STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285203	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Beatrice	401 S 22nd Street Beatrice, NE 68310

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility failed to follow the meatloaf recipe during meal preparation, this had the potential to affect all residents that eat food served from the kitchen. The facility census was 60 at the time of the survey. An observation on 01/22/2026 at 11:16 AM revealed Lead [NAME] (LC) beginning to prepare meatloaf to be served the following day. LC removed 20 lbs. (pounds) of ground beef from the walk in refrigerator, applied gloves, removed the ground beef from the outer wrap, removed gloves and washed hands with soap and water. LC then referred to recipe.A record review of the meatloaf recipe with a copyright date of 2025 revealed the ingredients needed to make 70 servings:Liquid eggs: 2 3/4 cups Milk: 1 QT (quart) 3 TBS (tablespoon) Ground beef: 17.5 lbs.Tomato paste 1 lbs. 1 ozGarlic minced 8.5 oz (ounce)Salt 1 Tbs. 1 tsp. (teaspoon)Onion 1 lbs. 1ozBreadcrumbs 2 lbs.Pepper: 3/4 tsp Directions:1. In mixer bowl, combine eggs and milk with paddle at medium speed 1-2 minutes or until combined.2. Add beef, tomato paste, garlic, salt, pepper, onions and breadcrumbs to egg mixture. Mix for 2-3 minutes at low speed or until blended. DO NOT over mix.3. Press mixture into 12x20x2 inch pans sprayed with nonstick vegetable spray.LC proceeded to place the 20 lbs. of ground beef into a pan. LC then measured the liquid eggs, pouring them directly over the ground beef, and not in a separate mixing bowl as the recipe states. LC said that since the recipe calls for 17.5 lbs of ground beef and there is 20 lbs in the pan (gender) will just add a little more of each ingredient. LC stated that (gender) will just eyeball the amount needed of each ingredient. LC proceeded to measure each ingredient and then add a little more.LC then used gloved hands to mix the ingredients together and not with the mixer as the recipe instructs. LC covered the meatloaf mixture with foil and placed it in the walk-in refrigerator. LC said the meatloaf will sit overnight and if looks too dry tomorrow, (gender) will add extra eggs or milk. When asked if LC has had to adjust recipes often, LC replied sometimes but it's much easier to do when it's made on the stove because they can taste test it along the way and add more seasoning or broth if it's too bland. LC also said that sometimes (gender) will add less of a spice if (gender) feels it's too spicy. When asked why the extra 2.5 lbs were not removed before starting the recipe, LC replied that it would go to waste unless it could be browned and used for another meal. LC confirmed that the recipe should be followed as written and that it was not.An interview on 01/22/2026 at 1:14 PM with the Food Service Director revealed that it an expectation that the cooks follow the recipes provided.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, interviews and record reviews, the facility failed to maintain and serve foods at a safe and appetizing temperature to prevent the potential for food borne illnesses on unit 1. This had the potential to affect all 16 residents on unit 1 who eat from the kitchen.Findings:An observation on 01/26/2026 at 11:25 AM revealed a [NAME] (C-B) transferring an insulated food cart from the main kitchen to the 100's dining room. The cart was filled with stainless steel pans of the different hot food items to be served for lunch. C-B placed each pan on the stream table, covering the pans with a lid.C-B then took the temperature of each hot food item using the facility's thermometer which revealed:The Breaded Chicken was 150 degrees FahrenheitThe Pureed Chicken was 115 degrees FahrenheitThe Potato Casserole was 160 degrees FahrenheitThe Un-breaded chicken was 140 degrees FahrenheitThe Peas were 140 degrees FahrenheitThe Cauliflower was 140 degrees FahrenheitC-B then went to the small unit kitchen to obtain the drinks for each resident and proceeded to pass the drinks to the residents in the dining room.C-B then performed hand hygiene with soap and water and applied gloves. At 11:45 AM C-B began to place food on the plates. During this process the lids were off the pans and were not replaced at any time. Residents in the dining room were served first and then those residents who chose to eat in their rooms were served next.C-B began to set up the room trays and pass them out. C-B was unable to locate insulated covers for the room trays, so C-B placed a Styrofoam plate over the food. The dessert, a room temperature mixed fruit cobbler with ice cream, was delivered to the rooms, uncovered. At 12:25 PM C-B was asked to obtain another set of temperatures for a test tray. The available items and their temperatures were:The Breaded Chicken was 120-130 degrees FahrenheitThe Potato Casserole was 138-140 degrees FahrenheitThe Peas were 120 degrees FahrenheitOn 01/26/2026 at 12:30 PM a taste test of the lunch items was conducted by the survey team.The temperatures at the time of the tasting were: The Breaded Chicken was 110 degrees FahrenheitThe Potato Casserole was 106 degrees FahrenheitThe Peas were 105 degrees FahrenheitThe survey team reported that the chicken was tough and all items were barely warm.C-B reported that the food was OK, not the best but not the worst. C-B confirmed that the serving temperatures should be over 135 degrees Fahrenheit and confirmed that none of the foods on the test tray were above 135 degrees Fahrenheit.Record review of the facility's policy titled Food Temperature Monitoring-Food and Nutrition Services dated 12/19/2025 revealed the proper holding temperature for hot foods should be greater than 135 degrees Fahrenheit and the proper serving temperature should be appetizing for the residents.An interview on 01/27/2026 at 9:30 AM with the Food Service Supervisor (FSS) revealed that it is an expectation that food is served between 135-145 degrees Fahrenheit.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.007.04(D) Based on observation, interview, and record review the facility failed to ensure the ventilation (the provision of fresh air to a room, building, etc.) systems were operational in seven resident bathrooms (rooms 120, 301, 303, 305, 308, 309, and 313) out of 24 resident rooms sampled. The facility census was 60. Findings are: Observations on the initial tour on 1.21.2026 at 9:30 AM revealed the bathroom ventilation was not functioning in seven resident rooms (rooms 120, 301, 303, 305, 308, 309, and 313). Observations during a facility tour on 1.26.2026 at 10:40 AM with Water Management (WM) revealed the bathroom ventilation was not functioning in seven resident rooms (room [ROOM NUMBER], 301, 303, 305, 308, 309, and 313). In an interview on 1.26.2026 at 10:40 AM with the WM, it was confirmed the bathroom ventilation was not functioning in seven resident rooms (room [ROOM NUMBER], 301, 303, 305, 308, 309, and 313) and it should be. WM confirmed the company that services the HVAC system was notified and they provided a report that showed the reason the bathroom vents are not working was because of the cold temperatures and the coils were frozen. Also confirmed that the bathroom vents are not checked when the temperature drops below freezing, and the issue would have been identified when the vents are checked this month, and the vents are checked quarterly. A record review of the facility Vents Resident Rooms and Hallways log dated October 2025 revealed the most recent bathroom vent check was completed in October 2025.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 175 NAC 12-006.09(G)(i)Based on record review and interviews, the facility failed to complete a discharge summary for Resident 67(A) after a medical appointment with a direct admission to the hospital. Resident 69 (B) was transferred to hospital and did not return to facility. This affected 2 out of 2 residents with a closed record review. The facility reported a census of 60.Findings are: A Record review of Resident 67's hospital Discharge summary dated [DATE] revealed a primary diagnoses of sepsis (an extreme, life-threatening response to an infection), severe thrombocytopenia (a condition where the blood has very few platelets, causing prolonged bleeding), cirrhosis of the liver with ascites (permanent scaring of the liver causing a buildup of fluid in the abdomen). Record review of Resident 67's admission Record revealed an admission date to the facility of 10/16/2025. Record reviews of Resident 67's Electronic Medical Record (EMAR) revealed no documentation of a transfer notice or a discharge summary that included: resident's medical information, resident's emergency contact information, special instructions for ongoing care, etc. An interview with the Social Service Director on 01/22/2026 3:36 PM revealed that facility had transported Resident 67 to an appointment in [NAME] and the clinic then sent Resident 67 to the hospital due to kidney failure. An interview with the Director of Nursing on 01/26/2026 12:15 PM confirmed that the facility did not notify Resident 67's representative in writing, of the transfer to the hospital or the subsequent discharge from the facility. B. A record review of Resident 69's admission Record revealed that resident was admitted on [DATE]. A record review of the electronic health record (EHR) revealed that Resident 69 was discharged on 12/19/2025. Further investigation of EHR revealed that no Discharge Summary (a comprehensive document that summarizes a patient's stay including diagnosis, treatment and condition upon leaving) was completed by the facility for Resident 69. In an interview on 01/27/2026 at 10:04 AM with Director of Nursing (DON) confirmed the facility did not complete a Discharge Summary for Resident 69.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g)Based on record reviews, observations, and interviews, the facility failed to obtain a doctor's order for a continuous positive airway pressure machine (CPAP, a bedside device that uses mild air pressure to keep airways open during sleep) for one (Resident 2) of one sampled resident. The facility census at the time of the survey was 60. Findings are:Observations of Resident 2's room on 01/21/2026 at 12:42 PM revealed a CPAP machine on the bedside table with a CPAP mask in the drawer and the water chamber 1/4 full of water. Record review of Resident 2's admission Record revealed an admission date to the facility on [DATE] with a diagnosis of obstructive sleep apnea (a sleep disorder where the airway becomes blocked or narrowed resulting in a brief loss of breathing). Record review of Resident 2's order summary revealed no order for pressure settings for the CPAP machine. Record review of Resident 2's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/30/2025 in section O Special Treatments, Procedures, and Programs revealed that Resident 2 uses a noninvasive ventilator or CPAP. Record review of Resident 2's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revised on 07/10/2025 revealed that Resident 2 is at risk for altered respiratory status related to sleep apnea. Interview on 01/22/2026 at 2:07 PM with Licensed Practical Nurse (LPN-B) reports that Resident 2 does wear a CPAP every night and that LPN-B removes the CPAP in the morning. LPN-B confirmed that there was no order for the CPAP in Resident 2's Electronic Medical Record. Interview with the Director of Nursing (DON) on 01/22/2026 at 2:21 PM confirmed that there is no physician's order for the CPAP settings for Resident 2. Follow up interview with the DON on 01/27/2026 at 12:39 PM confirmed that the facility was unable to locate an order for the CPAP settings because Resident 2 was admitted from home with the CPAP. Interview with Clinical Care Leader on 01/27/2026 at 12:53 PM CCL revealed that the facility does not have a system in place to ensure that residents admitted with a personal CPAP have an order and they should have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18Based on record reviews, observations, and interviews, the facility failed to follow infection control practices during catheter care for 2 Residents (Resident 4 and Resident 12) out of 2 observed for catheters, and during wound care for 2 Residents (Resident 12 and Resident 19) out of 5 observed for wound care. The facility census was 60.Findings are: A record review of the facility's Hand Hygiene policy last reviewed 11/13/2025 revealed that when using alcohol-based hand rub (ABHR) for hand hygiene (HH- a general term that applies to either handwashing or applying hand sanitizer to prevent the spread of disease causing organisms) the staff member should apply enough ABHR to one palm, then rub hands together, covering all surfaces of the hands and fingers until hands are dry, which should take 15 to 20 seconds. When washing the hands with soap and water, the staff member should wet their hands and apply soap, then rub hands together briskly, covering all surfaces of the hands, fingers, and wrists for at least 15 to 20 seconds. The policy also stated that HH should be performed between changing gloves.A record review of the facility's Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy last reviewed 04/06/2025 revealed that catheter (a tube placed into the bladder to drain urine) tubing should never touch the floor, and that performing catheter care for an indwelling catheter included to remove gloves, perform hand hygiene and don gloves prior to touching the catheter. A record review of the facility's Wound Dressing Change policy last reviewed 10/31/2025 revealed the procedure was that after staff removed and discarded the old dressing, they should remove their gloves and perform hand hygiene before putting on clean gloves. A.A record review of Resident 4's admission Record printed 01/22/2026 revealed the resident was admitted to the facility 08/27/2024 and had diagnoses of skin cancer, obstructive uropathy (a blockage that makes it difficult or impossible to urinate), and urinary retention (the inability to fully empty the bladder).A review of an undated list of residents on Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes. EBP involves wearing a gown and gloves during high-contact resident care activities, such as wound care, for residents known to be colonized or infected with a MDRO as well as residents at increased risk of MDRO acquisition [for example, residents with wounds or indwelling medical devices]) provided by the facility revealed that Resident 4 was on EBP due to having an indwelling medical device.An observation on 01/26/2026 at 2:57 PM of Licensed Practical Nurse (LPN) A performing wound and catheter care for Resident 4 revealed that after completing the wound care, the LPN removed their gloves performed HH, then took new gloves out of the box. The LPN dropped one of the gloves on the floor, then picked it back up and put it on. The LPN then threw away some trash, removed and discarded used gloves, and washed her hands with soap and water for six seconds. The LPN then put on new gloves and performed catheter care.An interview on 01/26/2026 at 3:39 PM with LPN A confirmed that the glove that fell on the floor should have been discarded and not used. The LPN further confirmed that handwashing should have been done for 20 seconds.An interview on 01/27/2026 at 11:01 AM with the Infection Preventionist (IP-a healthcare professional who makes sure healthcare workers and facilities are doing everything necessary to prevent the spread of infections) confirmed that Personal Protective Equipment (PPE-special equipment, including gloves, gown, masks, and eye protection, worn to prevent exposure to hazards such as infectious materials) that touches the floor should be thrown away and not used, and that HH should have been performed when gloves were changed.B.A record review of Resident 12's admission Record printed 01/22/2026 revealed the resident was admitted to the facility 06/30/2025 and had diagnoses of urinary retention and a stage 2 pressure ulcer (wound caused by prolonged pressure in one area, stage 2 is an open area that does not go all the way through the skin) on the right buttock.A record review of an undated list of residents on EBP provided by the facility revealed that Resident 12 was on EBP due to having an indwelling medical device.A record review of a wound clinic note for Resident 12 dated 01/19/2026 revealed the resident had open areas on both (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buttocks. The note further revealed that the wound clinic had diagnosed those areas as Moisture Associated Skin Damage (MASD-damage to the skin caused by prolonged exposure to moisture, such as urine, feces, or sweat), not pressure ulcers.An observation on 01/26/2026 at 1:55 PM of LPN A performing wound and catheter care for Resident 12 revealed the LPN put on a gown outside the room and took supplies into the room, then performed HH and put on gloves. LPN A took the stand-aide (specialized mobility equipment designed to help partially weight-bearing individuals transition from sitting to standing) to the resident, hung the catheter drainage bag on the lift, then assisted the resident to stand up. The LPN washed Resident 12's left buttock with soap and water, changed gloves without performing HH, used a wet 4 x 4 gauze sponge to rinse the area, changed gloves without performing HH, then patted the area dry, applied cream using gloved fingers and put on a clean dressing. LPN A changed gloves without performing HH, then washed Resident 12's right buttock with soap and water, changed gloves without performing HH, used a wet 4 x 4 gauze sponge to rinse the area, changed gloves without performing HH, then patted the area dry, applied cream using gloved fingers and put on a clean dressing. The LPN then changed gloves without performing HH, assisted the resident back into the recliner, and put the catheter drainage bag on the floor. LPN A removed their gloves, washed their hands with soap and water for seven seconds, then put on clean gloves. They then got some 4 x 4 gauze sponges wet, removed the right glove, got towels and more gloves, then put the right glove back on. Wearing the same gloves, LPN A washed the resident's suprapubic (SP-the area just above the pubic bone. A SP catheter is inserted into the bladder through the lower abdomen) catheter insertion site with soap and water, changed gloves without performing HH, used a wet 4 x 4 to rinse the area, changed gloves without performing HH, patted the area dry with a towel and covered the area with a dressing. LPN A removed their gloves, washed their hands with soap and water for four seconds, and put on clean gloves. The LPN then removed Resident 12's shoes, socks, and edema wear (a mesh compression garment to reduce swelling) from both legs, applied a medicated gel, then replaced shoes, socks and edema wear. LPN A changed gloves without performing HH, the put leg wraps on Resident 12's legs. Without changing gloves, LPN A moved the trash can, emptied it, then put a new bag in it, and hung the catheter drainage bag inside the trash can. The LPN bagged the trash and linens used during the wound and catheter cares, removed and discarded their gown and gloves, then left the room without performing HH. Discarded the bagged trash and linens, then used ABHR.An interview on 01/26/2026 at 3:39 PM with LPN A confirmed that they did not perform HH when changing gloves and should have, and that the catheter bag should not have been placed on the floor.An interview on 01/27/2026 at 11:01 AM with the IP confirmed that the catheter bag should not have been placed on the floor, and that HH should have been performed when gloves were changed.C.A record review of Resident 19's admission Record printed 01/22/2026 revealed the resident was admitted to the facility 05/16/2017 and had a diagnosis of multiple sclerosis (MS-a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control).A record review of an undated list of residents on EBP provided by the facility revealed that Resident 19 was on EBP due to having a chronic wound.A record review of a wound clinic note for Resident 19 dated 01/19/2026 revealed the resident had a deep tissue injury (DTI- damage to soft tissues beneath intact skin, appearing as a localized purple or maroon area, sometimes with a blood-filled blister, caused by pressure, often over bony areas like heels) on their left heel.An observation on 01/26/2026 at 2:25 PM of LPN A preparing to perform wound care for Resident 19 revealed that as the LPN was putting on a gown outside the room, the LPN dropped the gown, and it touched the floor. The LPN picked the gown up and put it on and continued to wear it during wound care.An interview on 01/26/2026 at 3:39 PM with LPN A confirmed that the LPN should not have used the gown that touched the floor but should have disposed of it and gotten a clean one for performing cares.An interview on 01/27/2026 at 11:01 AM with the IP confirmed that PPE that touches the floor should be thrown away and not used.