STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285193	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Osceola	600 Center Drive Osceola, NE 68651

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record review and interview the facility failed to ensure that a written summary of the baseline care plan (a written plan required to be developed within 48 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) was provided to the resident/resident representative and ensure that the baseline care plan was reviewed with the resident/resident representative. This prevented the resident/resident representative from participating in the care plan and identifying additional individual care needs of the resident. This affected 4 of 4 residents reviewed (Residents 25, 22, 30, and 16). The facility census was 30. Findings are: A record review of the facility policy titled Care Plan dated 12/2/24 revealed that the purpose is to develop a comprehensive care plan using an interdisciplinary team approach. The definition for Baseline care plan: Includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The policy revealed that a baseline care plan will be developed upon admission according to federal and state regulations. The facility must provide the resident and resident representative with a written summary of the baseline care plan. Use the Progress Note-Care Conference Note to document that the meeting occurred with the resident and representative and any significant discussion that occurred. A. A record review of the Admission Record for Resident 25 dated 1/28/25 revealed that Resident 25 admitted into the facility on [DATE]. Diagnoses included malignant neoplasm of the prostate (a type of cancer that originates in the prostate gland), history of falling, major depressive disorder, and Parkinson's Disease. A record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 11/21/24 for Resident 25 revealed that Resident 25 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 12/15. A score of 12 indicates moderate cognitive impairment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the medical record for Resident 25 revealed no documentation of a baseline care plan. A record review of the Care Conference Note for Resident 25 dated 8/29/24 at 11:57 AM revealed that the resident and their spouse were invited to the care conference but did not attend. The note contained no documentation of discussion of a baseline care plan with the resident/resident representative. The note contained no documentation that a written summary of a baseline care plan had been provided to the resident/resident representative. An interview on 1/26/25 at 2:12 PM with Resident 25 revealed that the resident had not had any discussion of a baseline care plan and had not had any care plan meetings. Resident 25 revealed that the resident had not received a written summary of a baseline care plan. An interview on 1/26/25 at 2:12 PM with the spouse of Resident 25 revealed that they had not had any discussion of a baseline care plan and had not had any care plan meetings since Resident 25 admitted into the facility. The spouse of Resident 25 revealed that they had not received a written summary of a baseline care plan from the facility. An interview on 1/28/25 at 4:05 PM with the Facility Administrator (FA) confirmed that the facility does resident data collection assessments that transfers information over to the comprehensive care plan (a written interdisciplinary comprehensive plan to meet the resident's needs that are identified in the resident's comprehensive assessment). The FA revealed that staff are to print that as the baseline care plan. The FA revealed that staff are expected to provide a copy of the care plan to the resident and a retain a signed copy for the facility. The FA confirmed that the facility did not have documentation that a written summary of a baseline care plan was provided to Resident 25 or their representative. The FA confirmed that the facility did not have documentation that a meeting to review the baseline care plan with the resident/resident representative occurred. B. A record review of the Admission Record for Resident 22 dated 1/27/25 revealed that Resident 22 admitted into the facility on [DATE]. Diagnoses included Alzheimer's Disease, heart failure, anxiety, and delusional disorders (a mental health condition characterized by persistent, false beliefs (delusions) that are not based on reality). A record review of the MDS dated [DATE] for Resident 22 revealed that Resident 22 had a BIMS score of 11/15. A score of 11 indicates moderate cognitive impairment. A record review of the medical record for Resident 22 revealed no documentation of a baseline care plan. A record review of the Care Conference Note for Resident 22 dated 11/14/24 at 11:41 AM revealed that the resident and their family were invited to the care conference but did not attend. The note contained no documentation of discussion of a baseline care plan with the resident/resident representative. The note contained no documentation that a written summary of a baseline care plan was provided to the resident/resident representative. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 1/28/25 at 4:05 PM with FA confirmed that the facility does resident data collection assessments that transfers information over to the comprehensive care plan. The FA revealed that staff are to print that as the baseline care plan. The FA revealed that staff are expected to provide a copy of the care plan to the resident and a retain a signed copy for the facility. The FA confirmed that the facility did not have documentation that a written summary of a baseline care plan was provided to Resident 22 or their representative. The FA confirmed that the facility did not have documentation that a meeting to review the baseline care plan with the resident/resident representative occurred. C. A record review of the Admission Record for Resident 30 dated 1/28/25 revealed that Resident 30 admitted into the facility on [DATE]. Diagnoses included fractured wrist and ankle, liver transplant, and diabetes. A record review of the MDS dated [DATE] for Resident 30 revealed that Resident 30 had a BIMS score of 15/15. A score of 15 indicates that the resident is cognitively intact. A record review of the medical record for Resident 30 revealed no documentation of a baseline care plan. A record review of the Care Conference Note for Resident 30 dated 11/27/24 at 3:39 PM revealed that the resident was invited to the care conference but did not attend. The note contained no documentation of discussion of a baseline care plan with the resident. The note contained no documentation that a written summary of a baseline care plan was provided to the resident. An interview on 1/28/25 at 4:05 PM with FA confirmed that the facility does resident data collection assessments that transfers information over to the comprehensive care plan. The FA revealed that staff are to print that as the baseline care plan. The FA revealed that staff are expected to provide a copy of the care plan to the resident and a retain a signed copy for the facility. The FA confirmed that the facility did not have documentation that a written summary of a baseline care plan was provided to Resident 30. The FA confirmed that the facility did not have documentation that a meeting to review the baseline care plan with the resident occurred. 50253 D. A record review of the Admission Record for Resident 16 dated 1/27/25 revealed that Resident 16 was admitted to the facility on [DATE]. A record review of Resident 16's Medical Diagnoses as documented on 01/27/2025 revealed the resident had the following medical issues; anxiety disorder, cognitive communication deficit, conduct disorder, disorientation, history of falling, insomnia, major depressive disorder, Parkinsonism, history of cancer of the bladder and thyroid, restlessness and agitation, unspecified abnormalities or gait and mobility, dementia with behavioral disturbances and anxiety, unsteadiness on feet, and vitamin D deficiency. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the MDS dated [DATE] for Resident 16 revealed this resident had a BIMS score of 11/15 which was indicative of moderate cognitive impairment. A record review of the medical record for Resident 16 revealed no documentation of a baseline care plan. A record review of the Care Conference Note for Resident 16 dated 06/27/24 at 11:41 AM revealed that the resident and family members were invited to the care conference but did not attend. The note contained no documentation of discussion of a baseline care plan with the resident or family members. The note contained no documentation that a written summary of a baseline care plan was provided to the resident or the family members. An interview on 1/28/25 at 4:05 PM with FA confirmed that the facility does resident data collection assessments that transfers information over to the comprehensive care plan. The FA revealed that staff are to print that as the baseline care plan. The FA revealed that staff are expected to provide a copy of the care plan to the resident and family members and retain a signed copy for the facility records. The FA confirmed that the facility did not have documentation that a written summary of a baseline care plan was provided to Resident 16. The FA confirmed that the facility did not have documentation that a meeting to review the baseline care plan with the resident occurred.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(F)(ii) Based on record review and interview the facility failed to ensure that the resident/resident representative was provided timely notice of care plan meetings (conferences). This had the potential to prevent the resident/representative from attending care plan meetings and participating in the comprehensive care plan (a written interdisciplinary comprehensive plan to meet the resident's needs that are identified in the resident's comprehensive assessment) review. This affected 2 of 12 residents reviewed (Residents 3 and 25). The facility census was 30. Findings are: A record review of the facility policy titled Comprehensive Care Plan and Care Conferences dated 12/4/23 revealed that the purpose is to develop a person-centered care plan for each resident and provide an ongoing method of assessing, implementing, evaluating, and updating the resident's care plan. The section titled Interdisciplinary Team Members revealed that the comprehensive care plan is developed by an interdisciplinary team. The interdisciplinary team consists of the resident and/or representative, registered nurse, social services, activity services, food and nutrition services, rehabilitation/restorative services, certified nursing assistants, physician and/or clinicians, other healthcare professionals, administrator (when available/appropriate), Director of Nursing (when available/appropriate), and environmental services (when available/appropriate). The section titled Coordinating the Care Plan revealed the designated employee will keep track of care conference dates and inform interdisciplinary team members at least two weeks in advance of scheduled care conferences. The social worker or designated employee will: Establish the time and place to hold care conferences. Invite residents and their representative (with resident's permission) at least two weeks in advance of the care conference. If the resident and/or representative is not invited to the care conference, an explanation must be included in the medical record. Care plans are to be reviewed with each MDS (Minimum Data Set, a mandatory comprehensive assessment tool used for care planning) completed. A. A record review of the MDS dated [DATE] revealed that it was a quarterly assessment for Resident 3. Resident 3 had an admitted into the facility of 3/30/23. The MDS revealed that Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 15/15 indicating that Resident 3 was cognitively intact. An interview on 1/26/25 at 1:38 PM with Resident 3 revealed that the facility only provides about a 1 day notice of Resident 3's care plan meetings. Resident 3 voiced concern that the facility does not provide adequate notice to allow the resident and family to participate in the care plan meetings. A record review of the Care Plan invitation letters for Resident 3 dated between 11/15/23-1/29/25 revealed: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Care Plan Invitation Letter dated 1/2/24 for the care plan meeting scheduled 1/11/24 (9 day notice). -Care Plan Invitation Letter dated 3/12/24 for care plan meeting scheduled 3/14/24 (2 day notice). -Care Plan Invitation Letter dated 8/27/24 for care plan meeting scheduled 9/5/24 (9 day notice). -Care Plan Invitation Letter dated 11/27/24 for care plan meeting scheduled 12/5/24 (8 day notice). A record review of the Care Conference Note dated 1/11/24 at 10:53 AM for Resident 3 revealed that the resident was invited but did not attend. A record review of the Care Conference Note dated 3/14/24 at 11:05 AM for Resident 3 revealed that the resident was invited but did not attend. A record review of the Care Conference Note dated 6/13/24 at 10:03 AM for Resident 3 revealed that Resident 3 was invited but did not attend. (The facility did not provide a Care Plan Invitation Letter for the 6/13/24 care plan meeting for Resident 3). A record review of the Care Conference Note dated 9/5/24 at 10:22 AM for Resident 3 revealed that Resident 3 was invited to attend and did attend. A record review of the Care Conference Note dated 12/5/24 at 1:26 PM for Resident 3 revealed that Resident 3 was invited but did not attend. An interview on 1/29/25 at 11:13 AM with the facility Social Services Director (SSD) confirmed that the SSD is responsible for sending the care plan meeting invitation letters for the facility. The SSD revealed that the SSD and MDSC (Minimum Data Set Coordinator- a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) complete a calendar for upcoming resident care plan meetings for 3 months at a time related to when the resident's MDS is due. The care plan meeting for each resident is scheduled for the week following the MDS due date. The SSD revealed that the calendar is then provided to the entire care team. The SSD confirmed that the care plan invitation letters to the resident/resident representative is required to provide at least a 2 week notice of the upcoming care plan meeting. The SSD revealed that the care plan invitation letters were being sent with only 1 week notice but some residents/representatives were not receiving the invitations in time. The SSD confirmed that the care plan invitation letters for Resident 3 dated 1/2/24, 3/12/24, 8/27/24, and 11/27/24 had not provided at least a 2 week notice as required. The SSD confirmed that the facility did not have a care plan invitation letter for Resident 3 for the 6/13/24 care plan meeting. B. A record review of the MDS dated [DATE] for Resident 25 revealed that it was a quarterly assessment for Resident 25. Resident 25 had an admitted into the facility of 8/15/24. The BIMS score for Resident 25 was 12/15, identifying Resident 25 as having moderate cognitive impairment. An interview on 1/26/25 at 2:12 PM with Resident 25 revealed that the resident had not had any care plan meetings while in the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 1/26/25 at 2:12 PM with the spouse of Resident 25 revealed that they had not had any care plan meetings with the facility since Resident 25 admitted into the facility. A record review of the Care Plan Review invite letters from 8/1/24-1/29/25 for Resident 25 revealed: -Care Plan Invitation Letter dated 8/12/24 for care plan meeting scheduled for 8/21/24 (9 day notice). -Care Plan Invitation Letter dated 11/11/24 for care plan meeting scheduled for 11/20/24 (9 day notice). A record review of the Care Conference Note dated 8/29/24 at 11:57 AM for Resident 25 revealed that Resident 25 and their spouse were invited but did not attend. A record review of the Care Conference Note dated 11/27/24 at 3:22 PM for Resident 25 revealed that Resident 25 and family were invited but did not attend. An interview on 1/29/25 at 11:13 AM with the facility Social Services Director (SSD) confirmed that the care plan invitation letters to the resident/resident representative is to provide at least a 2 week notice of the upcoming care plan meeting. The SSD revealed that the care plan invitation letters were being sent with only 1 week notice but some residents/representatives were not receiving the invitations in time. The SSD confirmed that the care plan invitation letters for Resident 3 dated 8/12/24 and 11/11/24 had not provided at least a 2 week notice as required.