STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285004	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Jane DE Chantal	2200 South 52nd Street Lincoln, NE 68506

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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. Licensed Reference Number 175 NAC 12-006.11(E)Based on observations, record reviews and interviews, the facility failed to ensure that the kitchen staff completed hand hygiene for 15 seconds and failed to ensure no cross contamination to prevent foodborne illness during meal preparation. This had the potential to affect 67 residents in the facility. The facility census was 80.Findings are:Observation of meal preparation on 01/06/2026 from 7:30 AM to 8:40 AM revealed the following:At 7:35 AM an observation of [NAME] D preparing the noon meal with gloves on puts all premeasured ingredients into a pot to cook and then mixes the hamburger, ground turkey into another pot and then takes soiled dishes to the dirty dish room. [NAME] D removed gloves and completed hand hygiene for 12 seconds, wipes sink, shuts off water and continued to dry hands with the same soiled paper towel. At 7:45 AM [NAME] F while preparing French toast with gloves on, picked up utensils and other items, then picked up French toast with the same soiled gloves on. [NAME] F removed gloves, completed hand hygiene and then wiped the sink and shut off the water with the same paper towels utilized to dry hands. At 8:00 AM [NAME] E while preparing eggs on the griddle with gloves on, cracked the eggs, touched the utensils and then poked the egg yolks on several eggs with the soiled gloved finger.At 8:05 AM [NAME] D added all premeasured dry ingredients in with the cooked meat mixture, washed hands for 15 seconds, wiped sink and shut off water with a paper towel that was then used to dry [NAME] D's arms. [NAME] D applied gloves and mixed the meat mixture by hand, with forearms touching the meat mixture and leaving visible tomato sauce on the cook's arm. The cook removed gloves and completed hand hygiene for 15 seconds, then uses the same paper towel to shut off the water and dry the cook's arms. Record Review of the facility policy titled Infection Prevention Hand Hygiene Procedure last revised 06/10/2025 revealed under number 2 that hand hygiene should be completed for 15 seconds and to not dry hands with the same paper towel used to turn off faucets. An interview on 01/06/2026 at 8:25 AM with the Production Manager (PM) confirmed that the cooks should not use soiled gloves to break egg yolks. An interview on 01/06/2026 at 8:26 AM with the Dietary Manager (DM) confirmed that hand washing should be longer than 10 seconds and that staff should not use the same paper towel to shut off water and wipe down sinks to dry their arms.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G)Based on observation, record review, and interviews, the facility failed to ensure informed consent was obtained before applying a physical restraint for 1 resident (Resident 2) of 1 sampled for restraints. The facility census was 80.Findings are:An observation on 01/06/2026 at 10:42 AM revealed Resident 2 wearing mitten restraints (padded, soft gloves used in healthcare to prevent patients-usually with a mental deficit-from pulling out vital tubes, such as tracheostomy [a surgically created hole in the neck to create an airway], catheter [a flexible tube inserted into the body to drain fluid, such as into the bladder to drain urine], or feeding tubes) on both hands.An observation on 01/06/2026 at 2:50 PM revealed Resident 2 resting on their back in bed with mitten restraints on both hands.An observation on 01/07/2026 at 7:25 AM revealed Resident 2 resting on their back on bed with mitten restraints on both hands.A record review of Resident 2's undated demographics sheet revealed that Resident 2 was admitted on [DATE].A record review of Resident 2's History and Physical (H&P) dated 09/30/2025 revealed the resident had diagnoses of respiratory failure, heart failure, obesity, difficulty swallowing, and encephalopathy (a change in brain function caused by injury or disease). Further review of the H&P revealed the resident had a tracheostomy, a catheter, and a feeding tube inserted into the stomach through the skin.A record review of Resident 2's Active Orders Report printed 01/06/2026 revealed the resident had an order for the following: Restraints, Medical. Agitation: YesImpulsive behaviors: YesImpaired judgement: YesMitt-Left: YesMitt-Right: YesMinimize risk for injury to self: YesInterference with treatment devices: YesStart: 1/5/2026 Stop: 1/6/2026PURPOSE OF RESTRAINT:; Minimize risk for injury to self DUE TO; Agitation; Impaired Judgement; Interference with treatment devices; Impulsive Behaviors TYPE OF RESTRAINT:; Mitt-Right; Mitt-LeftA record review of the Patient Orders (Displayed Orders) printed 01/08/2026 revealed that the order for restraint use was present when Resident 2 was admitted on [DATE].A record review of Resident 2's Comprehensive Care Plan (CCP-written instructions used to provide the resident with effective and person-centered quality care that meets professional standards) printed 01/06/2026 revealed the resident had a restraint care plan with a start date of 09/30/2025 to address the need for a physical restraint to prevent the resident pulling at the tracheostomy. Interventions for this care plan were to obtain signed consent before applying the restraint, and to fully inform the resident or family member of the risks and benefits of all options being considered, both with start dates of 09/30/2025.A record review of Resident 2's electronic health record revealed no evidence of the resident or family member being educated on the risks and benefits of restraint use, or of informed consent being obtained.A record review of the facility's Restraints procedure last reviewed 10/18/2023 revealed no mention of informed consent.An interview on 01/07/2026 at 3:03 PM with the Administrator (ADM) confirmed the facility did not have a consent form for the restraint.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to complete a new Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) for Resident 11 when new diagnoses were received. This affected 1 of 2 residents reviewed for PASARR completion. The facility reported a census of 80. Findings are:A record review of Resident 11's Face Sheet dated 01/08/2026 revealed the resident was admitted on [DATE].A record review of Resident 11's admission history and physical (H&P) dated 04/07/2020 revealed the resident had a diagnosis of depression. There was no mention of Post Traumatic Stress Disorder (PTSD)-a mental health condition triggered by experiencing or witnessing a traumatic event) or Intellectual Developmental Disabilities (IDD)-involves significant limitations in both intellectual functioning and adaptive behavior.A record review of Resident 11's Minimum Data Set (MDS - a standardized, federally mandated assessment tool used in nursing homes to comprehensively evaluate resident's health, functional abilities and needs), dated 10/08/2025 revealed a Brief Interview for Mental Status (BIMS -a quick 15-point cognitive screening tool used in healthcare to assess orientation, short-term memory and the BIMS assessment uses a point system that ranges from 0 to 15 points: 0 to 7 points indicates severe cognitive impairment; 8 to 12 points indicates moderate cognitive impairment; and 13 to 15 points indicates that cognition is intact) for Resident 11's score is a 15.A record review of Resident 11's PASARR dated 03/31/2020 revealed Resident 11 is a Level 1(a screening is used to identify if an individual has or suspected of having, a serious mental illness, IDD or condition related to IDD. A positive finding on Level 1 results in a Level 2 to be done.) no level 2 was required. A record review of Resident 11's PASARR dated 04/28/2020 revealed major depression with no level 2 required.A record review of a Psychiatric Progress Note dated 07/15/2022 revealed diagnoses of mild intellectual disability, post-traumatic stress disorder, and major depressive disorder.A record review of a diagnosis list dated 12/24/2025 revealed diagnoses of PTSD, IDD and Major Depressive Disorder were included.A record review of quarterly care plan (written instructions needed to provide effectiveness and person-centered care of the resident that meets professional standards of quality care)-dated 12/26/25 revealed no mention of moods, behaviors, IDD, or PTSD.A record review of the PASARR policy last revised 3/12/2024 revealed no guidance regarding receipt of new MI (Mental Illness) or IDD diagnoses.An interview with Resident 11 on 01/05/2026 at 11:40 AM revealed Resident 11 experienced trauma from the death of parents and grandparents. Resident 11 stated my father drank a lot and molested me during bath time."An Interview on 01/07/2026 at 10:30 AM with Registered Nurse (RN) MDS A confirmed that when a resident returns from a provider appointment the facility will obtain the office notes. RN MDS A will then add new diagnosis to the MDS, then a copy is given to the unit secretary where they then add the diagnoses to the face sheet.An interview on 01/07/2026 at 11:00 AM with SS-B confirmed that the facility did not know Resident 11 had new diagnoses of PTSD and IDD as of 07/15/2022. The SS-B further confirmed that a new PASSAR should have been done, and the diagnoses should have been added to Resident 11's care plan. An interview with RN MDS A on 01/07/2026 at 11:15 AM confirmed that they were not aware of a process to report new diagnosis and did not know with Resident 11's new dx on 07/15/2022 would trigger a new PASSAR or that it should have been care planned.An interview on 01/07/2026 at11:15 AM with RN MDS A is not aware of a process to report new diagnoses and did not know with Resident 11's new diagnoses that would trigger a new PASARR or that it should have been care planned. RN MDS A states that she does not know if the unit supervisor looks at consultation notes when resident returns from appointment. RN MDS A also confirmed that with a new diagnosis of PTSD/IDD it would be significant to obtain a new PASAAR and did not care plan the new diagnoses. An interview on 01/07/2026 at 11:25 AM with Licensed (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse (LPN) C revealed that the only information that comes back from an appointment is if there are any new orders or if they have a follow up appointment. LPN C confirmed that the unit secretary obtains any progress notes from any consultant appointments. LPN C also confirmed that leadership can add diagnoses or objectives to care plan.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to complete a Preadmission screening and resident review(PASARR)- that is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. A level 1 screening is a mandatory preliminary assessment for anyone entering a Medicaid certified nursing facility to quickly identify if they have a serious mental illness, Intellectual Disability, or Developmental Disability as defined by Medicaid. The facility failed to complete a PASARR for one (Resident 20) of two sampled residents. The facility census was 80.The findings are: Record review Resident 20's face sheet revealed admission date of 10/24/2025. Record Review of Resident 20's admission minimum data set (MDS) (is a standardized federally mandated assessment tool used in nursing homes to comprehensively evaluate the resident's health, functional abilities and needs) dated 10/19/2025 revealed the following: Section C showed a Brief Interview for Mental Status (BIMS) (is a 15-point cognitive screening tool used in healthcare to assess orientation, short-term memory, and recall, helping staff track changes in thinking learning and memory over time) revealed the resident's score was a 15, which indicated the resident was cognitively intact. Section D mood Patient Health Questionnaire -9 (PHQ 9) (self-report questionnaire for screening, diagnosing, and monitoring the severity of depression in adults by assessing symptoms over the past two weeks) showed the resident's score was a 1, indicating little depression. No other mood or behavior documented, Section GG showed the resident was dependent for all cares. Section A of the MDS revealed there was no documented PASARR in chart at this time. Section I revealed diagnoses of Arthritis, Anorexia, HTN, CKD, Weakness. Section N revealed Resident 20 is currently on antibiotics, opioids and antiplatelet.Record Review of Resident 20's care plan dated 10/24/2025 had no documentation of a PASARR being completed.Record Review of Resident 20's PASARR screening dated 12/07/2025 revealed a level 1 PASARR, that was completed after the resident went to the hospital and was readmitted to the facility.Record Review of policy Pre-admission screening and Resident Review last revised 03/12/2024 revealed that the admission team does the PASARR prior to admission to facility. This PASARR was not completed at time of admission [DATE].Interview on 01/06/2026 at 11:00AM with Social Service (SS)-B confirmed that Resident 20 was admitted on [DATE] with no completed PASARR.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 12-006.09(H)Based on observations, record review and interviews the facility failed to complete a wheelchair screening to ensure proper positioning for one (Resident 11) of one sampled resident. The facility identified a census of 80.Findings are: Record Review of Resident 11's Minimum Data System (MDS) (is a standardized, federally mandated assessment tool used in nursing homes to comprehensively evaluate resident's health, functional abilities and needs) dated 10/08/2025 reveled Section C Brief Interview for Mental Status (BIMS) (a quick 15-point cognitive screening tool used in healthcare to assess orientation, short-term memory and recall) Resident 11's score was a 15, indicating the residents cognition was intact. Section D of MDS revealed Resident 11 feels down, trouble sleeping, little energy, poor appetite, and trouble concentrating. The MDS also revealed a severity score of 10 on a Patient Health Questionnaire-9(PHQ-9) (which is a brief self-administered tool used for screening, diagnosing, and monitoring depression severity by asking for nine common symptoms) but revealed that there was no rejection of care, or behaviors to others. Section GG revealed that eating is independent(I), bed mobility rolling is independent, sit to lie is touch assist, sit to stand is dependent, transfers dependent, toileting is dependent. Section I revealed diagnoses of Heart Failure, Depression, Post Traumatic Stress Disorder (PTSD) and Orthopedic conditions. Section O revealed- No special programs or procedures. Section J revealed that Resident 11 receives scheduled pain medication, with no complaints of pain.An observation of Resident 11 on 01/05/2026 at 11:47 AM revealed Resident 11's buttocks are on the edge of the wheelchair cushion. The resident has complained that the resident is not comfortable in current wheelchair. The wheelchair arm rests are torn and that the metal wheel frame is dented. An observation of Resident 11 on 01/06/2025 at 9:30 AM propelling own wheelchair, leaning back in wheelchair, head on the top of the back rest, buttocks on the edge of wheelchair seat, and seat belt on for safety. An observation of Resident 11 on 01/07/2026 at 9:40 AM revealed the resident seated on edge of wheelchair cushion with feet down, seatbelt on tightly.An observation on 01/07/2026 at 1:35 PM revealed Resident 11 propelling self in wheelchair, not sitting upright, leaning back with head rested on back of back support, buttocks on the edge of wheelchair cushion and seat belt is on.An observation of Resident 11 on 01/07/2026 at 3:55 PM revealed Resident 11 sliding out of wheelchair and the seatbelt is holding Resident 11 in wheelchair. Resident 11 seat belt is so tight it is showing an indentation on Resident's abdomen. Resident 11 stated wheelchair is not comfortable. Resident 11 states I feel like I am sliding out of my wheelchair all the time.An observation of Resident 11 on 01/08/2026 at 9:25 AM observed buttocks on the front of wheelchair cushion and seat belt was secured tightly. A record review of an Outpatient of Physical Therapy (PT) evaluation from 02/18/2025 revealed no mention of evaluating Resident 11 for a new wheelchair.A record review of the facility inpatient division seating procedure, last revised 07/2024, revealed for a consult, states that if wheelchair is needed that a therapy consult should be placed prior to getting an order for a wheelchair evaluation. A record review of the facility inpatient therapy division seating and positioning specialist procedure, last revised 07/2024, revealed a new process for admission in the inpatient division but not for long term care division.An interview on 01/07/2026 at 1:45 PM with Licensed Practical Nurse(LPN) - C revealed that Resident 11 had fallen out of wheelchair on 08/14/2024 when volunteer staff pushed Resident 11 back from an activity without foot pedals on. LPN-C confirmed that when a resident complains of wheelchair issues, resident's get placed on a wheelchair clinic list that takes place every Tuesday. LPN-C confirmed that Physical Therapy is involved with wheelchair clinics.An Interview on 01/07/2026 at 2:42 PM with LPN-C confirmed that Resident 11 had not been seen in the wheelchair clinic.An interview on 01/07/2026 at 2:45 PM with Physical Therapist (PT)I confirmed that Resident 11 had not been evaluated at the wheelchair clinic that is performed every Tuesday in the facility.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify a history of trauma and failed to follow the recommended behavior therapy for 1 (Resident 11) of 1 sampled resident. The facility identified a census of 80.Findings are: An interview with Resident 11 on 1/05/2026 at 11:40 AM revealed that when the resident was asked if they had a history of trauma, the resident stated that the resident's father drank a lot and molested the me as a child. Record review of Resident 11's face sheet revealed the resident was admitted [DATE] with the following diagnosis, bilateral knee pain, osteoarthritis, heart failure. There was no mention of post-traumatic stress disorder (PTSD). Record review of Resident 11's admission history and physical dated 4/07/2020 revealed no diagnosis or mention of PTSD. Record review of Resident 11's preadmission screening and resident review (PASARR) (a process which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intellectual Disability) dated 03/21/2020 revealed the resident was a Level 1 indicating no serious mental illness or intellectual disability. Record Review of Resident 11's Minimum Data Set (MDS) (A federally mandated assessment used to identify cares for a resident) dated 10/8/2025 revealed the following: Section C, a Brief Interview Mental Status (BIMS)(is a screening tool help determine the resident cognition, a score of 15 being cognitively intact), the resident had a score of 15. Section D revealed that the resident 11 feels down, trouble sleeping, little energy, poor appetite, and trouble concentrating. The Patient Health Questionnaire (PHQ-2 to 9, a validated interview that screens for symptoms of depression. It provides a standardized severity score and rating for evidence of depressive disorder) the resident had a score of 10, which indicated moderate depression. Section GG revealed that the resident was dependent for transfers and toileting. Section I revealed a diagnosis of depression and PTSD. Section N revealed that the resident takes an antidepressant. Record Review of Resident 11's quarterly care plan dated 12/26/25 revealed a Quality-of-Life problem under mood and behavior that indicated that the resident was at risk for decreased quality of life, social interaction, and mood decline due to the history of severe degenerative joint disease to bilateral knees causing immobility, no mention of PTSD. Comments under this problem reflect that the resident gets frustrated and angry with the roommate, comments of feeling the resident would be better off dead, noted to throw temper tantrums, paranoid and delusional. Many notations of being agitated. According to the comments the resident was seen by psychiatry 5/5/2020 and was started on Lamictal 25 milligrams. On 2/26/2021 the resident Lamictal was increased and started on Ativan 1 milligram twice a day for anxiety. On 6/17/2022 revealed the Lamictal was increased to 50 milligrams at bedtime. On 9/1/2023 Lamictal was increased to 100 milligrams at bedtime. On 9/21/2023 the Lamictal was changed back to 50 milligrams (mg) at bedtime due to dizziness. On 3/06/2024 a note of the Resident being angry and agitated, on 11/13/2024 being irritable. On 2/06/2025 feeling socially isolated, this is documented again on 5/03/2025, 07/24/2025,10/09/2025 and 1/02/2026. Record Review of Resident 11's of psychiatric consultation dated 7/15/2022 revealed a new diagnosis (DX) of Intellectual Disability(ID) and PTSD with the recommendation for therapy for the resident's PTSD. Record review of Resident 11's psychiatric visit dated 12/16/2022 revealed the resident was still having periods of anxiety due to resident's past trauma. Record review of Resident 11's psychiatric visit dated 9/1/2023 revealed that the resident was still having issues with anxiety from resident's past trauma and issues with sleeping. An interview on 1/07/2026 at 10:30 AM with Registered Nurse (RN)A revealed that a new diagnosis of intellectual disability would trigger a new PASARR and care plan should have been updated. An interview on 1/07/2026 at 11:00 AM Social Services (SS) B revealed that the facility staff currently ask about trauma upon admission, but that practice did not start until September 2023, and Resident 11 admitted prior to this date. The SS-B confirmed that they were not aware of the new diagnosis of Intellectual disability and PTSD that resident received on (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/15/2022. The SS -B confirmed that a new PASARR should have been completed and the care plan updated. Record review of the facility policy titled Behavior Management and Modification, last revised 8/04/2025 does not mention trauma screening. An interview on 1/08/2026 at 8:45 AM with SS-B confirmed the trauma screen was never completed for Resident 11 and should have been.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to identify or provide recommended behavioral health services for 1 (Resident 11) of 1 sampled resident with a diagnosis of Post Traumatic Stress Disorder and Intellectual Disability. The facility identified a census of 80. Findings are: An interview with Resident 11 on 1/05/2026 at 11:40 AM revealed that when the resident was asked if they had a history of trauma, the resident stated that the resident's father drank a lot and molested me as a child. Record review of Resident 11's face sheet revealed the resident was admitted [DATE] with the following diagnosis, bilateral knee pain, osteoarthritis, and heart failure. There is no mention of post-traumatic stress disorder (PTSD). Record review of Resident 11's admission history and physical dated 4/07/2020 revealed no diagnosis or mention of PTSD. Record review of Resident 11's preadmission screening and resident review (PASARR) (a process which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intellectual Disability) dated 03/21/2020 revealed the resident was a Level 1, indicating no serious mental illness or intellectual disability. Record review of Licensed Mental Health Practitioner consultation note dated 04/09/2021 indicated no risk factors were identified for Resident 11. Record review of Resident 11's Minimum Data Set (MDS) (A federally mandated assessment used to identify cares for a resident) dated 10/8/2025 revealed the following: Section C, a Brief Interview Mental Status (BIMS) (is a screening tool to help determine the resident cognition, a score of 15 being cognitively intact), the resident had a score of 15. Section D revealed the resident 11 feels down, has trouble sleeping, has little energy, has a poor appetite, and has trouble concentrating. The Patient Health Questionnaire (a validated interview that screens for symptoms of depression. It provides a standardized severity score and rating for evidence of depressive disorder) revealed Resident 11 had a score of 10, which indicated moderate depression. Section GG revealed that the resident is dependent for transfers and toileting. Section I revealed a diagnosis of depression and PTSD. Section N revealed that the resident takes an antidepressant. Record Review of Resident 11's quarterly care plan dated 12/26/25 revealed a Quality-of-Life problem under mood and behavior that indicated that the resident was at risk for decreased quality of life, social interaction, and mood decline due to the history of severe degenerative joint disease to bilateral knees causing immobility, no mention of PTSD. Comments under this problem reflect that the resident gets frustrated and angry with the roommate, comments of feeling the resident would be better off dead, noted to throw temper tantrums, paranoid and delusional. Many notations of being agitated. According to the comments the resident was seen by psychiatry 5/5/2020 and was started on Lamictal 25 milligrams. On 2/26/2021 the resident Lamictal was increased and started on Ativan 1 milligram twice a day for anxiety. On 6/17/2022 revealed the Lamictal was increased to 50 milligrams at bedtime. On 9/1/2023 Lamictal was increased to 100 milligrams at bedtime. on 9/21/2023 the Lamictal was changed back to 50 milligrams (mg) at bedtime due to dizziness. On 3/06/2024 a note of the Resident being angry and agitated, on 11/13/2024 being irritable. On 2/06/2025 feeling socially isolated, this is documented again on 5/03/2025, 07/24/2025,10/09/2025 and 1/02/2026. Record Review of Resident 11's of psychiatric consultation dated 7/15/2022 revealed a new diagnosis (DX) of Intellectual Disability (ID) and PTSD with the recommendation for therapy for the resident's PTSD. Record review of Resident 11's psychiatric visit dated 12/16/2022 revealed the resident was still having periods of anxiety due to resident's past trauma. Record review of Resident 11's psychiatric visit dated 9/1/2023 revealed that the resident was still having issues with anxiety from resident's past trauma and issues with sleeping. An interview on 1/07/2026 at 10:30 AM with Registered Nurse (RN)A revealed they were not aware that a new diagnosis of Intellectual Disability would trigger a new PASARR and care plan should have been updated. An interview on 1/07/2026 at 11:00 AM with Social Services (SS) B (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that a new PASSAR should have been completed for Resident 11 and the care plan updated. Record review of Resident 11's progress notes from admission to 01/08/2026 revealed Resident 11 had anger, outburst towards staff and other residents, Resident 11's has a long history of depression and suicidal thoughts, and medication adjustments made over time. Resident 11 was seen by a psychiatrist in 2022 and there was a recommendation for therapy for newly Dx PTSD. No documentation that the facility implemented recommendation for therapy for Resident 11 due to new diagnosis of PTSD. Record review of behavior documentation by nursing for Resident 11 revealed the following:10/6/2025 - resident angry, impulsive, irritable.10/24/2025- anxious, behavior fluctuates, resident is getting upset easily stating I'm just going to my room to get out of everyone's way resident voice is harsher and more aggressive with conversations.11-11-25- agitated, anxious01-01-26- calm, cooperative, relaxed made no attempt to leave the unit remained in room all day Record Review of Electronic Medical Record (EMR) under mood and documentation revealed the following: 02/19/2023- verbally abusive, yelling03/16/2023 - rejection of cares, not listening to staff03/26/2023- wandering at 7:59 PM not listening to staff and socially inappropriate09/30/2024- socially inappropriate behavior12/31/2025- wandering through the facility An interview with SS-B on 01/08/2026 8:10 AM revealed that about a year and half ago, the facility started asking upon admission if a resident had a history of trauma. SS-B also verbalized that if a new diagnosis is identified during a resident's stay in the facility, the SS worker then does the trauma assessment that was added a year and a half ago. During the interview, the SS-B gave the surveyor a sheet of paper titled Trauma on the top of the page, with no date or facility identification to indicate this was a facility policy. Record review of the facility policy titled Behavior Management and Modification, last revised 8/04/2025 does not mention trauma screening. An interview on 1/08/2026 at 8:45 AM with SS-B confirmed the trauma screen was never completed for Resident 11 and should have been.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference Number 175 NAC 12-006.18Based on observations, record reviews, and interviews, the facility failed to ensure infection control practices related to hand hygiene (HH-cleaning the hands with soap and water or the use of an alcohol-based hand rub [ABHR] to help prevent the spread of infection) and use of personal protective equipment (PPE-special equipment, including gloves, gown, masks, and eye protection, worn to prevent exposure to hazards such as infectious materials) were followed during catheter (a flexible tube inserted into the body to drain fluid, such as into the bladder to drain urine) care for 1 (Resident 2) of 5 sampled residents for catheter care, and during wound care for 2 (Resident 2 and Resident 61) of 8 residents sampled for wound care. The facility census was 80.Findings are: A record review of the facility's Infection Prevention: Hand Hygiene policy last reviewed 06/04/2025 revealed that staff should use alcohol-based hand rub (ABHR) or wash their hands under the following circumstances: -before and after having any contact with a patient or patient environment, -after handling used dressings, catheters, linen or any patient care item, -after offering incontinence care or Foley (a type of catheter for draining urine) care, -before and after manipulating a feeding tube, -before and after emptying Foley catheter drainage bag or manipulating the catheter or the tubing, even if wearing gloves, -after contact with feces or open skin, -after handling items potentially contaminated with any patient's blood, excretions, or secretions, A record review of the facility's Use of Standard Precautions policy last reviewed 07/31/2025 revealed that Enhanced Barrier Precautions (EBP) refer to the use of gown and gloves during high contact resident cares to prevent the spread of Multi-Drug Resistant Organisms (MDRO). EBP should be followed during High Contact Care Activities. The policy referred the reader to the EBP Guidelines document. A record review of the facility's Enhanced Barriers Precautions Guidelines document updated 04/26/2024 revealed a table labelled Enhanced Barrier Precautions by Task. Further review of the table revealed: PPE needed for a full or partial bed bath was gloves and gown, PPE needed for changing bed linens if the resident was not in bed was gloves, and if the resident was in bed was gloves and gown. A record review of the facility's undated Standard Precautions Guideline revealed hand hygiene should be performed immediately after glove removal, and gloves should be changed frequently, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including when moving from a dirty to a clean task. A record review of the facility's Indwelling Urinary Catheter (IUC) Maintenance Guidelines last updated 06/29/2022 revealed in the instructions for peri/catheter care that staff should Follow proper catheter care procedure, hold tube next to body, clean the tubing starting at the body and wiping away from the body. A. A record review of Resident 2's undated demographics sheet revealed that Resident 2 was admitted on [DATE]. A record review of Resident 2's Active Orders Report printed 01/06/2026 revealed the resident had a history of MDRO and was on EBP. Further review revealed the resident had orders to care for a feeding tube (a tube placed through the skin into the stomach), a Foley catheter (a tube placed into the bladder to drain urine), an abdominal wound and wounds to the areas below the breast and the abdominal folds, and a tracheostomy (a surgically created hole in the neck to create an airway). An observation on 01/07/2026 from 11:00 AM to 11:36 AM revealed cares provided to Resident 2 by Registered Nurse (RN) G and Nurse Aide (NA) H. RN G and NA H were both wearing gowns and gloves. NA was rubbing lotion onto the resident's legs, and RN was cleaning the resident's abdominal wound. The RN, without changing gloves or performing HH washed and patted dry the feeding tube site, applied a new dressing, then changed gloves without performing HH. The NA changed their gloves with no HH, cleaned under Resident 2's left breast and armpit, changed gloves with no HH and got clean washcloths out of the resident's drawer. NA H, without changing gloves or performing HH, applied a cream to Resident 2's inner thighs, then changed gloves with no HH done. RN G patted the abdominal wound with a dry washcloth, then applied betadine to the area using swabs and changed gloves without performing HH. NA H cleaned below the resident's abdominal fold then began doing peri-care (washing the genitals and anal area) and catheter cares. The resident had been incontinent of feces, and the catheter tubing had feces on it. NA H cleaned the catheter tubing by holding the tubing and wiping it towards the resident's body. The NA then removed their gloves, did not perform HH, and got more clean washcloths, put on new gloves, then got the washcloths wet. RN G patted the area under Resident 2's left breast dry and applied a new dressing, then changed gloves without performing HH. The RN and NA then assisted Resident 2 to lie on their side. RN G continued cleaning Resident 2's buttocks and anal area. NA H removed their gloves, did not perform HH, went to get more washcloths wet, then put on new gloves. RN G changed gloves without performing HH, finished cleaning the resident's buttocks, changed gloves with no HH and positioned a disposable absorbent underpad under the resident. The RN and NA then positioned the resident on their back. RN G then wiped the resident's inner thighs with a damp washcloth. NA H changed gloves with no HH and held Resident 2's inner thighs and labia while the RN patted them dry. Without changing gloves, the RN and NA then used the ceiling lift to reposition the resident. NA H removed their gown and gloves, did not perform HH, then put on new gloves and no gown and repositioned a pillow and assisted to put on pressure relief boots for Resident 2. The NA's clothing did come into contact with Resident 2's gown during this process. RN G changed gloves with no HH, hooked up Resident 2's tube feeding. RN G and NA H both removed PPE and performed HH prior to leaving the resident room. An interview on 01/07/2026 at 11:40 AM with RN G confirmed that RN G and NA H should have performed hand hygiene with glove changes and did not. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 01/07/2026 at 11:40 AM with NA H confirmed that they should have wiped the catheter tubing away from the resident's body, put a gown back on before leaning over the resident to reposition the pillow and put on the boots, and should have performed hand hygiene with glove changes and did not. B. A record review of admission record for Resident 61 revealed that Resident 61 was admitted to the facility on [DATE] with the diagnosis of -Pyelonephritis, Right hip wound (Pyelonephritis is a severe kidney infection, while a right hip wound refers to an injury or surgical incision in the hip area. These conditions can potentially be linked, as severe deep-seated infections, can spread to adjacent structures, including the hip region) -Gangrene (the death of body tissue, typically in arms or legs, caused by a severe lack of blood flow (ischemia) or serious bacterial infection) -Pressure injury of sacral region, unstageable (injury is located at the tailbone, An unstageable pressure injury (sacral region) means full-thickness skin and tissue loss where the wound's true depth -Pressure injury of Left hip stage 2 (partial skin loss, appearing as a shallow open wound, blister, or scrape with a pink/red base, -Pressure injury of right hip state 4 (a severe, full-thickness wound extending into muscle, tendon, or even bone, characterized by deep, crater-like damage with visible bone/tissue, often with rolled edges, tunneling, pus, foul odor, and potential for serious infection) -Paraplegia (paralysis affecting the lower half of the body, including the legs, lower trunk, and pelvic organs, resulting from damage to the spinal cord in the thoracic, lumbar, or sacral regions) -Neuromuscular dysfunction of the bladder (a condition where nerve damage disrupts the communication between the brain and bladder muscles, preventing proper urine storage or emptying, leading to issues like incontinence, retention, urgency, or frequency, often seen with spinal cord injuries) A record review of Assessment and Interventions dated 12-17-17-2025 for the left hip pressure injury revealed for Resident 61 wound assessment- 12-17-2025 measurement for the left hip injury 2 with the length of 5cm, width of 1.8cm and depth of 1.4cm with undermining tunneling of 2.7cm and 2.8 cm exudate amount - light. A record review of Assessment and Interventions dated 12-17-2025 for the Right Hip injury stage 4 for Resident 61 revealed: Right hip stage 4 measurements:; Length 2.9cm, width 3 cm, and depth 0.4cm with exudate amount light A record review of Assessment and Interventions dated 12-17-2025 for the Coccyx full (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thickness/surgical, with measurements of length 1.6cm width 0.2 cm and depth 0.8cm. A record review of Nursing orders for Resident 61 revealed -left hip dressing change daily. Cleanse with soap and water, apply 3m no string skin prep, apply Vashe solution (used for cleaning, debriding, and moistening various wounds (cuts, burns, ulcers, scrapes) to create an optimal healing environment) moistened kerlix (cotton gauze bandage) to wound tucking into the tunneling, Cover with a 4x4 mepilex(soft silicone foam wound dressings) border dressing -Right hip dressing change 2 times a day. Cleanse with soap and water, moisten gauze with Vashe solution and lightly fill wound, cover with a ABD (is a large, highly absorbent gauze dressing used for heavily draining wounds) pad, tape to hold. -Coccyx dressing change 2 times a day. Cleanse with soap and water, apply a mepilex dressing An observation on [DATE]th 2025 at 11:10AM with Licensed Practice Nurse (LPN)-J revealed preparing to do dressing change on Resident 61. LPN-J gathered some abdominal pads from the supply room and put in their scrub top pocket. LPN -J did have on a face mask but did not put a gown on. LPN -J went into Resident 61's room with face mask and no gown and gathered the supply basket with dressings, packing strips, wound cleanser and tape that was in Resident 61's room. LPN -J put the dressing supplies on the bed with no barrier protection down. LPN -J then went into the bathroom and wet some wash clothes and put in a wash basin. LPN -J laid down the dry towel on the bed with no barrier protection. LPN -J did the Right hip ulcer wound first for Resident 61. LPN-J did apply gloves with no gown on and removed the dressing that had no drainage on the dressing. LPN-J then sprayed the wound cleanser into the wound and wiped with a wet wash cloth going over the wound back and forth twice with the same side of the wash cloth and then patted dry the wound with a towel. LPN-J did not perform hand hygiene or remove the gloves prior to placing the clean dressing to the right hip wound. LPN-J opened the abdominal pad and placed over the ulcer wound and put tape on each side of the abdominal pad. LPN-J then removed (gender) gloves and asked Resident 61 to roll onto the other side to be able to do the left hip ulcer. LPN-J then applied new gloves. LPN-J moved the catheter to the right side of the bed that had been on the left side of the bed. LPN-J did not change (genders) gloves after moving the catheter to the other side of the bed. LPN-J proceeded to remove the dressing from the left hip ulcer that had large amount of brown drainage on the dressing. LPN-J sprayed the wound cleanser on the wound and then took a wet wash cloth from the basin and proceeded to wash the wound with going back and forth across the wound 2 times with the same side of the wash cloth and then patted the wound dry with the same towel (gender) used for the right hip dressing change. LPN-J cut the packing strips applied the Vashe solution and packed the wound were it had started tunneling. LPN-J did not change gloves or wash hands after removing the soiled dressing. LPN -J put on a new Mepilex. LPN -J removed gloves. LPN-J did not wash hands. LPN -J applied new gloves to do the wound care on the coccyx. LPN-J removed the old Mepilex and sprayed the area with wound cleanser. LPN-J with a wet wash cloth wiped the area going back and forth x 2 and then patted the wound dry with the towel that was used for the right hip and left hip dressing change. LPN-J applied no sting skin prep to the coccyx and applied the Mepilex. LPN-J removed (genders) gloves. An interview on 11/5/26 at 11:45 AM with LPN-J confirmed that (gender) didn't change (genders) gloves in between dirty and clean of the dressing change between the right hip, left hip and coccyx wounds. LPN-J confirmed that (gender) should of changed gloves after moving the catheter from one (continued on next page)

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