional Abilities, Urinary Incontinence, Psychosocial Well-Being, Activities, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Dental Care, Pressure Ulcer/Injury, and Pain.Review of Resident 19's CAA Worksheet for the comprehensive MDS dated [DATE] revealed the following:-The Cognitive Loss/Dementia CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Visual Function CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Functional Abilities CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Communication CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026. -The Urinary Incontinence CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Psychosocial Well-Being CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Activities CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Falls CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.- The Nutritional Status CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Dehydration/Fluid Maintenance CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Dental Care CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Pressure Ulcer/Injury CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 04/01/2026.-The Pain CAA in the analysis of findings area no descriptive narrative that formats the relationship that the risk factors/complications and confounding problems have on the resident. In the Care Plan Considerations section, it was documented that Visual Functions would be addressed on the care plan. There was no overall objective documented and no description of the impact or the rational for this care plan decision documented. The CAA was signed as completed by the MDSC on 03/20/2026.In an interview completed on 04/13/2026 at 1:52 PM with the facility MDSC, the MDSC confirmed that Resident 19's CAA's for the comprehensive assessment dated [DATE] were not completed as outlined in the facility policy and should have been.

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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. Licensure Reference Number 175 NAC12-006.09 (F)Based on record review, observation, and interview, the facility failed to review and revise a residents care plan when the residents care needs changed for 1 resident (Resident 19) of 3 sampled residents. The facility census was 36.Findings are:Record review of a facility policy titled Care Plan and dated 12/01/2025 revealed each resident will have an individualized, person-centered, comprehensive plan of care that will be modified to reflect the care currently required/provided for the resident.Record review of an admission Record revealed the facility admitted Resident 19 on 02/11/2026 with diagnosis of Cerebral Infarction (a loss of blood flow to an area of the brain causing tissue death resulting in sudden weakness, speech difficulties, and vision loss) and generalized muscle weakness.The comprehensive 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 03/27/2026 revealed that Resident 19 had short- and long-term memory problems and severely impaired cognitive skills for daily decision making. The resident required partial to moderate assistance with eating and was dependent on staff assistance for transfers and toilet use. The resident was documented to have an indwelling urinary catheter (a tube inserted into the bladder to drain urine).Record review of resident 19's Care Plan on 04/09/2026 revealed a focus of the resident required Enhanced Barrier Precautions (EBP) due to having an indwelling foley catheter dated 02/16/2026. The focus of the resident had the potential of impairment of skin integrity dated 02/13/2026 with a intervention listed to watch the placement of the foley catheter drain tub and not dated. The focus of the resident having an activities of daily life self-performance deficit with a revision date of 03/10/2026 with an intervention listed of toilet use and the resident having a foley catheter with directions to provide catheter cares twice daily and as needed dated 02/16/2026.Record review of Resident 19's Progress Notes revealed documentation on 04/03/2026 at 8:24 AM that the resident had removed their indwelling foley catheter. The residents provider was notified of this and the provider gave guidance to not replace the catheter at this time.In an observation completed on 04/08/2026 at 11:22 AM Resident 19 was observed to be sitting in their room in their recliner. There was no visible evidence that the resident had an indwelling foley catheter. There was no signage indicating the resident was on Enhanced Barrier Precautions (EBP) and no isolation personal protective equipment items were observed inside or outside of the residents room.In an observation completed on 04/09/2026 at 07:47 AM Resident 19 was observed to be lying in their bed in their room flat on their back. There was no visible evidence that the resident had an indwelling foley catheter. There was no signage indicating the resident was on EBP and no isolation personal protective equipment items were observed inside our outside of the residents room.In an interview completed on 04/13/2026 at 10:15 AM with Registered Nurse B (RN-B), RN-B confirmed that Resident 19 no longer had a indwelling foley catheter and was no longer on EBP.In an interview completed on 04/13/2026 at 1:52 PM with the facility MDS Coordinator (MDSC), the MDSC confirmed that Resident 19's care plan was not accurate and up to date reflecting the residents current care needs due to the care plan reflecting the resident had an indwelling foley catheter and requiring EBP.In an interview completed on 04/13/2026 at 3:15 PM with the facility Director of Nursing (DON), the DON confirmed that Resident 19's care plan was up to date reflecting the current care needs by the resident and should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Licensure Reference Number 175 NAC 12-006.09Based on record review and interview, the facility failed to follow a provider order to hold/not administer a medication based on ordered parameters for 1 resident (Resident 9) of 1 sampled residents. The facility census was 36.Findings are:Record review of Resident 9's Physician Orders on 04/09/2026 revealed Resident 9 had an order for Carvedilol (a medication used to help regulate blood pressure) 12.5 milligrams with directions to administer one tablet by mouth twice daily (AM (morning) and HS (night) and to hold the medication if the systolic (top number) of the blood pressure was less than 100 or the diastolic (bottom number) of the blood pressure was less than 55.Record review of Resident 9's Medication Administration Record (MAR) for the month of February 2026 revealed the following:-On 02/02/2026 a blood pressure documented of 107/53 in the HS. The MAR also revealed documentation that the residents' Carvedilol 12.5 milligrams was signed as administered indicating the resident received the HS dose of the medication though the residents diastolic blood pressure was less than 55.-On 02/07/2026 a blood pressure documented of 107/54 in the AM and HS. The MAR also revealed documentation that the residents Carvedilol 12.5 milligrams were signed as administered indicating the resident received both the AM and HS dose of the medication though the residents diastolic blood pressure was less than 55. -On 02/08/2026 a blood pressure of 102/52 was documented in the AM and HS for Resident 9. The MAR also revealed documentation that the residents Carvedilol 12.5 milligrams were signed as administered indicating the resident received both the AM and HS dose of the medication though the residents diastolic blood pressure was less than 55. Record review of Resident 9's MAR for the month of March 2026 revealed the following:-On 03/07/2026 a blood pressure documented of 129/35 in the HS. The MAR also revealed documentation that the residents' Carvedilol 12.5 milligrams was signed as administered indicating the resident received the HS dose of the medication though the residents diastolic blood pressure was less than 55.-On 03/27/2026 a blood pressure documented of 132/52 in the HS. The MAR also revealed documentation that the residents' Carvedilol 12.5 milligrams was signed as administered indicating the resident received the HS dose of the medication though the residents diastolic blood pressure was less than 55.In an interview completed on 04/13/2026 at 10:20 AM with Medication Aide H (MA-H), MA-H stated that the Medication Aides or who ever is giving Resident 9 their medications takes their blood pressure first and then if the residents blood pressure is not above the parameters written in the order they do not give the medication or they hold the medication. The MA stated that if they do not give the medication, they do not sign out the medication as given in the MAR and let the nurse know that the medication was not administered due to the residents' blood pressure. The MA confirmed that Resident 9 should not receive their Carvedilol medication if their systolic blood pressure was not greater than 100 and their diastolic blood pressure was not greater than 55. The MA confirmed that the medication should be held if either number was outside of the parameters.In an interview completed on 04/13/2026 at 11:15 AM with the facility Director of Nursing (DON), the DON confirmed that Resident 9's Carvedilol medication should have been held and not administered when their systolic blood pressure was less than 100 and their diastolic blood pressure was less than 55 per the providers parameters. The DON confirmed that Resident 9 received their Carvedilol medication when they should not have due to their blood pressure being outside of the providers ordered parameters.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5)Based on record review and interview the facility failed to provide care and services to promote regular bowel movements for 1 resident (Resident 19) of 2 sampled residents. The facility census was 36.Findings are:Record review of a facility supplied document titled Bowel Protocol and not dated revealed on day one with no bowel movement to do nothing, on day two with no bowel movement to do nothing, on day three with no bowel movement to push fluids, and for prune juice to be given in the morning at breakfast by the day shift medication aide. If no bowel movement throughout the day to then administer Milk of Magnesia (a medication used to promote bowel movements) in the evening shift by around 3pm. On day four if no bowel movement for night shift charge nurse to administer a suppository and if no bowel movement to repeat the prune juice at breakfast by the medication aide and Milk of Magnesia by the medication aid. On day five if no bowel movement for the night shift charge, nurse to administer an enema (a medication used to promote bowel movements).Record review of an admission Record revealed the facility admitted Resident 19 on 02/11/2026 with diagnosis of Cerebral Infarction (a loss of blood flow to an area of the brain causing tissue death resulting in sudden weakness, speech difficulties, and vision loss) and generalized muscle weakness.The comprehensive 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 03/27/2026 revealed that Resident 19 had short- and long-term memory problems and severely impaired cognitive skills for daily decision making. The resident required partial to moderate assistance with eating and was dependent on staff assistance for transfers and toilet use. The resident was documented to always be incontinent of bowel.Record review of Resident 19's Electronic Medical Health Record (EMHR) POC Response History Toileting Question 5 for 03/16/2026 through 04/13/2026 revealed documentation that on 03/25/2026 (Day 1), 03/26/2026 (Day 2), 03/27/2026 (Day 3), 03/28/2026 (Day 4), 03/29/2026 (Day 5) and 03/30/2026 (Day 6) Resident 19 did not have a documented bowel movement. Record review of Resident 19's Medication Administration Record (MAR) for the month of March 2026 revealed the following:-An order for Milk of Magnesia Suspension with directions to administer 30 milliliters every 12 hours as needed for constipation with a start date of 03/23/2026. This medication was not signed as administered from 03/25/2026 through 03/30/2026. -An order for Bisacodyl Laxative Suppository 10 milligrams with directions to insert u suppository every 24 hours as needed for constipation dated 03/23/2026. This medication was documented as administered on 03/30/2026 (Day 6 without a documented bowel movement) at 1:41 PM. Record review of Resident 19's Progress Notes from 03/25/2026 through 03/30/2026 revealed no documentation of the resident having a bowel movement or the resident receiving an intervention to promote the resident to have a bowel movement.Record review of Resident 19's Electronic Medical Health Record (EMHR) POC Response History Toileting Question 5 for 03/16/2026 through 04/13/2026 revealed documentation that on 04/02/2026 (Day 1), 04/03/2026 (Day 2), 04/04/2026 (Day 3), 04/05/2026 (Day 4), and 04/06/2026 (Day 5) Resident 19 did not have a documented bowel movement. Record review of Resident 19's MAR for the month of April 2026 revealed the following:-An order for Milk of Magnesia Suspension with directions to administer 30 milliliters every 12 hours as needed for constipation with a start date of 03/23/2026. This medication was not signed as administered from 04/02/2026 through 04/06/2026. -An order for Bisacodyl Laxative Suppository 10 milligrams with directions to insert u suppository every 24 hours as needed for constipation dated 03/23/2026. This medication was not signed as administered from 04/02/2026 through 04/06/2026. Record review of Resident 19's Progress Notes from 04/02/2026 through 04/06/2026 revealed no documentation of the resident having a bowel movement or the resident receiving an intervention to promote the resident to have a bowel movement.In an interview completed on 04/14/2026 at 10:35 AM with the facility Director of Nursing (DON), the DON confirmed that Resident 19 went without a documented bowel movement from (continued on next page)

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	04/14/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	03/25/2026 to 03/30/2026 and 04/02/2026 to 04/06/2026. The DON confirmed that the facilities protocol to promote bowel movements for residents was not followed and should have been.

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	04/14/2026

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Licensure Reference Number 175 NAC 12-006.09(H)Based on observation, record review, and interview the facility failed to ensure that it implemented care and services for hemodialysis (a life-sustaining medical treatment that filters waste, toxins, and excess fluids from the blood when the kidneys have failed) resident nutrition as required for 1 of 1 resident reviewed (Resident 3). The facility census was 36.Findings are:Record review of the facility policy titled Dialysis Services dated 9/30/25 revealed that residents who receive dialysis may receive services at on outside dialysis service or by a contract dialysis company. The facility will be responsible for transportation to and from dialysis. Care plan care specific to the resident. The clinical monitoring-dialysis assessment is available for use in monitoring the resident receiving dialysis. Record review of the Outpatient Dialysis Services Coordination Agreement dated 9/9/19 revealed that the obligations of the facility includes ensuring that all appropriate medical and administrative information accompanies the resident at the time of referral to the dialysis center. The long term care facility will ensure that residents are prepared to spend an extended length of time at the dialysis center and have received proper nourishment and any medications prescribed before coming to the dialysis center. Record review of the facility admission Agreement dated 10/2025 revealed that the facility agrees to furnish the resident with food and nutrition services included in the daily rate. Record review of the facility Resident's Rights for Skilled Nursing Facilities dated 11/28/16 revealed that a facility must treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences. The resident has the right to choose schedules (including sleeping and waking times) consistent with his or her interests, assessments, and plan of care. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Record review of the admission Record dated 4/8/26 for Resident 3 revealed that Resident 3 admitted into the facility on 6/20/24. Resident 3 had a diagnosis of end stage renal (kidney) disease (a condition where 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 3/4/26 for Resident 3 revealed that Resident 3 receives hemodialysis treatment. Record review of the comprehensive care plan dated 4/8/26 for Resident 3 revealed that Resident 3 requires hemodialysis related to chronic kidney disease. Interventions included dialysis three times weekly at the dialysis center: Monday, Wednesday, and Friday. Chair time is scheduled for 7:00 AM for approximately 4 hours. Adjust medications on dialysis days as ordered. Send meal to dialysis with resident Monday, Wednesday, and Friday as resident requests.Interview on 4/9/26 at 11:20 AM with Resident 3 revealed that Resident 3 leaves the facility for dialysis around 7:15 AM on Mondays, Wednesdays, and Fridays. Resident 3 revealed that some early morning medications are provided before Resident 3 leaves and some medications are sent with Resident 3 to dialysis. Resident 3 revealed that Resident 3 does not get breakfast before leaving for dialysis. Record review of the Point of Care task (electronic medical record documentation of care provided to a resident) titled What percentage of the meal was eaten dated 4/9/26 for Resident 3 over the past 30 days revealed that the result was documented as Resident Not Available for the breakfast meal on 3/11/26 (Wednesday dialysis day), 3/13/26 (Friday dialysis day), 3/16/26 (Monday dialysis day), 3/18/26 (Wednesday dialysis day), 3/20/26 (Friday dialysis day), 3/23/26 (Monday dialysis day), 3/25/26 (Wednesday dialysis day), 3/30/26 (Monday dialysis day), 4/1/26 (Wednesday dialysis day), 4/3/26 (Friday dialysis day), and 4/6/26 (Monday dialysis day). Record review of the Point of Care task titled What percentage of the meal was eaten dated 4/14/26 for Resident 3 over the past 30 days revealed that the result was documented as Resident Not Available for the breakfast meal on 4/8/26 (Wednesday dialysis day) and 4/10/26 (Friday dialysis day).Record review of the Point of (continued on next page)

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	285192	A. Building B. Wing	04/14/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care task titled What percentage of the meal was eaten dated 4/9/26 for Resident 3 over the past 30 days revealed that the result was documented as 76-100% eaten for the breakfast meals on 3/12/26, 3/14/26, 3/15/26, 3/17/26, 3/19/26, 3/21/26, 3/22/26, 3/24/26, 3/26/26, 3/27/26, 3/28/26, 3/29/26, 3/31/26, 4/2/26, 4/4/26, 4/5/26 (Resident 3 ate 76-100% of the breakfast meal on all non-dialysis days).Record review of the Point of Care task titled What percentage of the meal was eaten dated 4/14/26 for Resident 3 over the past 30 days revealed that the result was documented as 76-100% eaten for the breakfast meals on 4/7/26, 4/9/26, 4/11/26, 4/12/26, and 4/16/26 (Resident 3 ate 76-100% of the breakfast meal on all non-dialysis days).Observation on 4/9/26 at 8:18 AM (a non-dialysis day for Resident 3) in the facility dining room revealed that Dietary Aide-I (DA-I) delivered the breakfast meal to Resident 3. The meal consisted of 2 fried eggs, 2 slices of toast, a bowl of cream of wheat, and a small yogurt cup. Resident 3 poured a small cup of brown sugar on the cream of wheat and began to eat.Observation on 4/9/26 at 8:35 AM in the facility dining room revealed that Resident 3 pushed themself back from the dining room table and propelled themself out of dining room. Resident 3 ate 100% of the provided breakfast meal.Observation on 4/13/26 at 7:21 AM in the room of Resident 3 revealed that Resident 3 was not in the room. The wheelchair of Resident 3 was gone.Interview on 4/13/26 at 7:26 AM with Nurse Aide-J (NA-J) revealed that Resident 3 left for dialysis before 6:00 AM, prior to NA-J starting their shift. NA-J revealed that they were not sure if Resident 3 gets breakfast before leaving. Interview on 4/13/26 at 11:19 AM with Transportation Driver (TD) revealed that TD thinks that Resident 3 eats before TD takes Resident 3 to dialysis on Monday, Wednesday, and Friday. TD revealed that Resident 3 is usually waiting in the tv area by the nurse's station for TD to take Resident 3 to dialysis. Interview on 4/13/26 at 11:27 AM with Resident 3 confirmed that Resident 3 was not provided with any breakfast this morning. Resident 3 confirmed that the facility does not provide any breakfast meal prior to dialysis on Monday, Wednesday, or Friday. Interview on 4/13/26 at 12:53 PM with Resident 3 confirmed that the staff never ask if the resident would like a breakfast meal before leaving for dialysis. Resident 3 confirmed that Resident 3 would like breakfast to eat before leaving for dialysis. Interview on 4/13/26 at 12:59 PM with Registered Nurse-B (RN-B) revealed that RN-B sees Resident 3 prior to leaving for dialysis around 6:30 AM. RN-B revealed that the RN does not provide any breakfast to Resident 3 before dialysis. RN-B revealed that nourishment is probably provided by the night staff, like toast, when the night staff gives Resident 3 their early morning medications before dialysis. Interview on 4/13/26 at 1:02 PM with the facility Dietary Manager (DM) revealed that Resident 3 does not receive the breakfast meal prior to leaving for dialysis. Observation on 4/14/26 at 8:37 AM (a non-dialysis day for Resident 3) revealed that Dietary Aide-I (DA-I) delivered a bowl of oatmeal and a plate with biscuits and gravy to Resident 3. DA-I sat the items on the table for Resident 3. Observation on 4/14/26 at 8:57 AM in the facility dining room revealed that Resident 3 sat at the table. Resident 3 ate 100% of the biscuits and gravy and 100% of the oatmeal. Resident 3 drank a 1/2 cup of cappuccino. Resident 3 used a spoon to eat ice chips from a tall Styrofoam cup. Interview on 4/14/26 at 10:03 AM with Resident 3 revealed that the resident's family does not come to dialysis or bring food to dialysis. Resident 3 revealed that patients are not allowed to eat at dialysis. Resident 3 confirmed that they eat all of the breakfast meal on non-dialysis days and would like a breakfast meal on dialysis days. Interview on 4/14/26 at 10:33 AM with the facility Director of Nursing (DON) confirmed that Resident 3 is to be provided a pre-dialysis meal. The DON confirmed that the facility did not have documentation of pre-dialysis meals provided to Resident 3.