STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285036	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eastmont	6315 O Street Lincoln, NE 68510

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on record reviews and interviews, the facility failed to ensure all orders that were prescribed by a medical practitioner for the use of oxygen when needed, were entered into the resident's Order Summary for 2 (Resident 5 and Resident 6) of the 6 residents sampled . The facility census was 19. Findings are: Record review of Resident 5's admission Record dated 04/14/2026 revealed that the resident was originally admitted to the facility on [DATE] with a diagnosis of a pulmonary embolism (a sudden and dangerous blockage of one of the lungs arteries caused by a blood clot). Record review of Resident 5's admission Orders dated 12/18/2025 revealed an order, signed by the resident's Primary Care Provider (PCP) for oxygen as needed to keep sats (blood oxygen saturation) 90%.Record review of Resident 5's Order Summary dated 12/30/2025 revealed no order for oxygen to be administered as needed to keep blood oxygen saturation at 90%. Record review of Resident 6's admission Record dated 04/14/2026 revealed that Resident 6 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD, a long-term lung disease that makes it hard to breathe due to lung damage). Record review of Resident 6's Compressive Care Plan (CCP, a document that includes measurable objectives and timelines to meet resident's medical, mental and psychosocial needs) revealed that the resident is at risk for respiratory distress and the goal is that the resident's oxygen saturation would remain above 88%. Record review of Resident 6's admission Orders dated 11/04/2025 revealed an order, signed by the resident's PCP for oxygen as needed to keep sats at 90%.Record review of Resident 6's Order Summary dated 11/25/2025 revealed no order for oxygen to be administered as needed to keep blood oxygen saturation at 90%. Record review of Resident 6's Weight and Vitals Summary revealed that on 02/18/2026 the resident's oxygen level was 82%. Record review of Resident 6's Progress Notes for 02/18/2026 revealed that at 7AM the resident's oxygen was 90%. The nurse reassessed the resident's oxygen at 9:30AM and it was 82%. No documentation that any supplemental oxygen was provided to the resident. Record review of the facility's policy titled Medication Administration with a reviewed date of 11/10/2025 revealed that the facility ensures that all medications are documented in accordance with the physicians' order. Interview with the Director of Nursing (DON) on 04/14/2025 at 5:13 PM revealed that all residents should have standing orders (pre-approved written instructions from a doctor that allows nurses to provide specific medications that are not regularly administered to the resident). The standing orders are obtained upon admission for each resident and if a resident transferred from a skilled (higher level of care) floor to a long-term care floor, the standing orders would transfer with them. The DON revealed that charts are not consistently reviewed to ensure that all orders are placed and available for the residents. The DON confirmed that it is the facility's expectation that every resident has standing orders available for administration in the resident's EMAR. Interview with the DON on 04/15/2026 at 8:46 AM confirmed that Resident 5 and Resident 6 had admission orders (standing orders) to administer oxygen as needed to keep oxygen at 90% but were not entered into Resident 5 and Resident 6's Order Summary and should have.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Licensure Reference Number: 175 NAC 12-006.09(H)(vi)(3) Based on record review and interview, the facility failed to ensure 3 (Residents 2, 6, and 8) of 6 sampled residents were provided with oxygen in accordance with physician orders. The facility had a total census of 19 residents. Findings are:Record review of Weights and Vitals Summary dated 03/28/2026 at 7:02 AM revealed that Resident 2 had an oxygen (O2) saturation (the percentage measurement of oxygen circulating in the blood) of 89% on room air (RA). Record review of Mayo Clinic definition of hypoxemia (low levels of oxygen in the blood) considers oxygen saturation values under 90% to be low (https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930). Record review of Resident 2's The Administration Record revealed Resident 2 had an order to apply oxygen to keep oxygen saturations greater than 90% as needed for decreased O2 saturations. Record review of Progress Notes dated 03/28/2026 charted by Registered Nurse (RN) revealed that 911 was called at 7:15 AM and Resident 2 left the facility at 7:41 AM. An interview on 04/14/2026 at 9:46 AM with Medication Aide (MA) revealed that they (MA) reported that Resident 2 had an O2 saturation of 89% to RN by phone call. MA reported that they remained with Resident 2 until RN arrived at the bedside. An interview on 04/15/2026 at 10:01 AM with RN confirmed that if a resident had an O2 saturation below 90% they would look oxygen order, call the doctor and request an order if there was not one, and administer oxygen. RN confirmed the location of oxygen and that it was readily available in the event it was needed. RN reported that MA called the nurse cell phone the morning of 03/28/2026 to report that Resident 2 had low blood pressure and an O2 saturation of 89%. RN confirmed that it took approximately three minutes to get to the Resident 2's room. RN confirmed that they assessed the resident, then went back to the office to make the phone call to 911 and print the paperwork. RN reported that they took the crash cart (a portable wheeled cart that contains necessary equipment used during critical care situations, including oxygen) to the outside of Resident 2's room, but 911 had arrived at that time. RN confirmed that they did not administer oxygen to Resident 2 per the physician's order and did not recheck the O2 saturation. Record review of Weights and Vitals Summary dated 02/18/2026 at 9:39 AM revealed that Resident 6 had an O2 saturation of 82% on RA. The admission Order dated 11/03/2025 revealed that Resident 6 had an order to apply oxygen as needed to keep O2 saturations above 90%. Record review of the Care Plan (a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) that was initiated 06/14/2022, revised 09/02/2025, with a target date of 02/14/2026 revealed that resident 6 was at risk for respiratory distress. The goal was that O2 saturations were to remain above 88% daily. Record review of Progress Notes dated 02/18/2026 charted by RN revealed that Resident 6 vomited and looked tired at 7:00 AM and O2 saturation was 90% on RA. At 9:30 AM, Resident 6 was noted to be lethargic (a general state of sluggishness, being tired) and their O2 saturation was 83% on RA. Record revealed that RN called the Power of Attorney (a person to look after one's affairs when they cannot manage due to mental incapacity or physical disability) and 911. Resident 6 left the facility at 9:58 AM. An interview on 04/14/2026 at 2:30 PM with Resident 6 and a family member confirmed that resident had influenza A (inflammation of the mucous membranes of the respiratory tract) and was sent out via 911. Resident 6 revealed that they were lethargic so they cannot remember if oxygen was put on them. Resident 6's family member stated that Resident 6's O2 saturation was 70%. An interview on 04/15/2026 at 10:01 AM with RN confirmed that they could not recall if oxygen was administered for Resident 6 and that it was unclear if any staff remained with the resident while waiting for 911 arrival. RN confirmed that they left the room for an unknown amount of time to obtain paperwork needed for transfer. RN confirmed that they should have put oxygen on first, make sure the resident were comfortable, then make phone calls. RN confirmed that the nurse's cell phone was always carried with them and that they had access to a portable computer if needed in emergency situations. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Progress Notes dated 02/18/2026 at 12:30 PM charted by RN revealed that Resident 8 had an O2 saturation of 88% on RA. A phone call was placed to the provider at that time. The Weights and Vitals Summary dated 02/18/2026 at 5:11 PM revealed that the O2 saturation was 89% on RA. Record review of Progress Notes dated 02/18/2026 at 6:07 PM revealed that Resident 8 was transferred via ambulance to the emergency department at 5:58 PM. An interview on 04/15/2026 at 9:44 AM with Resident 8 revealed that they were unable to recall if oxygen was administered prior to transferring to the hospital. Resident 8 confirmed that they were very sick and cannot remember what happened during that time. An interview on 04/15/2026 at 10:01 AM with RN confirmed that they called Resident 8's primary care provider to report their condition. During that phone call, RN confirmed they asked for an oxygen order. RN stated, I think I put oxygen on them that day, but I do not remember. RN confirmed that there was no documentation of oxygen being administered to Resident 8. An interview on 04/14/2026 at 1:05 PM with the Director of Nursing (DON) confirmed that the oxygen supply was on the fourth floor and an oxygen tank was on the crash cart at the nurses' station on the fifth floor. The oxygen tank at the nurses' station was checked monthly by the DON. The DON confirmed that oxygen is readily available for patient needs. An interview on 04/14/2026 at 5:13 PM with the DON revealed that it is their expectation that all orders are followed as written and that if a resident has an O2 saturation below 90%, they are to try deep breathing and rest. If it is still below 90%, then apply oxygen. An interview on 04/15/2026 at 8:46 AM with the DON confirmed with a record review that Residents 2, 6, and 8 all had O2 saturations documented below 90% and the facility nursing staff did not have oxygen applied prior to hospital transfer. The DON confirmed that the care plan goal to keep O2 saturations above 88% for Resident 6 was not met. DON further confirmed that the only training completed on oxygen is during new hire orientation, which included the facility's standing orders. Record review of RN revealed that they completed new employee orientation on 04/28/2022. Part of the orientation included education on the oxygen room, crash cart education and location, processes binder, processes for the charge nurse phone, orders and faxing, and the transfer out process.