STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285285	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Grand Island Village	4061&4055 Timberline Street&2912 Good Samaritan Pl Grand Island, NE 68803

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review, the facility failed to implement interventions to prevent accidents for 1 (Resident 1) of 3 sampled residents. The facility census was 44. Findings are: A record review of the facility's Fall Prevention And Management policy dated 07/29/2024 revealed a fall is an unintentional coming to rest on the ground. An accident is any unexpected or unintentional incident which may result in injury or illness to a resident. Root cause analysis is a method for identifying the cause or problem so that the best solutions can be identified and put into place. Following a fall, the staff should complete a falls tool, document if teaching was done, communicate the fall to administration, provider, and family, and review and update the care plan with any new/changes to the care plan interventions. A. A record review of Resident 1's Clinical Census dated 03/26/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's Medical Diagnosis dated 03/26/2025 revealed the resident had diagnoses of Cerebral Infarction (stroke), Traumatic Subdural Hemorrhage (bleeding near the brain caused by a head injury), Repeated Falls, Parkinsonism (syndrome with muscle rigidity, tremors, unstable posture, leading to abnormal walking), Vertigo (dizziness), Muscle Weakness, Lack Of Coordination, and Need For Assistance With Personal Care. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 02/12/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 14 which indicated the resident was cognitively aware. The resident had limited range of motion on one side of the upper extremities (shoulder to hand or hip to toe). The resident required setup or clean-up assistance with eating and oral hygiene (cleaning), partial/moderate assistance with toileting, dressing, footwear, and personal hygiene, and substantial/maximal assistance with bathing. The resident required partial/moderate assistance with positioning and transfers. The resident was not on a toileting program. The resident did not have pain or hurting at any time. The resident had 0 falls with no injury, 0 falls with major injury, and 2 falls with injury in the lookback period. A record review of the facility's Incidents By Incident Type report dated 09/26/2024 - 03/26/2025 revealed Resident 1 had fallen on: -10/02/2024, -10/05/2024, -10/28/2024, -11/17/2024, -02/01/2025, -03/02/2025. A record review of the facility's Found on Floor dated 11/17/2024 revealed Registered Nurse (RN)-A was called to the room after the Nursing Assistant (NA) found the resident on the floor next to the toilet with a small cut above the right eye. Resident 1 reported the resident stood up to pull up the resident's pants and lost (gender) balance. NA-B's statement revealed NA-B put Resident 1 on the toilet and left the room to get the nurse to get a bandage for a scratch on the resident's hand and when NA-B went back in the room, Resident 1 was on the floor. A record review of Resident 1's Progress Notes dated 11/18/2024 at 1:13 AM revealed the resident was sent to the hospital following an unwitnessed fall, and the resident suffered a compression fracture of the first thoracic vertebrae (T1, bone in the middle section of the spine) and a left closed rib fracture. A record review of Resident 1's Care Plan with an admitted [DATE] revealed: A focus area of falls, 10/02/2024 fall with no injury, 10/05/2024 witnessed fall, 10/28/2024 lowered to the floor, 11/17/2024 fall with major injury, 02/01/2025 fall out of the facility with minor injury, and 03/02/2025 fall with major injury. Interventions included provide a safe environment with call light in reach with a dated initiated 10/02/2024, toileting schedule with a date initiated of 11/21/2024, staff to stay with resident at all times when in the bathroom with a date initiated of 11/22/2024, and moved rooms to benefit using the resident's right side in the bathroom with a dated initiated of 03/10/2025. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility's Cottonwood East/Cottonwood [NAME] report sheet revealed the resident was a sit-to-stand (a mechanical lift), **FALLS**DO NOT LEAVE ALONE IN RESTROOM. A record review of the facility's Investigation Report dated 03/07/2025 revealed on 03/02/2025 Resident 1 fell from the toilet and hit the resident's head, there was a small amount of blood on the floor, and the resident was transferred to the hospital for a possible head injury. The resident returned a couple of hours later with no head injury noted and an order for a follow-up magnetic resonance imaging (MRI, detailed images of the body's internal structures). The resident continued to complain of back and right flank (side of the lower back) pain and pain medicine was administered. The resident was sent back to the hospital and an Xray of the back revealed a hairline fracture of the first lumbar vertebrae (L1, bone in the lower spine). The outcome of the facility investigation was the resident attempted to stand and pull up the resident's pants without assistance. The permanent measure put in place to prevent it from happening again was to move the resident to a different room that would have a restroom that would be set up better for the resident to utilize the resident's stronger side. A record review of the facility's Found on Floor dated 03/02/2025 revealed Registered Nurse (RN)-A heard a loud noise while in the hallway outside of Resident 1's room, entered the room, and the resident was lying on the resident's left side on the floor in the bathroom. Blood was seen under the resident's head, and 911 was called to take the resident to the hospital. A note on the Found on Floor dated 03/02/2025 revealed the resident was left alone in the bathroom and staff was educated that the resident should not be left in the bathroom alone. A record review of Resident 1's Emergency Department (ED) Provider Notes dated 03/02/2025 revealed the resident was evaluated for a head injury and the resident had a l-shaped 2 centimeter right posterior (back) scalp laceration (cut) that required 5 staples to close. The resident complained of low back pain and a computer tomography (CT, detailed cross-sectional images of the body) revealed degenerative (declining) changes of the lumbar spine without acute finding (no specific findings). A record review of Resident 1's Progress Notes dated 03/04/2025 revealed resident continued to complain of back pain and right flank pain. The daughter requested to resident be sent back to the ED for pain control related to the resident's fall. The provider was contacted, and the resident was transferred to the ED. A record review of Resident 1's Emergency Department (ED) Provider Notes dated 03/04/2025 revealed resident was complaining of 8 out of 10 back pain that radiated (went) down the bilateral lower extremities. Results of the MRI and another CT scan revealed the resident had an acute L1 compression fracture and recommended kyphoplasty (surgical procedure to treat painful vertebral compression fractures). In an interview on 03/26/2025 at 10:50 AM, Resident 1 confirmed on 03/02/2025 the NA took the resident to the bathroom and told the resident not to move, and the next thing the resident remembered was waking up on the floor in the bathroom. The resident got a cut on the back of the head and fractured something or the other. The resident confirmed the resident was in pain until after the surgery. The resident confirmed the NA left the resident alone in the restroom to go get something. The only changes the resident was aware of to prevent the falls from happening again was to call for help and changed room to where everything was on the right side not the left. The resident confirmed the resident was just very right-handed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 10:20 AM, Physical Therapy Assistant (PTA)-D confirmed prior to Resident 1's 03/02/2025 fall. Resident 1 was a stand-pivot (a technique to assist transferring a resident from one surface to another) transfer with 1 staff assistance. PTA-D confirmed the resident should not have been left alone in the bathroom. In a telephone interview on 03/26/2025 at 5:15 PM, RN-A confirmed RN-A was the charge nurse on the night of Resident 1's fall (03/02/2025). RN-A confirmed RN-A was the one that heard the resident fall and found the resident on the bathroom floor bleeding. RN-A confirmed there was no other staff in the room when RN-A entered the resident's room. NA-C was the NA that had taken the resident to the bathroom and left the resident alone in the bathroom and should not have. In a telephone interview on 03/27/2025 at 7:53 AM, NA-C confirmed NA-C was the NA that had Resident 1 the night of the fall on 03/02/2025. Resident 1 called NA-C to use the restroom and NA-C got the resident up and took Resident 1 to the bathroom. There was a NA on the other side of the hall that needed help with a resident, so NA-C left to help the other NA. NA-C confirmed just as NA-C left Resident 1's room, NA-C heard a loud boom and NA-C seen RN-A run into Resident 1's room. NA-C confirmed this was not the first time NA-C had left a resident in the restroom alone. NA-C likes to give the residents privacy so NA-C walks out and does something else. NA-C then confirmed that NA-C left Resident 1 standing in front of the toilet, not seated on the toilet. NA-C confirmed again that NA-C helped Resident 1 into the restroom and left Resident 1 standing there and the resident fell getting onto the toilet. Resident 1 transferred the resident's self before the fall, they (staff) never put Resident 1 on the toilet. In an interview on 03/26/2025 at 4:03 PM, the facility's Director of Nursing (DON) confirmed that Resident 1's new intervention for the 03/02/2025 fall of moved rooms to benefit using the resident's right side in the bathroom with a dated initiated of 03/10/2025 was not a direct intervention related to the cause of the fall, the intervention related to the 03/02/2025 fall was already in place to not leave the resident on the bathroom alone, it was just not followed and should have been. In an interview on 03/27/2025 at 10:34 AM. The DON confirmed Resident 1 should not have been left in the restroom alone. B. A record of the facility's Bowel & Bladder: Evaluation, Assessment, Toileting Programs policy dated 05/21/2024 revealed Habit Training/Scheduled Toileting is a behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding (evacuating bowels or bladder) habits or needs. Voiding intervals are adjusted to match the individuals voiding patterns/incontinence (inability to control) patterns to the toileting schedule usually every 2-3 hours. A record review of the facility's Incidents By Incident Type report dated 09/26/2024 - 03/26/2025 revealed Resident 1 had fallen on: 10/02/2024 10/05/2024 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/28/2024 11/17/2024 02/01/2025 03/02/2025 A record review of the facility's Found on Floor dated 11/17/2024 revealed Registered Nurse (RN)-A was called to the room after the Nursing Assistant (NA) found the resident on the floor next to the toilet with a small cut above the right eye. Resident 1 reported the resident stood up to pull up the resident's pants and lost (gender) balance. NA-B's statement revealed NA-B put Resident 1 on the toilet and left the room to get the nurse to get a bandage for a scratch on the resident's hand and when NA-B went back in the room Resident 1 was on the floor. A record review of Resident 1's Progress Notes dated 11/18/2024 at 1:13 AM revealed the resident was sent to the hospital following an unwitnessed fall and the resident suffered a compression fracture of the first thoracic vertebrae (T1)(bone in the middle section of the spine) and a left closed rib fracture. A record review of Resident 1's Care Plan with an admitted [DATE] revealed: A focus area of falls, 10/02/2024 fall with no injury, 10/05/2024 witnessed fall, 10/28/2024 lowered to the floor, 11/17/2024 fall with major injury, 02/01/2025 fall out of the facility with minor injury, and 03/02/2025 fall with major injury. Interventions included provide a safe environment with call light in reach with a dated initiated 10/02/2024, toileting schedule with a date initiated of 11/21/2024, and staff to stay with resident at all times when in the bathroom with a date initiated of 11/22/2024. A record review of Resident 1's Task: Toileting dated 03/26/2025 revealed that the resident was toileted: 03/26/2025 at 5:59 AM and 10:04 AM 03/25/2025 at 2:29 PM and 11:29 PM 03/24/2025 at 10:33 AM 03/23/2025 at 6:29 AM 03/22/2025 at 12:29 AM, 6:40 AM, and 10:29 PM 03/21/2025 at 2:22 AM, 2:29 PM, 10:29 PM, and 11:06 PM 03/20/2025 at 4:47 AM 03/19/2025 at 10:29 PM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/18/2025 at 2:29 PM and 10:29 PM 03/17/2025 at 3:48 AM and 10:41 AM 03/16/2025 at 5:59 AM, 10:28 AM, 3:25 PM 03/15/2025 at 4:38 AM and 10:44 AM 03/14/2025 at 5:25 AM and 10:29 PM A record review of the white board in the nurse's station did not reveal fall interventions for Resident 1, just transfer method. An observation on 03/26/2025 at 12:53 PM revealed NA-E assisted Resident 1 to restroom using a sit-to-stand lift without concern. An observation on 03/27/2025 at 7:01 AM revealed Resident 1 was seated in the wheelchair watching television with the resident's call light curled up on the bed about 4 feet behind the resident and not in reach. In an interview on 03/26/2025 at 1:20 PM, NA-E confirmed NA-E can look care plan interventions for falls in the electronic medical record (EMR) or can ask the nurse. The only fall interventions NA-E knew for Resident 1 was to keep the call light in reach and don't leave alone in the restroom. NA-E confirmed there were report sheets the staff has for specific resident needs, but NA-E did not grab one today. NA-E confirmed there was not a specific toileting schedule for Resident 1. In an interview on 03/26/2025 at 4:31 PM, NA-F confirmed there was not really a schedule to toilet any of the residents. In an interview on 03/26/2025 at 4:55 PM, NA-E confirmed NA-E checks all residents every odd hour to see if they need to use the restroom, NA-E was not sure of a specific schedule for any of the residents. In an interview on 03/27/2025 at 7:20 PM, NA-F confirmed that Resident 1 was not on a toileting schedule. NA-F confirmed that NA-F was the NA that got Resident 1 out of bed and transferred into the wheelchair and that NA-F did not clip the call light to the resident and it was not in reach. In an interview on 03/27/2025 at 7:37 AM, NA-H confirmed not sure what fall care plan interventions were for each resident other than the basis ones of don't leave unattended in the restroom, frequent checks, and keep call light in reach. NA-H would ask the nurse to look at the care plan. There was a board in the nurse station that would have the interventions. NA-H did not know how to access the Kardex and did not have a report sheet. In an interview on 03/26/2025 at 6:04 PM, the DON confirmed that a resident's fall interventions are listed in the Kardex in the resident's EMR, and staff is trained how to access the Kardex on hire and all staff should know how to access the Kardex. The staff should also put the information on the white board in the nurse's station and pass the information along and report and staff should have a detailed report sheet with them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/27/2025 at 10:34 PM, the DON confirmed there was not a true, specific, toileting schedules for residents. The staff was just supposed to do before and after meals and at bedtime and the staff should have known that.