STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285057	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Lincoln Care Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.11(E), 12-007.01(A) Based on observations, record review and interview, the facility failed to ensure foods stored were not expired, had been sealed and dated when opened, and the facility failed to prevent cross-contamination between spices and the meat products. This had the potential to affect all residents who had meals from the kitchen. The facility census was 140. Findings are: A. An observation of the kitchen on 4/27/26 at 7:30 AM revealed: In the prep refrigerator -a bag of flour tortilla opened with no date on the bag and the bag had slits on the front of the bag -Caesar dressing opened with no date on the bottle. An observation of the freezer on 4/27/26 at 7:35 AM revealed: - a bag of sweet potatoes fries opened with no date and not sealed, - a bag of mixed vegetables opened with no date, - a bag of potatoes chunks with no date on it, - a bag of Broccoli opened not sealed with no date, -a bag of chopped onions with no date on it, - a bag of celery opened not sealed with no date, - a bag of carrots 2 bags opened not sealed with no date, -Frozen pasta [NAME] 2 bags open without dates, -Roselia Cesar shredded cheddar opened, no sealed, no date, An observation of the dry storage area on 4/27/26 at 7:45 AM revealed: -2 bags of hot dogs buns opened with no date, (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- a bag of Chinese noodles in sandwich bag with no date, -a bag of ritz crackers in sandwich bag with no date, -3 bags of noodles opened with no date, - a 25 lb. bag of carrot cake mix opened not sealed no date, - a bag of raspberry gelatin mix opened with no date, -Soy Sauce, 1 gallon, opened but not dated. A record review of the Storage Hierarchy with no date revealed: All foods must be covered, labeled, and dated. No prepared foods past 5 days, Resident meals 2 days. A record review of the Food Storage Guidelines with no date revealed: Any foods in the cooler that aren't labeled or dated need discarded immediately. 04/27/2026 8:51 AM An interview with the Nutrition and Culinary Director confirmed that (genders) expectations are that the cooks and kitchen staff open, seal and date items used and put pack in the refrigerator or freezer and it was not. The Nutrition and Culinary Director confirmed that there was expired foods in the dry storage area and there was food that had been opened and not dated or sealed and it should have been. The Nutrition and Culinary Director confirmed that (gender) was getting ready to box the expired items up and take to the food bank. B. Observation of the facility's frozen and refrigerated storage on 4/27/2026 at 7:35 AM revealed: Two bags of frozen pasta open without dates. A box with loose French fries spilled in the bottom but otherwise empty. An unsealed bag of chopped onion with no date. Two bags of opened carrots in unsealed bags with no date. A container of celery opened and not sealed without date. A box of sliced red onions with the bag opened and not dated. An opened container of shredded cheddar, not sealed, not dated. A box of broccoli, opened and not sealed, not dated. A bag of chopped potatoes opened but not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the facility's dry storage room revealed: Six 67-ounce [NAME] Traditional Jars expired 12/7/25. Seven cans of 14.5-ounce Hunts stewed tomatoes expired 4-25-25. Plus, one full box of 12 cans in package expired 4-25-25. [NAME] Hines Chewy [NAME] Brownie Mix 18.3-ounce expired 12-12-25. [NAME] Hines Devil's food cake 12 boxes oz 15.25-ounce expired 4-19-25. [NAME] Hines Butter [NAME] Cake mix 15.25 oz expired 12-18-26 x 5 boxes. Van [NAME] and Beans 15-ounce, 16 cans expired 11-7-24. Six Miracle Whip 12-ounce containers expired 4-22-26. Soy Sauce, 1 gallon, opened but not dated. Canned 11-ounce mandarin oranges expired 12-7-24, 1 loose plus full box of 24 expired 12-7-24. Three 33.8-ounce bottles of espresso syrup, expired 9/24. Four 25.1-ounce bottles of peppermint syrup, expired 9-19-25. Small box of Jello instant banana cream pudding expired. Case of small boxes of Jello instant chocolate pudding with many individual packages, all expired. Small box of Jello instant pistachio pudding 1 full case plus one single box all expired. Record review of facility's food Storage Hierachy policy (undated) revealed that all foods must be covered, labeled, dated and that foods that aren't labeled or dated need discarded immediately. Interview with Nutrition and Culinary Director (NCD-E) at 8:51 AM on 04/27/26 confirmed that all expired items need to be removed and that all opened items need to be rewrapped and dated.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Licensure Reference Number NAC 175 12-006.07(C) Based on interviews and record review, the facility failed to reevaluate and revise the plan of corrective action to prevent recurrence of past performance issues. This had the potential to affect all residents residing in the facility at the time of the survey. The facility census was 140. Findings are: A record review of the facility provided, undated Current List of Active Performance Improvement Plans (PIP's) on 4.27.2026 included Client Satisfaction, Skin/Wound Documentation, Psychotropic Medications, and Falls. A record review of the facility's Statement of Deficiencies dated 12.17.2024 revealed deficient practice areas including care planning, medication errors, and infection control practices. A record review of the Medication Administration facility task for the survey ending 4.30.2026 revealed a medication error rate of 12.82%, according to Centers for Medicare and Medicaid Services (CMS), the acceptable rate for medication errors is <5%. A record review of the facility citations for the survey ending 4.30.2026 revealed deficient practice including infection control, free of medication error rate, and develop/implement comprehensive care plan. During an interview on 4.30.2026 at 8:28 AM with the Quality Assurance/Infection Control Coordinator (QA/IFC Coord) it was confirmed the Quality Assurance (QA) committee reviews the facility's previous Plan of Correction (POC) for areas of improvement opportunities. It was also confirmed that care planning, medications errors, and infection control practices were previous deficient practices and continue to be a concern. During an interview on 4.30.2026 at 8:45 AM with the Executive Director (ED), it was confirmed the previous POC concerns relating to care planning, medication errors, and infection control had not been corrected and continue to be a facility issue.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **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. A. An observation on 04/28/2026 at 8:52 PM revealed Medication Aide (MA) C administering the following medications to Resident 54: Pravastatin (a cholesterol medication) 10 mg (milligrams). 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. An interview on 04/28/2026 at 8:54 PM with MA C confirmed that the Pravastatin was administered late. B. An observation on 04/28/2026 at 9:20 PM revealed MA C providing the following medications to Resident 78: LiquaCel (a protein supplement used to encourage wound healing) 30 cc (cubic centimeters); and Juven (a nutritional supplement used to encourage wound healing) 1 packet. 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 An interview on 04/28/2026 at 9:38 PM with MA C confirmed the LiquaCel and Juven were provided late. C. An observation on 04/29/2026 at 7:37 AM revealed Licensed Practical Nurse (LPN) D administering the following medication to Resident 8: 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. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/29/2026 at 7:50 AM revealed Resident 8 did not have food. 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. An observation on 04/29/2026 at 8:18 AM revealed staff delivering Resident 8's meal tray. 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. 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. 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. 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. D. 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. 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. 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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(i)(1)Based on record reviews, observations, and interviews, the facility failed to store medications securely for Residents 5, 7, 14, 26, 43, 54, 55, 78, 83, 96, 108, and 154; and the facility failed to ensure medication carts were kept locked when unattended. The facility census was 140.Findings are: A record review of the facility's Medication Administration and Storage policy and procedure dated 02/16/2026 revealed that medications should be stored in a designated and secured (locked) area. A. An observation on 04/28/2026 at 8:04 PM revealed Medication Aide C walked away from the medication cart with the cart unlocked and multiple medication cards, topical creams, and eye drops left on top of the cart. There were no other staff around the cart. A review of the medication cards, topical creams, and eye drops left unattended on the cart revealed the following list of medications and residents: Resident 5 Sertraline (an antidepressant) 25 mg (milligrams) tablets. One card containing 14 tablets. Memantine (a medication for dementia) 10 mg tablets. Two cards containing 14 tablets each. Resident 7 Omeprazole (a medication to reduce stomach acid) 20 mg capsules. One card containing 15 capsules. Resident 14 Memantine 10 mg tablets. Two cards containing 30 tablets each. Resident 26 Calmoseptine ointment (a cream used as a skin protectant and moisture barrier). One 4 ounce (oz) tube. Resident 43 Diclofenac 1% (a medication applied to the skin to treat pain). One 3.53 oz tube. Resident 54 Amlodipine (a medication for high blood pressure) 5 mg tablets. One card containing 14 tablets. Potassium (a supplement) 20 mEq (milliequivalent) ER (extended release) tablets. One card (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	containing 14 tablets. Resident 55 Eliquis (a blood thinner) 5 mg tablets. Two cards of 14 tablets each. Donepezil (a medication to treat confusion and memory loss) 5 mg tablets. One card containing 14 tablets. Resident 78 Metoprolol (a medication for high blood pressure) 25 mg ER tablets. One card containing 14 half tablets Multivitamin Men 50 (a multivitamin designed for men over 50) tablets. One card containing 14 tablets. Pantoprazole (a medication to reduce stomach acid) 40 mg tablets. One card containing 14 tablets. Atorvastatin (a cholesterol medication) 40 mg tablets. One card containing 14 tablets. Metformin (a medication to control blood sugars) 500 mg tablets. Two cards containing 28 tablets each. Duloxetine (an antidepressant) 60 mg capsules. One card containing14 capsules. Tamsulosin (a medication used to treat symptoms of an enlarged bladder, such as difficulty urinating) 0.4 mg capsules. One card containing 14 capsules. Sitagliptin (a medication to control blood sugars) 100 mg tablets. One card containing 14 half tablets. Melatonin (a medication to help with sleep) 1 mg tablets. One card containing 14 tablets. Midodrine (a medication for low blood pressure) 5 mg tablets. One card containing 30 tablets. Pregabalin (a medication used to treat nerve pain) 25 mg capsules. One card containing 42 capsules. Olopatadine (treatment for itching eyes) 0.1% eye drops. One 5 ml (milliliter) bottle. Dorzolamine/timolol (used to lower high pressures in the eyes) 2-0.5% eye drops. One 10 ml bottle. [NAME] tears (treatment for dry eyes) 0.5% eye drops. One 15 ml bottle. Latanoprost (used to lower high pressures in the eyes) 0.005% eye drops. One 125mcg(microgram)/2.5mL bottle. Brimonidine (used to lower high pressures in the eyes) 0.2% eye drops. One 10 ml bottle. Resident 83 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Alendronate (a weekly medication used to increase bone density) 70 mg tablets. One card containing 4 tablets. Refresh Plus (treatment for dry eyes) 0.5% eye drops. One box of 30 single use vials, 0.01 fluid oz each. Resident 108 Pantoprazole 40 mg tablets. One card containing 14 tablets. Eucerin Skin Cream Calming (a moisturizing skin cream). One 8 oz tube. Resident 154 Amlodipine 2.5 mg tablets. One card containing 14 tablets. Solifenacin (a medication used to treat bladder problems) 5 mg tablets. One card containing 14 tablets. An interview on 04/28/2026 at 8:20 AM with MA C confirmed they should not have left the medication cart unlocked and unattended and further confirmed they should not have left medications on top of the medication cart unsecured and unattended. B. An observation on 04/28/2026 at 6:27AM revealed an unattended medication cart that was unlocked and accessible to residents on the first-floor resident hallway until 6:31AM. An observation on 04/28/2026 at 10:19AM revealed Medication Aide- I (MA-I) walked away from the medication cart, left it unattended, and entered a patient room. The cart was unlocked and unattended on the first-floor hall until 10:22AM, MA-I returned to lock the cart and walked away. An interview with MA-I at 10:26AM confirmed that they left the medication cart unlocked and unattended. They confirmed that the expectation was that the medication cart should not be left unlocked and unattended. They revealed that there are controlled medications (controlled medications carry a risk of misuse and dependence) locked within the medication cart that should be double locked. An interview on 04/29/2026 at 7:13AM with Licensed Practical Nurse-J (LPN-J) confirmed that the expectation when leaving the medication cart unattended was to lock the cart, close the screen or put in privacy mode, not leave any medications sitting out, and hide all confidential information. They confirmed controlled medications were locked in a locked box within the medication cart. An interview on 04/29/2026 at 7:40AM with Resident Care Manager-H (RCM-H) confirmed that their expectation of the medication cart when left unattended, was to be locked with no medications on top, the screen should be down and minimized with no patient information visible. Record review of Policy and Procedure: Medication Administration and Storage revealed that medications would be stored in a designated and locked area. Controlled substances would be locked (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in a permanently fixed compartment and double locked. C. Record review of Resident 96's electronic medical record revealed that they were admitted to the facility on [DATE] with diagnoses of encephalopathy (a disorder impacting brain function which may lead to altered mental status), epilepsy (a disorder of the brain causing seizures due to abnormal electrical activity in the brain), acute kidney failure (a sudden loss of kidney function), hypertensive heart disease with heart failure (a heart condition caused by high blood pressure) and sleep apnea (a disorder characterized by interruptions in breathing during sleep). Observation of Resident 96's room on 04/27/2026 at 8:40 AM revealed that 4 medications were left on his bedside table: Mupirocin ointment Brimonidine eye drops Latanoprost eye drops Dorzolamide eye drops During this observation, it was noted that no lock box for medication storage in a resident room was found in Resident 96's room. During interview of Resident 96 at 8:40 AM, they stated that they do not self-administer their own medications and did not know why those (pointing toward medications) were left in the room. Observation of Resident 96's room at 1:25 PM on 04/27/2026 revealed Dorzolamide 10mg eye drops remained in box at bedside but the other 3 medications previously laying on bedside table were no longer present. Observation of Resident 96's room at 2:45 PM revealed that Dorzolamide eye drops remained on bedside table. Record review of Resident 96's physician orders on 04/27/26 at 3:15 PM revealed no order for or assessment for self-administration of medications. Self-administration of medications was not included in the baseline care plan. Resident 96's initial Minimum Data Set (MDS, a comprehensive assessment used in Long-term care facilities to evaluate residents' needs) was not complete at time of record review. A Brief Interview for Mental Status (a tool to evaluate cognitive function) is included on the MDS but the result of this evaluation was not available at time of record review. Record review of facility's Medication Self Administration policy, dated 02/16/2026, revealed that that residents should be assessed to determine if they desired to self-administer medications and are able to fulfill the policy criteria. If a resident was able to qualify for medication self-administration, a lock box would be provided for the medications to be stored in their room. Record review of Resident 96's electronic medical record did not reveal that Resident 96 had received an evaluation for self-administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility's Medication Administration and Storage policy, dated 02/16/2026, revealed that medications will be stored in a designated and secure area. Observation of resident 96's room on 04/29/26 at 7:20 AM revealed that 3 medications were left on the bedside table (Mupirocin ointment, Brimonidine eye drops and Latanoprost eye drops). A vial of Dorzolamide eye drops was on the floor between bed and nightstand. No lockbox for Resident 96's medications was observed in the room. Observation of Resident 96's room on 4/29/26 at 8:35 AM revealed that 4 medications (Mupirocin ointment, Brimonidine eye drops and Latanoprost eye drops and Dorzolamide eye drops) were found on the bedside table. Interview with LPN-J on 4/29/26 at 8:35 AM confirmed Resident 96 does not self-administer medications. LPN-J also confirmed that these medications should be locked up in the medication cart. At this time, LPN-J was observed removing the 4 medications from Resident 96's room and locking them in the medication cart.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC St. 71-6022(2) Based on record review and interview, the facility failed to notify the Ombudsman (an independent official who investigates complaints against organizations-typically government agencies or specific industries like healthcare-to resolve disputes and protect rights) of the hospitalizations on 2/8/26, 3/9/26, 4/4/26 and 4/17/26 for Resident 123, and 2/27/2026 for Resident 5, out of 28 residents sampled. The facility census was 140. Findings are: Findings are: A. A record review of the Clinical Census for Resident 5 revealed an admission date of 12.15.2025. A record review of Resident 5's Minimum Data Set (MDS) (this comprehensive assessment evaluates each resident's functional capabilities) with a target date of 3.10.2026 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident had moderate cognitive impairment. A record review of the Clinical Census for Resident 5 revealed a Hospital Leave on 2.27.2026. A record review of the progress note for Resident 5 dated 2.27.2026 at 9:49 PM revealed Resident 5 was transferred to the hospital for further evaluation due to a fall. A record review of the Policy and Procedure Notice of Transfer or Discharge dated 2.16.2026 revealed: the notice of transfer or discharge will include the name, address, and telephone number of the State Long-Term Care Ombudsman (an independent official, appointed by the government, corporations, or organizations, who investigates, mediates, and resolves complaints from individuals regarding unfair treatment, administrative failures, or policy violations) During an interview on 4.29.2026 at 2:02 PM with the Director of Nursing (DON) confirmed the State Long-Term Care Ombudsman was not notified of Resident 5's transfer to the hospital on 2.27.2026 and should have been. B: A record review of the admission Record with the printed date of April 29th 2026 revealed that Resident 123 was admitted to the facility on [DATE] with the diagnosis of Acute Chronic Systolic Congestive Heart Failure (causes fluid backup (congestion) in the lungs and body, resulting in fatigue, shortness of breath, and swelling), Acute Kidney Failure (a sudden, often reversible, loss of kidney function), Hypotension (abnormally low blood pressure) , Anxiety Disorder (health conditions characterized by excessive, persistent fear or worry that interferes with daily life) , and Shortness of Breath (sensation of not being able to get enough air). A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated Feb. 19, 2026 revealed Resident 123 had a BIMS (Brief Interview for (continued on next page)

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Eventide Lincoln Care Center	4720 Randolph Street Lincoln, NE 68510

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 15. A record review of the Progress notes revealed that Resident 123 was admitted to the hospital on [DATE] for Acute heart failure, 3/9/26 for Congestive Heart Failure, 4/4/26 for renal failure and 4/17/26 for chest pain and low blood pressure. A record review of the February 26 and March 26th of notification to the Ombudsman revealed that in the month of February and March there was no notification of Resident 123 being discharged to the hospital. A record review of eventide Policy and Procedure Notice of Transfer or discharge date d 2.16.26 revealed: 3)The notice of Transfer or Discharge will include the following: The name, address, and telephone number of the State Long-Term Care Ombudsman. An interview on 4/29/26 at 7:06 AM with the Director of Nursing confirmed that the facility was unable to locate a notification to the Ombudsman for the discharge to the hospital for Resident 123 on 2/8/26, 3/9/26, 4/4/26 and 4/17/26 and the Director of Nursing confirmed that the Ombudsman should of been notified of the discharges to the hospital for Resident 123.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.09C1a Based on observation, interview, and record review; the facility failed to ensure the baseline care plan (BCP, a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission) had interventions to address healthcare needs for Resident 125 who had an indwelling suprapubic urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage. The tube is inserted into the bladder through a hole in the lower abdomen) This failure had the potential to affect 1 of 2 sampled residents recently admitted to the facility. The facility census was 147. Findings are: An observation and interview on 04/27/2026 at 07:48AM revealed Resident 125 in their room with a catheter present hung at the side of their chair. They reported that they had a suprapubic catheter for many years due to medical reasons. Record review of the Order Summary Report (a listing of the physician orders for a resident) dated 04/28/2026 for Resident 125 revealed that Resident 125 admitted to the facility on [DATE]. Diagnoses included neuromuscular dysfunction of bladder (occurs when nerve damage from diseases or injuries interrupts signals between the brain, spinal cord, and bladder muscles, causing loss of control, urinary retention, or overactive bladder symptoms) and presence of urogenital implants (medical devices surgically inserted to treat urinary incontinence or structural issues in the genitourinary system). Record review of the admission Orders dated 04/21/2026 revealed that the resident did not have an indwelling urinary device on admission and no orders were placed at that time. Record review indicated that an MDS had not been completed due to Resident 125 being newly admitted . Record review of the Care Plan Report of the BCP revealed that there was no information indicating that Resident 125 had an indwelling urinary device. Review of the Policy and Procedure: Catheter- Suprapubic revealed that the care plan must include the type of catheter and the indication for use. An interview on 04/29/2026 at 2:08PM with the Director of Nursing (DON) confirmed that the BCP did not indicate that Resident 125 had a catheter present on admission. They confirmed that Resident 125 did have an indwelling suprapubic catheter in place upon admission and it was not documented in the BCP but should have been.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Licensure Reference Number 175 12- 0006.09(E) (iii) Based on observations, interviews, and record review, the facility failed to care plan the services that are provided to attain or maintain the resident's highest practicable well-being for two residents (Resident 16 and Resident 110) out of eight residents sampled. The facility census was 140 at the time of the survey. Findings are: A. A record review of Resident 16's Minimum Data Set (MDS) (this comprehensive assessment evaluates each resident's functional capabilities) with a target date of 2.15.2026 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. An observation on 4.27.2026 at 10:24 AM revealed Resident 16 with an oxygen nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen to people with breathing conditions), and a nebulizer machine (a medical device that converts liquid medication into a fine mist for direct inhalation into the lungs) at the bedside. During an interview on 4.28.2026 at 7:50 AM with Medication Aide (MA-K), it was confirmed that Resident 16 received nebulizer treatments and oxygen therapy. A record review of Resident 16's medical diagnosis revealed a history of COVID-19, Obstructive Sleep Apnea (a serious sleep disorder where throat muscles excessively relax, causing airway collapse and repeated breathing interruptions during sleep), and anxiety. A record review of Resident 16's Clinical Physician Orders with a print date of 4.28.2026 at 6:25 AM revealed orders for inhalation therapy (delivers medication directly to the lungs). A record review of the Care Plan (a mandatory, individualized document detailing a resident's medical, physical, and emotional needs, along with specific interventions to address them) with an admission date of 2.9.2026 for Resident 16, did not include a focus area for respiratory care, including the nebulizer machine and oxygen therapy. During an interview on 4.28.2026 at 10:54 AM with the Director of Nursing (DON) confirmed that Resident 16's respiratory orders, nebulizer treatments, and oxygen therapy is not a focus area on the care plan and should be. B. Record review on 04/29/2026 at 7:44 AM of Resident 110's admission record revealed an admission date of 03/04/2024. Record review on 04/29/2026 at 7:45 AM of Resident 110's diagnosis record revealed the following diagnosis: chronic pain, age related osteoporosis with out a current pathological fracture, and unspecified kyphosis (forward rounding of the upper back (thoracic spine) exceeding 50 degrees often (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called hunchback, causes range from poor posture and abnormal vertebral development to osteoporosis related fractures, injuries or birth defects. Record review on 04/29/2026 at 7:50 AM Resident 110's Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 02/19/2026 revealed a Brief Interview for Mental Status (BIMS-a screening tool used to assess cognition relating to the mental process involved in knowing, learning, and understanding things. The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points indicates severe cognitive impairment; 8 to 12 points indicated a moderate cognitive impairment; and 13 to 15 points indicates that cognition is intact) Resident 110's score was a 13. During an observation on 04/27/2026 at 12:36 PM revealed Resident 110 was sitting in recliner and was unable to hold head up straight, Resident 110's neck was leaning on the left shoulder. During an observation on 04/28/2026 at 9:45 AM it was revealed Resident 110 was awake, sitting in recliner, feet are elevated, no complaints of pain and head was leaning on left shoulder with a soft pillow behind head. During an observation on 04/28/2026 at 2:05 PM revealed Resident 110 was sleeping in recliner with gown on and neck was resting on left shoulder. In an interview on 04/29/2026 at 12:10 PM with Resident 110 confirmed that holding (gender) head upright can be tiring. Resident 110 further confirmed how long it had been since having therapy. During an observation on 04/29/2026 at 12:29 PM Resident 110 was propelling self in wheelchair with Resident 110's head leaning on left shoulder. Record review on 04/29/2026 at 12:55 PM of care plan last revised on 02/02/2026 that the facility had not care planned about Resident 110's positioning of neck or interventions to assist with neck positioning. Record review on 04/30/2026 at 7:07 AM of physical therapy notes dated 12/21/2025 revealed that physical therapy had provided Resident 110 with strengthening interventions to do on [gender]'s own. In an interview on 04/29/2026 at 12:37 PM with the Director of Nursing (DON) confirmed that Resident 110 has had therapy, and that facility should have care planned how Resident 110 positions neck with a diagnosis of kyphosis and interventions put in place to assist Resident 110 with proper neck positioning.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10 Based on record review and interview, the facility failed to ensure Physicians orders were followed for one (Resident 9) of 3 sampled residents. The facility census was 140. Findings are: A record review of the admission Record with the printed date of 4/27/26 revealed that Resident 9 was admitted to the facility on [DATE] with the diagnosis of Bipolar (a chronic mental health condition characterized by intense, fluctuating mood shifts, including extreme highs (mania/hypomania) and severe lows (depression), Type 2 diabetes (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) , Essential tremors (involuntary, rhythmic shaking, most commonly in the hands during movement), Post-Traumatic Stress disorder (condition triggered by experiencing or witnessing terrifying events, such as assault, disasters, or combat), Attention-Deficit hyperactivity (characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning), Atherosclerotic Heart Disease of Native coronary artery without Angina Pectoris (where plaque builds up in the heart's original arteries without causing chest pain). A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's functional capabilities) dated January 29th 2026 revealed a BIMs (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) for Resident 9 a BIMs score of 15 meaning cognitive intact.A record review of Physicians Visit Record dated 2/25/26 revealed that the physician ordered Quetiapine (antipsychotic medication used to treat schizophrenia, bipolar disorder, and major depressive disorder) 200mg at bedtime to be reduced to Quetiapine 100mg at bedtime for Resident 9 and was noted off by the nurse showing that the nurse completed the order.A record review of the Pharmacist's Recommendation to Prescriber dated 3/18/26 revealed the pharmacy recommendation was to reduce Quetiapine 200 mg at bedtime. A note from the physician written on the Pharmacist's Recommendation to Prescriber form revealed attached is an order from 2/25/26 that was not initiated with the reduction of Quetiapine from 200 mg to 100 mg.A record review of the Medication Record dated February 2026 revealed that Resident 9 received Quetiapine 200mg on Feb. 25, 26, 27, and 28th at bedtime.A record review of the Medication Record dated March 2026 revealed that Resident 9 received Quetiapine 200 mg on March 1, 2, 3 ,4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24,and 25th.A record review of the Medication Record dated March 2026 revealed that Resident 9 was not started on the Quetiapine 100mg till March 26th.An interview on 4/29/26 at 12:12 PM with the Director of Nursing confirmed that the Physicians' orders had not been followed for Resident 9 and the physicians orders should have been followed for Resident 9. The Director of Nursing confirmed that there were no policy and procedure per say when taking off Physicians orders. The Director of Nursing confirms that the nurse has a form called Physicians Visit Record that has a place where pharmacy, care plan, and computer should be marked when completion of the orders and they had not been marked as completed by the nurse for Resident 9.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 12-006.09D3(1) Based on observation, interview, and record review the facility failed to ensure an active physician's order for the continued use of an indwelling suprapubic urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage. The tube is inserted into the bladder through a hole in the lower abdomen) and associated maintenance care was established for 1 (resident 125) of 1 resident reviewed. The facility census was 147. Findings are: An observation and interview on 04/27/2026 at 07:48AM revealed Resident 125 in their room with a catheter present hung at the side of their chair. They reported that they had a suprapubic catheter for many years due to medical reasons. Record review of the Order Summary Report (a listing of the physician orders for a resident) dated 04/28/2026 for Resident 125 revealed that they admitted to the facility on [DATE]. Diagnoses included neuromuscular dysfunction of bladder (occurs when nerve damage from diseases or injuries interrupts signals between the brain, spinal cord, and bladder muscles, causing loss of control, urinary retention, or overactive bladder symptoms) and presence of urogenital implants (medical devices surgically inserted to treat urinary incontinence or structural issues in the genitourinary system). Record review of the Order Summary Report dated 04/28/2026 of active orders for Resident 125 revealed no order for the use of a suprapubic urinary catheter or associated maintenance care. An order for as needed (PRN) dressing changes to the suprapubic insertion site active 04/21/2026 was noted. Record review of the admission Orders dated 04/21/2026 revealed that the resident did not have an indwelling urinary device on admission and no orders were placed at that time. Record review indicated that an MDS had not been completed due to Resident 125 being newly admitted . Record review of the Care Plan Report of the baseline care plan (a plan of care for the resident that includes the minimum information needed to provide effective, person-centered care immediately upon admission) revealed that there was no information indicating that Resident 125 had an indwelling urinary device. Record review of Policy and Procedure: Catheter- Suprapubic revealed that the care plan must include the type of catheter and the indication for use. The electronic treatment administration record (eTAR- an electronic system for documenting or authorizing patient care) entries would be in place for any procedure related to the catheter (irrigation, other treatments ordered, discontinuation). A provider order was needed to replace a suprapubic catheter and would be changed PRN, the drainage bags would be changed every two weeks and PRN. An interview on 04/29/2026 at 07:40AM with Resident Care Manager-H (RCM-H) confirmed that Resident 125 did not have an order for their suprapubic catheter or any associated maintenance care. An interview on 04/29/2026 at 02:08PM with Director of Nursing (DON) confirmed that the Baseline Care Plan and admission Orders did not indicate that the resident had a catheter present on admission. They confirmed that the resident did have a catheter in place upon admission. They confirmed that Resident 125 did not have any physician orders for continued use of an indwelling suprapubic urinary catheter or associated maintenance care.

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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 12-006.18(B)(D) Based on observations, interviews and record reviews, the facility failed to ensure proper hand hygiene was completed, glove use during wound care for Resident 6, medication administration for Resident's 54 and 78, and failure to store C-pap(continuous positive airway pressure machine is the primary treatment for obstructive sleep apnea using a mask and steady airflow to keep airways open) to prevent cross contamination for 4 out of 4 sampled resident's. The facility census was 140. Findings are: A. Record review of Resident 96's electronic medical record reveal that they were admitted to the facility on [DATE] with diagnoses of encephalopathy (a disorder impacting brain function which may lead to altered mental status), epilepsy (a disorder of the brain causing seizures due to abnormal electrical activity in the brain), acute kidney failure (a sudden loss of kidney function), hypertensive heart disease with heart failure (a heart condition caused by high blood pressure) and sleep apnea (a disorder characterized by interruptions in breathing during sleep). Observation of Resident 96's room on [DATE] at 8:40 AM revealed that Continuous Positive Airway Pressure or CPAP (a device that delivers continuous air pressure to help individuals with sleep apnea breathe more easily during sleep) tubing and mask were on the floor and under edge of bed. Tubing was not dated. Observation of Resident 96's room at 10:15 AM revealed that CPAP remained on the floor at edge of bed. Interview of Resident 96 at 10:15 AM revealed that Resident 96 does not store CPAP equipment on the floor at their home. Record review on [DATE] at 12:30 PM revealed that CPAP was ordered at the time of admission. Observation of Resident 96's room on [DATE] at 10:00 AM revealed that CPAP equipment is laying on bedside table. Interview of resident 96 at 10:00 AM regarding the placement of the CPAP facemask and tubing, revealed statement at least it is not on the floor. Observation of Resident 96's room on [DATE] at 07:20 AM revealed that CPAP equipment is on floor, pieces had separated and were laying under the bed. Interview of resident 96 at 7:20 AM revealed that it came apart last night and I couldn't fix it. When asked if they called for assistance with the device, Resident 96 stated no, staff never help me with it. Observation of Resident 96's room at 8:35 AM revealed that CPAP remained on the floor. Interview with Charge Nurse (LPN-J) at 8:35 AM on [DATE] revealed that staff are supposed to wash the CPAP chamber each day. LPN-J states that after washing, the equipment is left to dry on a paper towel on the bedside table. LPN-J was asked how the equipment should be stored after drying. LPN-J confirmed that CPAP equipment should not be stored on the floor and further stated that this CPAP equipment should be stored in a bag at the bedside. LPN-J added comment that several of the equipment bags for residents on Unit 1 are missing. LPN-J further stated that they would work on getting those today. Record of Resident 96's Medication and Treatment Administration Records review on [DATE] at 1:00 PM revealed that nursing staff had signed that CPAP was applied to Resident 96 every evening at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedtime. Record review of baseline care plan at 1:00 PM revealed that CPAP is not included on the document. The facility's Policy on Care Plans, dated [DATE], states that the baseline care plan must include the minimum healthcare information necessary to properly care for the resident, including physician orders and clinical monitoring and treatment. This policy further states that the baseline care plan will include a summary of any services/treatments to be administered by the facility. Interview with Director of Nursing (DON) on [DATE] at 1:05 PM regarding training for respiratory therapy and ensuring that staff providing respiratory therapy services have received training to ensure competency revealed that DON stated that all information available had already been provided to a fellow surveyor. This information, training on administration of oxygen, provided to facility staff in [DATE] did not address provision of respiratory therapy, including CPAP administration. However, the training document did state that tubing must be kept off the floor and that tubing must be labeled. DON did not produce any documentation regarding which staff have been trained and were competent to provide respiratory therapy. Observation of Resident 96's room on [DATE] at 2:15 PM revealed that CPAP mask was now laying on resident 96's bedside table but tubing was not dated. B. Record review on [DATE] at 1:30 PM revealed Resident 6 was admitted on [DATE] and is a DNR (order is a legally binding medical document instructing healthcare professionals not to perform CPR (cardiopulmonary resuscitation if a patient's heart stops or they stop breathing). Resident 6's BIMS (brief interview for mental status used in nursing homes and post- acute care to evaluate a resident's cognitive function specifically attention, orientation or memory. Scoring interpretation 13-15 cognitively intact, 8-12 moderately impaired, 0-7severely impaired), Resident 6's BIMS score was a 14. Resident 6's active diagnosis revealed an admission for a displaced comminuted fracture of the shaft to right tibia, with a subsequent encounter for closed fracture malunion. During an observation on [DATE] at 9:40 AM Licensed Practical Nursing (LPN-B) gathered Personal Protective Equipment (PPE- specialized clothing or gear designed to protect workers from physical, chemical, biological or radiological hazards) to complete Resident 6's wound care. LPN-B then exits room with gown and gloves on to obtain a bedside table, LPN-B then takes off gown and placed it in a trash can in lounge area. LPN-B then performed hand hygiene for 22 seconds, LPN-B shuts the water off after drying hands. LPN-B then puts on new gown and reaches for gloves in scrub pocket and puts gloves on. LPN-B then obtained dry gauze, xeroform (sterile non-adherent, and occlusive wound dressing made of the fine mesh gauze impregnated with petrolatum and 3 percent bismuth tribromophenate), scissors from drawer in Resident 6's room. LPN-B then uses scissors to cut brown sticky wrapping (Coban) from right lower extremity. LPN-B then performed hand hygiene for 24 seconds and then reached behind gown and into scrub pocket to obtain a new pair of gloves. LPN-B then cuts a small piece of yellow moist gauze to place on right lower ankle, LPN-B then wraps white kerlix around right lower ankle, uses white tape to date and initial dressing. LPN-B then performs hand hygiene for 23 seconds and puts on a new pair of gloves that were obtained from scrub pocket behind gown. LPN-B then opens a sterile 4x4 white gauze and moistens with normal saline, LPN-B then places wet dressing to right knee, wraps with white kerlix, used white tape to date and initial dressing change. LPN-B then takes gloves, gown and face mask, performed hand hygiene for 20 seconds and placed all unused supplies back in Resident 6's drawer. LPN-B then leaves the room and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enters another resident's room with soiled trash from doing wound care. In an interview on [DATE] at 10:13 AM LPN-B confirmed that LPN-B should have cleaned the bedside table, opened wound supplies prior to performing treatment, and that gloves should have been readily available instead of obtaining from scrub pocket behind gown after performing hand hygiene. LPN-B further confirmed that the soiled trash from doing Resident 6's wounds should not go into another resident's room. LPN-B further confirmed that LPN-B should not have exit Resident 6's room with a gown and gloves on and dispose of them in a common area. Record review on [DATE] at 11:15 AM of Hand Hygiene policy last revised on [DATE] stated that hand hygiene should be done before and after resident care, before every clean procedure, after every dirty procedure and as needed. Handwashing consists of: 1.Turn water on in sink 2.Wet hands and wrists thoroughly, keeping hands lower than elbows 3. Apply soap 4. Lather all surfaces of wrists, hands, and fingers 5. Scrub using friction for at least 20 seconds do not rinse during this 6. Rinse all surfaces, keeping hands lower than elbows 7. Use a clean dry paper towel to dry and shut off the faucet 8. Then dispose of the paper towel in the wastebasket 9. Do not touch the inside of the sink Record review on [DATE] at 9:04 AM of Policy and Procedure guidelines for Wearing Gloves last revised [DATE] revealed that gloves must be worn following standard precautions. To prevent the spread of infection and protect employees from potential hazardous materials. Obtain appropriate gloves from utility rooms, resident bathrooms, or other designated areas. Gloves are disposable and should be changed between residents and between dirty and clean procedures on the same resident. Change gloves per policies and procedures. Do not double gloves. Do not carry gloves in your pocket for later use. Always perform hand hygiene before putting on gloves and after removing them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285057	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Lincoln Care Center	4720 Randolph Street Lincoln, NE 68510

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on [DATE] at 2:00 PM of Policy and Procedure Simple Dressing Change last revised on [DATE] revealed that all dressing changes will be completed in a clean and sterile technique as appropriated for wound care ordered by the provider. 1. Review providers order for dressing change. 2. Perform hand hygiene and assemble supplies. 3. Identify the residents and explain the procedure. 4. Put on gloves and clean the working surface with germicidal wipe according to manufacturer's instructions. 5. Place trash receptacle with reach. 6. Remove gloves and perform hand hygiene. 7. Set up supplies on clean surface. 8. Position resident. 9.Remove gloves and perform hand hygiene. 10. Apply gloves 11. Remove dressing. Fold dressings with drainage contained inside and remove gloves inside out. If the dressing is small remove gloves inside over the dressing. 12. Dispose of gloves and soiled dressing in trash. 13. Perform hand hygiene. 14. Apply gloves 15. Cleanse wound as ordered. 16.Remove gloves and perform hand hygiene. 17.Apply gloves. 18. Apply clean dressing as ordered. 19. Ensure dressing is dated. 20. Remove gloves and perform hand hygiene. 21. Assist the resident to a comfortable position. 22. Clean the working surface with germicidal wipe according to manufacturer's instructions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	23.Remove trash from room. 24. Perform hand hygiene 25. Document the dressing change. Record review on [DATE] at 2:18 PM of current orders revealed that wound care to Resident 6's right lower extremity is as follows: 1. Anterior Knee Dressing-Wet to dry dressing applied over anterior knee wound twice a day. moisten gauze with normal saline and place over wound bed, then apply dry dressing over top and secure with kerlix, to remove gently pull gauze off wound, if it's adhered slightly damped the gauze as needed every day and evening for wound care. 2. Medial ankle wound- Change xeroform dressing to ankle wound daily until fully healed. 3. Right calf and left lower extremity ruptured blisters: wash with soap and water, apply xeroform, cover with gauze then ace wrap, only cover with mepilex (soft silicone foam dressing designed for treating chronic and acute wounds), change every 3 days and as needed. In an interview on [DATE] at 2:30 PM with the DON (Director of Nursing) confirmed that LPN-B should not have reached for clean gloves behind LPN-B gown. DON further confirmed that LPN-B should not have taken wound care trash into another resident's room. DON also confirmed that LPN-B should not have exited Resident 6's room with gown and gloves on and disposed of them in a common area. It was further confirmed that LPN-B should have had supplies opened prior to beginning wound care. C. An observation on [DATE] at 8:40 PM revealed Medication Aide (MA) C performed hand hygiene and began to prepare medications for Resident 54. An observation on [DATE] at 8:45 PM revealed MA C knocked over the medication cup and spilled pills onto the medication cart. MA C picked the pills up with their bare hands and put them back in the cup. An interview on [DATE] at 8:54 PM with MA C confirmed that they should not have touched pills with their bare hands to put them back in the medication cup, but should have put gloves on. D. An observation on [DATE] at 8:57 PM revealed MA C performed hand hygiene, put on gloves, and began to prepare medications for Resident 78. The MA opened a bottle of eye drops, then threw away the seal. MA C began looking through the drawers of the cart to find the LiquaCel, touching multiple bottles and the drawers of the cart with their gloved hands. After finding the LiquaCel, MA C removed their gloves and went to another medication cart on the floor to get the Juven. Without performing hand hygiene, MA C put on a new pair of gloves and opened the Juven packet. MA C put the powder into a cup, then threw away the empty packet, touching the trash with their gloved hand. MA C then finished preparing Resident 78's medications. MA C removed their gloves to sign the controlled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication out and then put on new gloves without performing hand hygiene. A record review of the facility's Hand Hygiene policy and procedure dated [DATE] revealed no information about glove use. A record review of the facility's Guidelines for Wearing Gloves policy and procedure dated [DATE] revealed that hand hygiene should be performed before putting gloves on and after removing them. An interview on [DATE] at 8:46 AM with the Director of Nursing (DON) confirmed that staff should perform hand hygiene when changing gloves.