

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Eventide Lincoln Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4720 Randolph 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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)Based on observations, record reviews, and interviews, the facility failed to ensure their medication error rate was less than 5%. There were 39 opportunities for error and five errors observed, for a total medication error rate of 12.82%. The facility census was 140. Findings are: A record review of the facility's Medication Administration and Storage policy dated 02/16/2026 revealed that medications will be considered as given at the correct time if administered one hour before or one hour after the scheduled time.</p> <p>A.</p> <p>An observation on 04/28/2026 at 8:52 PM revealed Medication Aide (MA) C administering the following medications to Resident 54:</p> <p>Pravastatin (a cholesterol medication) 10 mg (milligrams).</p> <p>A record review of Resident 54's Medication Administration Record (MAR) revealed an order for pravastatin tab 10 mg take 1 tablet by mouth every evening. The time scheduled for administration was 7:00 PM.</p> <p>An interview on 04/28/2026 at 8:54 PM with MA C confirmed that the Pravastatin was administered late.</p> <p>B.</p> <p>An observation on 04/28/2026 at 9:20 PM revealed MA C providing the following medications to Resident 78:</p> <p>LiquaCel (a protein supplement used to encourage wound healing) 30 cc (cubic centimeters); and</p> <p>Juven (a nutritional supplement used to encourage wound healing) 1 packet.</p> <p>A record review of Resident 78's MAR revealed an order for Liquacel + Juven two times a day 30 cc liquael [sic] mixed with 1 packet juven [sic] in 240 cc fluid of choice with morning and evening medication administration. The times scheduled for administration were 8:00 AM and 7:00 PM</p> <p>An interview on 04/28/2026 at 9:38 PM with MA C confirmed the LiquaCel and Juven were provided late.</p> <p>C.</p> <p>(continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation on 04/29/2026 at 7:37 AM revealed Licensed Practical Nurse (LPN) D administering the following medication to Resident 8:</p> <p>Humalog (a fast acting mealtime insulin used to control high blood sugars) Kwikpen (a multi-dose, prefilled, single-patient-use injection device used for insulin administration) 4 units injected subcutaneously (under the skin). The resident did not have a meal or other food at the time of administration.</p> <p>An observation on 04/29/2026 at 7:50 AM revealed Resident 8 did not have food.</p> <p>An interview on 04/29/2026 at 8:15 AM with LPN D revealed the LPN did not know how quickly food should be provided after giving fast acting insulin.</p> <p>An observation on 04/29/2026 at 8:18 AM revealed staff delivering Resident 8's meal tray.</p> <p>A record review of Resident 8's MAR revealed an order for Humalog KWPN [Kwikpen] inject 4 units subcutaneously before meals. The morning dose was scheduled for 7:00 AM.</p> <p>A record review of the facility's Insulin-Subcutaneous policy and procedure dated 02/16/2026 revealed no information about the timing of administration related to meals.</p> <p>A record review of the [NAME] Lilly Humalog Prescribing Information revised 01/2026 revealed that the medication should be given within 15 minutes before a meal or immediately after a meal.</p> <p>An interview on 04/29/2026 at 1:48 PM with the Director of Nursing (DON) confirmed that Humalog should be given within 15 minutes before receiving a meal or immediately after eating and that Resident 8's insulin was administered too long before the meal.</p> <p>D.</p> <p>During an observation on 04/28/2026 at 7:20 AM Medication Aide (MA-G a certified professional who safely administers routine medications in nursing homes, assisted living, and home care settings under nurse supervision). MA-G performed hand hygiene for 20 seconds, then verified medication with EMAR (electronic medication administration record is a digital, often mobile-enabled system that replaces paper record for documentation medication administration in healthcare facilities). MA-G administers Acetaminophen (over the counter analgesic and antipyretic drug to treat mild-to moderate pain) 500 milligrams 2 tablets orally every 6 hours (6 AM, 1200 PM, 6 PM, and midnight). MA-G administers Acetaminophen at 7:30 AM. MA-G is also unable to locate Ingrezza (a prescription medication used to treat adults with tardive dyskinesia characterized by uncontrollable movements) 80 milligrams 1 capsule orally daily. MA-G double checked the medication cart, also looked in the pharmacy reorder binder and confirmed the medication had not come in from the pharmacy. MA-G then reordered the medication.</p> <p>During an interview on 04/29/2026 at 11:00 AM MA-G confirmed that the scheduled Acetaminophen should have been given at 6 AM and not 7:30 AM.</p> <p>During an interview on 04/29/2026 at 11:58 AM with the DON (Director of Nursing) confirmed that Acetaminophen should have been given at 6:00 AM and not at 7:30 AM.</p>		