STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285197	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Albion	1222 South 7th Street Albion, NE 68620

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 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** Licensure Reference Number 175 NAC 12-006.09(I)(i) Based on observation, record review and interview; the facility failed to identify causal factors and to develop and/or revise interventions for the prevention of ongoing falls for 2 (Residents 39 and 18) of 6 sampled residents. The facility census was 48. Findings are: A. A record review of the facility Fall Prevention and Management Policy with reviewed/revised date of 7/29/24 revealed the purpose of the policy was to promote the resident's well-being by developing and implementing a fall prevention and management program. The facility was to identify risk-factors and implement interventions before a fall occurred. If a fall did occur the staff were to complete the following process: -assess the resident for injuries and obtain a set of vital signs including a blood pressure, pulse, respirations, temperature, and pulse oximetry (a non-invasive medical procedure that measures the oxygen saturation of the blood). -if the fall was not witnessed then staff were to perform neurological assessments (a comprehensive evaluation of a person's nervous system, including the brain, spinal cord, and nerves, to identify any abnormalities or damage). -complete an Incident Report. -complete the Fall Scene Huddle Worksheet. -if any teaching was done, it was to be documented in the medical record. -communicate to other staff/shifts that a fall had occurred. -review and update the care plan with any changes or new interventions. B. (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 the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) for Resident 39 dated 3/11/25 revealed the resident was admitted [DATE] with diagnoses of arthritis, dementia, depression, and psychotic disorder. The following was assessed for Resident 39: -severe cognitive impairment. -required staff assistance with personal hygiene, toileting, dressing, bed mobility and transfers. -2 falls without injury and 2 falls with injury (except major) since previous assessment. -use of bed and chair alarms daily. A record review of the current Care Plan dated 8/5/24 revealed Resident 39 was at risk for falls due to diagnoses of dementia with episodes of confusion, impulsive decision making and no awareness of safety needs, history of falls and psychoactive medication use. The following interventions with their date of development/implementation were identified: -8/5/24 encourage the resident to participate in activities that promote exercise and physical activity. -8/5/24 ensure the resident is wearing appropriate footwear. -8/29/24 toilet before meals and then position in the Commons area for increased supervision. -9/7/24 bolster mattress and extra call light added to the resident's room. -9/16/24 sensor pad (an electronic pressure sensitive sensor pad designed for use in chairs or beds which will alarm if a resident tries to get up without assistance) to recliner, wheelchair and dining room chair and silent alarm to bed. Ensure alarms are connected to the call light system. A record review of an Incident Report for Resident 39 dated 8/15/24 at 5:53 PM revealed the staff heard the resident's fall alarm and found the resident in their room and lying on their back. The resident reported being in a hurry to go to the evening meal and fell when taking self to the bathroom. New interventions were identified for the resident to be evaluated by Occupational Therapy, Physical Therapy and Speech Therapy; the resident was to be toileted and then positioned in the Commons area prior to the meal service and the resident was no longer to use the 4 wheeled walker. A record review of an Incident Report for Resident 39 dated 8/18/24 at 7:35 PM revealed the staff responded to the resident's call light and fall alarm and found the resident on the floor in front of the recliner. The footrest of the recliner was in the upright/extended position. The resident's medication regimen was reviewed, and a new order was received for Ativan (medication used to treat anxiety) in the early evening when the resident had increased restlessness. A record review of an Incident Report for Resident 39 dated 9/16/24 at 8:00 AM revealed the staff heard a noise from the corridor and found the resident on the bathroom floor. The resident was incontinent and was found without their walker. Further review of the investigation revealed the resident had not been toileted since 9:17 PM on 9/15/24. In addition, the connectors were not secured to the resident's fall alarm, and did not sound when the resident self-transferred. The alarm pad (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	connections were immediately secured so the alarm would come through the call light system. The staff did not address the resident's toileting schedule or provide further investigation as to why the resident had not been toileted since 9:17 PM (10 hours and 42 minutes) the previous evening. A record review of an Incident Report for Resident 39 dated 11/21/24 at 7:06 PM revealed the resident was found on the floor in the Commons area near the public bathroom. The resident indicated needing to have a bowel movement and used the 4 wheeled walker (use was to be discontinued on 8/15/24) to try and get to the bathroom, lost balance and fell. The report indicated staff were to continue current plan of care and interventions as the resident's falls were unavoidable. Further review revealed current interventions were not revised and staff did not develop any new interventions. In addition, the resident continued use of the 4 wheeled walked despite an intervention to no longer use the 4 wheeled walker identified with the resident's fall on 8/15/24. A record review of an Incident Report for Resident 39 dated 1/6/25 at 4:45 PM revealed the resident was found on the floor next to the Nurse's Station. An intervention was identified to change the 4 wheeled walker (use was to be discontinued on 8/15/24) to a front wheeled walker with a basket for the resident's belongings. In addition, staff were to transfer the resident into a wheelchair when restless and then to keep the resident with a staff member for closer supervision. A record review of an Incident Report for Resident 39 dated 1/10/25 at 4:55 PM revealed the resident had been toileted and was ambulating with staff assistance to the recliner. The resident continued use of the 4 wheeled walker which was to have been discontinued on 8/15/24 and on 1/6/25. The resident tried to sit down on the seat of the walker, was too close to the edge and was lowered to the floor by staff. The 4 wheeled walker was removed from the resident's room and was replaced with a front wheeled walker. A record review of an Incident Report for Resident 39 dated 2/12/25 at 9:09 PM revealed the resident was found lying on the floor of the Commons area. The resident's fall alarm was sounding and the resident reported trying to get to my room. An intervention was identified for the physician and the Consultant Pharmacist to review the resident's medications and to have the National Campus Risk Team review the resident's falls. The report indicated the resident's falls were unavoidable and to continue current interventions. Review of the resident's medical record revealed no revision of current interventions or development of new interventions to prevent further falls. A record review of an Incident Report for Resident 39 dated 2/13/25 at 7:28 PM revealed the resident was found on the floor of the Common's area by the Nurse's Station. The resident reported trying to get to the resident's room. An intervention was identified for staff education to ensure the resident was toileted after the evening meal and then the resident was positioned in a recliner and not the wheelchair in the Common's area. A record review of an Incident Report for Resident 39 dated 2/25/25 at 7:00 AM revealed the staff heard the resident's call light and found the resident on the bathroom floor of the resident's room. The resident identified a need to use the bathroom. Further review of the report revealed the resident had last been toileted at 2:30 AM (4 and ½ hours prior). The Maintenance Supervisor did review the flooring threshold between the resident's room and the bathroom, but no changes were made. The report indicated the resident's falls were unavoidable due to dementia and to continue the current plan of care. The resident's toileting schedule was not addressed, and no further interventions were developed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Nurse Aide (NA)-H and NA-I on 4/2/25 at 3:40 PM revealed the resident was to be toileted before and after meals and every 2 hours throughout the evening/night. During an interview on 4/3/25 at 10:21 AM the Director of Nursing (DON) confirmed the following regarding Resident 39's falls: -high risk for falls with impaired safety awareness. -staff were to assess the resident after each fall and complete an Incident Report and a Fall Scene Huddle Worksheet to determine causal factors and to develop or revise interventions to prevent further falls. -with fall on 8/15/24 the Incident Report indicated the resident was no longer to use the four wheeled walker. -with fall on 11/21/24 the Incident Report identified the resident continued use of the 4 wheeled walker. -with fall on 1/6/25 the Incident Report specified the 4 wheeled walker (which was to have been discontinued on 8/15/24) was to be changed to a front wheeled walker. -with the fall on 1/10/25 the resident's 4 wheeled walker was finally removed from the resident's room and was replaced with a front wheeled walker. C. A record review of Resident 18's MDS dated [DATE] revealed the resident had a diagnosis of non-Alzheimer dementia and unsteadiness on feet. The following was assessed regarding the resident: - severe cognitive impairment. - inattention and disorganized thinking. - hallucination and delusions. - dependent on staff for toileting hygiene, lower body dressing and putting on footwear. -required substantial assistance with upper body dressing and personal hygiene. -required partial assistance with sitting to standing and toilet transfer. - always continent of bowel and frequently incontinent of bladder. - 2 or more falls, 1 with injury and 1 without injury since previous assessment. - bed and chair alarms were used daily. A record review of Resident 18's current Care Plan dated 2/24/24 revealed the resident had an activity of daily living deficit related to history of stroke, dementia, weakness, unsteady gait and history of falls. Nursing interventions with development dates included the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2/14/25 assist to lift recliner chair for positioning when in the room. Remote control placed behind chair for staff control. A record review of a Nursing Progress Note dated 3/7/25 at 9:55 PM revealed Resident 18 was observed lying on the resident's back on the floor at the foot of the bed. The resident's alarm was sounding, staff entered the room and observed the resident ambulating independently. Gait belt was placed around the resident's waist, the resident lost balance and was lowered to the floor. A record review of the Incident Report for Resident 18 dated 3/7/25 at 9:50 PM revealed the resident needed to use the bathroom, used the remote to the chair to lower the legs and elevate the seat of the recliner. A record review of the fall review documentation for Resident 18 on 3/21/25 revealed the root cause of the fall was due to the resident ambulating across the room independently, staff responded to the alarm and assisted, but resident lost balance and was lowered to the floor by staff. Further review of the fall review documentation revealed the care plan was reviewed and current interventions in place were correct and applicable for the resident. To continue to use current care plan interventions. No additional interventions were identified. An observation on 4/1/25 at 11:20 AM with NA-K revealed that Resident 18 was transferred with 1 assist, gait belt and front wheeled walker from recliner. The remote to the recliner was behind the recliner, NA-K picked up the remote from behind the recliner that was hanging from an elastic band that was wrapped around the back of the recliner, lowered Resident 18's legs and elevated the recliner to assist the resident to a standing position. An interview on 4/3/25 at 8:30 AM with the DON confirmed the remote for Resident 18's recliner was behind the recliner and was to be screwed into the recliner. Reviewed the investigation report from 3/7/25 with the DON that revealed the resident used the remote to the chair to lower the legs and elevate the seat of the recliner and during the observation on 4/1/25 the remote to the recliner was not screwed into the recliner. An interview on 4/3/25 at 9:00 AM with the Maintenance Manager confirmed that the remote for Resident 18's recliner was on a band wrapped around the back of the recliner. Maintenance Manager confirmed that the recliner remote was connected to the back of the recliner with a screw on 4/3/25 at 8:45 AM. An interview on 4/3/25 at 10:55 AM Thw Director of Nursing confirmed that the cause of Resident 18's fall on 3/7/25 was due to the resident using the remote to the recliner to lower the legs and elevate the seat of the recliner allowing the resident to transfer self independently.