STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285187	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - SUPERIOR	**1710 IDAHO STREET SUPERIOR, NE 68978**

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** - Many	**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 12-006.09D7 Based on observation, interview and record review, the facility failed to provide supervision to prevent the potential for accident or injury for 3 residents (Residents 2, 3, and 4) of 3 residents staying on the designated COVID-19 Unit. The facility identified a census of 45. Findings are: A. Interview on 7/8/20 at 8:20 AM with the DON (Director of Nursing) revealed the facility had a dedicated COVID-19 unit where newly admitted residents would be under isolation precautions for 14 days. The DON revealed all other areas of the facility were Green Zones (rooms designated for residents with no known exposure to COVID-19 and no symptoms). B. Observation on 7/8/20 from 10:00 AM - 10:40 AM of the designated COVID-19 Unit revealed the fire doors were closed, separating the COVID-19 Unit from the rest of the hall. On the unit, all resident room doors were shut. No staff were observed on the unit for 40 minutes. C. Interview on 7/8/20 at 10:40 AM with Employee H confirmed the fire doors were kept closed and resident room doors on the COVID-19 unit were kept closed. Employee H also confirmed staff were floating between the COVID-19 unit and the rest of the resident rooms on the other side of the closed fire doors. Employee H confirmed it would not be known if a resident on the COVID-19 unit fell or were injured until the resident would be found by staff. D. Interview on 7/8/20 at 10:47 AM with the DON (Director of Nursing) confirmed resident room doors on the COVID-19 unit were kept closed. The DON revealed the staff member assigned to the COVID-19 unit was expected to conduct safety checks on the residents staying on the unit every 30 minutes, and that the DON had prior concerns about resident safety related to the fire doors being kept closed. The DON revealed the facility did not have enough staff to dedicate a staff member to the COVID-19 unit and prevent wandering residents from entering the unit. E. Interview on 7/8/20 at 11:29 AM with Resident 2 revealed Resident 2 was unable to answer surveyor questions related to the reason for admission or the date of admission. Resident 2 was able to follow cues to utilize the call light. Review of Resident 2's Comprehensive MDS (Minimum Data Set - a federally mandated process for clinical assessment of residents in nursing homes) dated 5/12/20 revealed Resident 2's BIMS (Brief Interview for Mental Status - a structured evaluated aimed at evaluating aspects of cognition) indicated the resident had severe cognitive impact. Resident 2's MDS also indicated the resident required supervision when transferring and walking in the resident's room. Resident 2's MDS revealed the resident utilized a wander/elopement alarm daily. Review of Resident 2's Care Plan revised 8/23/18 revealed the resident had impaired cognitive function related to a closed head trauma received at the age of 16, history of alcoholism, and a history of [MEDICAL CONDITION]. The facility's interventions included cueing, reorienting, and to provide supervision as needed. Review of Resident 2's Care Plan revised 6/28/20 revealed the resident was at risk for falls as evidenced by the need for assistance with mobility and transfers and history of falls in the facility. Resident 2's care plan revealed the resident had falls on 5/30/20 (fell on the base of a fan), 6/13/20 (fell while using the over bed table instead of a walker), and 6/28/20 (fell due to inappropriate footwear/bare feet). Review of Resident 2's Progress Note dated 7/6/20 at 4:20 PM revealed the resident was readmitted to the facility from the hospital. Resident 2 was confused but cooperative and not anxious. The resident required cuing and was unsteady when transferring using a walker and assistance of 1 staff member. F. Interview on 7/8/20 at 11:52 AM with Resident 3 revealed Resident 3 was able to make their needs known and utilize the call light Review of Resident 3's undated Care Plan revealed [DIAGNOSES REDACTED]. Review of Resident 3's Progress Note dated 7/7/20 at 2:14 PM revealed Resident 3 was alert and oriented, and slow to answer questions at times. Resident was assisted with all ADL's except eating, and pivot transfers with a walker and assistance of 1 staff member. Review of Resident 3's Care Plan dated 7/7/20 revealed the resident had the potential for impaired cognitive function related to the [DIAGNOSES REDACTED]. [MEDICAL CONDITION] (when the flexible tissues at the ends of bones wear down). Interventions included assistance of 1 staff using a 4 wheeled walker and a gait belt for transfers. Resident 3's Care Plan also indicated the resident was at risk for falls. G. Interview on 7/8/20 at 11:47 with Resident 4 revealed Resident 4 was not able to answer the surveyor's questions or follow commands to utilize the call light. Review of Resident 4's undated Care Plan revealed [DIAGNOSES REDACTED]. Review of Resident 4's Nursing Admit Re-Admit Data Collection dated 7/1/20 revealed Resident 4 had a history of [REDACTED]. Resident 4 was alert at the time of assessment but was not oriented to person, place, or time. Resident 4 was able to walk using a front wheeled walker. Review of Resident 4's Falls Tool dated 7/1/20 revealed Resident 4 was identified to be at medium risk for falls. Cognitive status was noted to be severely impaired, and problems identified included restlessness, confusion, and disorientation. Review of Resident 4's Falls Tool dated 7/7/20 revealed Resident 4 was identified to be at high risk for falls, and experienced 1 or more falls in the last 3 months while a resident. Cognitive status was noted to be moderately impaired, and problems identified included confusion and poor memory. Review of Resident 4's Care Plan dated 7/7/20 revealed Resident 4 had impaired cognitive function related to the [DIAGNOSES REDACTED]., and has difficulty expressing self at times. Interventions included providing supervision/assistance with decision making. Review of Resident 4's Care Plan dated 7/1/20 revealed Resident 4 had an activities of daily living (ADL) self-care performance deficit. Interventions included information that Resident 4 used a front wheeled walker independently for ambulation and used the walker for transfers. Review of Resident 4's Care Plan dated 7/1/20 revealed Resident 4 had the potential for elopement related to dementia and wandering. Interventions included a Secure Care Bracelet to alert staff to Resident 4's movement. Review of Resident 4's Care Plan dated 7/1/20 revealed Resident 4 was at risk for falls, and the resident had 2 falls in 05/2020. Interventions included having staff check on the resident every 30 minutes and check if the resident needed to use the bathroom/make a clear pathway to the bathroom. H. Interview on 7/8/20 at 12:45 PM with the DON revealed the fire doors were closed 2 weeks prior due to being unable to prevent confused residents from other halls from wandering onto the COVID-19 unit.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.04C Based on observation, interview and record review, the facility failed to provide sufficient staffing to prevent the potential for accidents for 3 residents (Resident 2, Resident 3, and Resident 4) of 3 residents residing on the COVID-19 unit. The facility identified a census of 45. Findings are: A. Interview on 7/8/20 at 8:20 AM with the DON (Director of Nursing) revealed the facility had a dedicated COVID-19 unit where newly admitted residents would be under isolation precautions for 14 days. The DON revealed all other areas of the facility were Green Zones (rooms designated for residents with no known exposure to COVID-19 and no symptoms). B. Observation on 7/8/20 from 10:00 AM - 10:40 AM of the designated COVID-19 Unit revealed the fire doors were closed, separating the COVID-19 Unit from

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

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.

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Interventions included information that Resident 4 used a front wheeled walker independently for ambulation and used the walker for transfers. Review of Resident 4's Care Plan dated 7/1/20 revealed Resident 4 had the potential for elopement related to dementia and wandering. Interventions included a Secure Care Bracelet to alert staff to Resident 4's movement. Review of Resident 4's Care Plan dated 7/1/20 revealed Resident 4 was at risk for falls, and the resident had 2 falls in 05/2020. Interventions included having staff check on the resident every 30 minutes and check if the resident needed to use the bathroom/make a clear pathway to the bathroom. H. Interview on 7/8/20 at 12:45 PM with the DON revealed the fire doors were closed 2 weeks prior due to being unable to prevent confused residents from other halls from wandering onto the COVID-19 unit.