STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285138	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Syracuse	1622 Walnut Street Syracuse, NE 68446

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Licensure Reference Number 175 NAC 12-006.09D Based on observation, record review and interview; the facility failed to ensure the MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) was coded to reflect the resident used a wander guard system (a medical alert device used to send an alert to staff or sound an alarm to prevent elopement for wandering residents)for 1 (Resident 6) of 11 residents that utilized a wander guard system. The facility census was 42. Findings are: Observation on 01/16/25 at 8:34 AM revealed Resident 6 seated in a recliner in their room. Resident 6 had a wander guard system bracelet present on the right wrist. Interview on 01/15/25 at 3:18 PM with the facility Social Worker confirmed that the wander guard was placed on Resident 6 on 12/19/24. The Social Worker further confirmed that Resident 6 was at risk for elopement. Record review of Resident 6's CCP (Comprehensive Care Plan, a individualized plan of care which identifies care needs for the resident) dated revised 12/19/24 revealed that Resident 6 had the potential for elopement related to exit-seeking due to Dementia. Interventions included: Wander guard used to alert staff to resident near exits. This was initiated on 12/19/2024. Record review of Resident 6's annual MDS annual 12/26/24, with a review period between 12/20/24 and 12/26/24, revealed an admission date of 2/8/24 and diagnoses that included Unspecified Dementia, Depression and Generalized anxiety Disorder. Resident 6's MDS identified a BIMS (Brief Interview for Mental Status, aides in detecting cognitive impairment) score of 05 which indicated severely impaired cognitive ability, wandering occurred 1-3 days during the assessment review dates, no impairment with range of motion, walker and wheelchair use, independent while in a manual wheelchair with wheeling 50 feet - 150 feet, and no wander guard used. Interview on 01/16/25 at 9:40 AM with the MDS Coordinator confirmed the information in the CCP and that a wander guard was placed on Resident 6 on 12/19/24. The MDS Coordinator confirmed that there was an error in the MDS and that the wander guard system was not coded correctly in Section P0200 E of the MDS to identify the use of a wander guard system for Resident 6. Record review of facility Order Listing Report dated 1/16/25 revealed a total of 11 residents with orders for a wander guard system.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. D. Record review of Resident 17's Quarterly MDS (Minimum Data Set - a comprehensive standardized assessment of resident's functional capabilities and health needs) dated 11/8/24 revealed an admission date of 2/2/23 and diagnoses that included Malignant Neoplasm of Oropharynx; Dysphagia (difficulty swallowing); and Gastrostomy Status (presence of a feeding tube in the stomach for nutrition and hydration support). The MDS identified BIMS (Brief Interview for Mental Status, aids in detecting cognitive impairment) score of 14 which indicated the resident was cognitively intact. The MDS identified Resident 17 did not eat due to a medical condition and had a feeding tube while a resident with 51% or more calories by feeding tube and 501 cc or more for fluids. Record review of Resident 17's Physician Orders revealed the following orders: - 12/01/2023 NPO (nothing by mouth) diet, - 11/08/2024 Nutren 2.0 Oral Liquid (Nutritional Supplements) Give 250 ml via G-Tube three times a day with minimum of 100 ml water before and after each feeding - By Gravity. Observation on 01/15/25 at 08:20 AM revealed Resident 17 was in isolation due to use of the feeding tube. A sign on the door indicated that personal protective equipment, including gowns, gloves, N-95 mask, and eye protection were required during cares. Observation on 01/15/25 at 08:20 AM revealed LPN (Licensed Practical Nurse) C knocked on the door, entered the room in goggles, an N 95 Mask, a gown and gloves. LPN C explained the procedure to Resident 17, cleaned the bedside table with a disinfectant cloth and placed a tissue barrier. With the same gloves and no hand hygiene performed, LPN C reached into the pocket of their uniform pants, retrieved a set of keys, unlocked the supply cabinet and replaced the keys into the same pocket. With the same gloves in place and no hand hygiene performed, LPN C placed 3 cups on the barrier and retrieved a bottle of tube feeding from a box on the floor. LPN C shook the tube feeding well, opened and poured the contents of the bottle into a cup. LPN C retrieved an open bottle of distilled water from the floor and poured 240 cc into one of the cups. LPN C proceeded to check placement and administer tube feeding with water flushes as ordered. During the administration LPN C did not change gloves or perform hand hygiene. LPN C disconnected the syringe and capped the gastrostomy tube. With the same gloves in place and no hand hygiene performed, LPN C adjusted the 4x4 gauze dressing at the gastrostomy site, then adjusted Resident 17's clothing. With the same gloves in use and no hand hygiene, LPN C rinsed out the syringe and placed it back into the cabinet where clean supplies were stored. Interview on 01/15/25 at 8:35 AM with LPN C confirmed that the facility always keeps tube feeding supplies on the floor and that soiled gloves should have been removed and hygiene performed after the keys were touched. LPN C confirmed that the keys would have been considered soiled because they were in a pocket. Interview on 01/15/25 at 02:04 PM with Clinical Care Lead Coordinator (CCLC) confirmed that tube feeding supplies and water should not be stored on the floor and that hand hygiene and a glove change should have been performed after the keys were touched. The CCLC confirmed that the keys would be considered soiled as they were in a pocket. Licensure Reference Number 175 NAC 12-006.18 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review the facility staff failed to ensure hand hygiene and gloving techniques were followed during wound care for 1(Resident 34) and tube feeding for 1(Resident 17), failed to ensure wound care supplies were not contaminated for 1 (Resident 34), failed to implement interventions to prevent the spread of Covid-19 and failed to ensure the facility had a Legionella water management plan. The facility failure had the potential to effect all residents in the facility. The facility had a census of 42. Findings are: A. A record review of Resident 34's hospice wound care order dated 12/16/2024 revealed the following instructions: -Wash left heel with wound wash, dry with gauze, apply layer of Vaseline gauze to wound and cover with dry gauze dressing and secure with Medi pore tape. Hospice nurse to complete twice a week. If dressing becomes soiled or is removed, apply dry dressing and secure as needed (PRN). An observation on 01/15/2025 at 10:47 AM of wound care performed by the Clinical Care Lead (CLL) for Resident 34 revealed the following: - The CCL entered the resident room wearing a gown and face mask. They washed their hands and donned gloves. The CLL placed a pair of scissors, a pack of Kerlix (a brand of gauze bandage), a roll of tape, a foam dressing 4 x 4 (a wound care product that absorbs drainage), an open package of Vaseline gauze (a sterile non-adhesive wound dressing that's made of fine mesh gauze and white petrolatum) and a bottle of wound cleanser directly on the residents' bed. The resident raised their left leg and the CLL removed the soiled bandage from the residents' foot by cutting the kerlix with the scissors and discarded the dressing in the trash. The CCL removed their gloves and donned clean gloves. The CCL did not use hand sanitizer or wash their hands between taking gloves off and replacing them. The CLL opened the roll of kerlix and cut a portion of it off with the scissors. The scissors were placed directly on the residents' bed. The CCL soaked a piece of kerlix with wound cleaner and wiped the residents left heel wound and discarded the wet kerlix. The CCL used the scissors, which had not been cleaned, to cut a piece of Vaseline gauze. The scissors were placed directly on the bed. The Vaseline gauze was placed on the open area of the wound. The CCL opened a foam dressing package, placed the dressing over the wound and secured it in place by wrapping the remaining kerlix over it. The CCL cut a piece of tape and used it to secure the dressing in place. The CLL secured the wound care dressings in a plastic container and washed their hands, removed their gown and face mask and exited the room. An interview on 01/15/2025 at 11:05 AM with the CLL confirmed they had not washed their hands or used hand sanitizer between glove changes and they should have done so. The CLL confirmed the scissors should have been cleaned in between cutting the dirty dressing and the clean kerlix and the wound care supplies should have been placed on a barrier sheet, not directly on the residents' bed. A record review of the facility Hand Hygiene (hygiene - the practice of keeping clean to prevent disease and maintain good health) policy dated 3/29/2022 revealed the following information: -Policy All employees in patient care areas (unless otherwise noted in their policy) will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Entering Room. 2. Before Clean Task 3. After Bodily Fluid/Glove removal 4. Exiting Room 5. Zones: Patient zone and Health care zone. The preferred method of hand hygiene for most patient care settings is the use of waterless alcohol-based hand sanitizer. -Gloves are a protective barrier for the Health Care Worker (HCW) according to standard precautions. 1. Gloves are never to be reused or sanitized. 2. Hand hygiene should be performed after glove removal. -Procedure. HCW will use waterless alcohol-based hand sanitizer or soap and water to clean their hands: -When entering patient room. If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves. After removing gloves regardless of task completed. After contact with a patients' non-intact skin, wound dressings, secretions, excretions, mucous membranes, as long as hands are not soiled. B. A record review of the Infection Control Assessment and Promotion Program (ICAP) Summary of Recommendations for Covid-19 in a long-term care facility, revised on 05/11/2013 under the heading Isolation of Resident Identified to have Covid-19 (Red Zone) states that Resident door should be kept closed. On 1/13/2025 the facility provided a list of residents who were positive for Covid-19. These residents were in the following rooms.:100, 102,103, 104, 106, 107, 109, 112, 201, 205, 207, 213, 210, 301, 311, 312, 313, 316, 402. 405, 411 and 500. An observation on 1/13/2025 at 9:56 AM revealed the doors to rooms 201, 205, 207, 213, and 312 were open. An observation on 1/14/25 at 7:50 AM revealed the doors to rooms 312, 402, 210, 205, and 109 were open. An observation on 1/15/2024 at 9:15 AM revealed the doors to rooms 112, 109, 106, 102, 201, 207, 210, 213, and 500 were open. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 1/15/2025 at 9:15 AM with the Clinical Care Lead (CCL) confirmed having the doors open in a Covid-19 positive room was an infection control breach. The CCL confirmed the Airborne Precautions from the Centers for Disease Control and Prevention (CDC) sign on each door stated the doors were to be kept closed at all times. The CCL confirmed the facility is following the Infection Control Assessment and Promotion Program (ICAP) Summary of Recommendations for Covid-19 in a long-term care facility, revised 5/11/23. The CCL confirmed the ICAP summary stated the Resident door should be kept closed. C. An interview on 1/16/2024 at 9:40 AM with the Maintenance Director (MD) confirmed the facility uses The Equipment Lifecycle System (TELS system - a system which helps with life safety, asset management, maintenance and repairs and is used to track and document repairs and maintenance in a facility). The MD was unable to produce a text and flow diagram (a visual representation of a process or workflow where each step is described with text and connected by arrows to show the sequence of actions) to show the areas where Legionella and other waterborne pathogens could grow and spread in the facility's water system. An interview on 01/16/2024 at 9:45 AM with the Facility Administrator confirmed they did not know if there was a Legionella Water Management program team and did not know if there was a water flow diagram for the facility. An interview on 1/16/2024 at 10:12 AM with the facility Maintenance Director confirmed there was not a water management program team in the facility, The facility did not have a water system flow diagram and there were no confirmatory procedures to show that the program is being followed as written and to validate that the program is effective. The MD confirmed the facility did not have the measures required by the facility policy to prevent the growth of Legionella. A record review of the Company's Plumbing Systems, Resource packet Policy, containing the Legionnaires disease and water management program Policy revised on 1/17/2024 revealed the following information: -Policy -All Good Samaritan Society rehab/skilled locations will identify a water management team at their location that will annually and with any major maintenance and water service change, identify where Legionella could grow. This team will determine the water management program for the location. Revisions will be made as needed to the water management plan. Documentation of control measures will occur in the Society's approved environmental services management software system. -Water Management Program The written program should include at least the following: Program team including names, titles, contact information and roles on the team. At a minimum the team should include: Someone who understands accreditation standards and licensing requirements, Someone with expertise in infection prevention, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A clinician with expertise in infectious diseases and Risk and Quality management staff. Describe your building water system using a flow diagram; this should be a simple diagram that is easily understood by all team members. Identify areas where Legionella could grow and spread: Using the water system flow diagram, identify where potentially hazardous conditions could occur in your building water system, -Apply control measures: Control measures and limits should be established for each control point. Include confirmatory procedures to show that the program is being followed as written and to validate that the program is effective.