STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285066	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador Health of Lincoln	4405 Normal Blvd Lincoln, NE 68506

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Licensure Reference Number 175 NAC 12-006.05(F) Based on interviews and record reviews, the facility failed to honor the resident rights of one resident (Resident 1) by performing Cardiopulmonary resuscitation (CPR) when the resident was a Do Not Resuscitate (DNR), out of four residents sampled. The facility census was 87 at the time of the survey. Findings are: A record review of Resident 1's Minimum Data Set (MDS)(this comprehensive assessment evaluates each resident's functional capabilities) dated 3.4.2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. A record review on 3.11.2025 of Resident 1's current physician order report dated 2.11.2026 revealed a Do Not Resuscitate (DNR) order, which is a legally binding medical document signed by a physician, instructing healthcare providers not to perform Cardiopulmonary Resuscitation (CPR) if the heart stops or respirations cease. A record review of Resident 1's nursing progress note dated 2.23.2026 at 9:47 AM revealed the resident was found to be unresponsive, without a pulse, and CPR was initiated by facility staff. During an interview on 3.11.2026 at 10:00 AM with the Administrator (ADM), it was confirmed that CPR was initiated on Resident 1 on 2.23.2026, that Resident 1 was a DNR, and CPR should not have been initiated due to the residents wishes to be a DNR . During an interview on 3.11.2026 at 11:20 AM with Resident 1, it was confirmed the facility initiated CPR on 2.23.2026 against physician orders and resident wishes. Resident 1 confirmed being happy to be alive but would not want CPR to be initiated again, and continues to be a DNR.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02 (H) Based on interviews and record reviews, the facility failed to report an adverse event which involved violating resident rights of one resident (Resident 1) by performing Cardiopulmonary resuscitation (CPR) when the resident was a Do Not Resuscitate (DNR), out of four residents sampled. The facility census was 87 at the time of the survey. Findings are: A record review of Resident 1's Minimum Data Set (MDS) (this comprehensive assessment evaluates each resident's functional capabilities) dated 3.4.2026 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. A record review on 3.11.2026 of Resident 1's current physician order report dated 2.11.2026 revealed a Do Not Resuscitate (DNR) order, which is a legally binding medical document signed by a physician, instructing healthcare providers not to perform Cardiopulmonary Resuscitation (CPR) if the heart stops or respirations cease. A record review of Resident 1's nursing progress note dated 2.23.2026 at 9:47 AM revealed the resident was found to be unresponsive, without a pulse, and CPR was initiated. In a record review of the facility's undated Code Blue- Resident 1 event documentation revealed: Resident 1 was in the dining room at approximately 8:50 AM and went unresponsive and CPR was initiated During the CPR, the facility staff noted that Resident 1 had a DNR status, but CPR continued Resident 1 was ultimately transferred to acute care at approximately 9:30 AM In a record review of the facility's 2026 Reportable Events revealed the event involving Resident 1 on 2.23.2026, including the investigation was not reported to Adult Protective Services (APS). During an interview on 3.11.2026 at 10:00 AM with the Administrator (ADM), it was confirmed that CPR was initiated on Resident 1 on 2.23 2026, that Resident 1 was a DNR, and CPR should not have been initiated due to the resident's wishes to be DNR. It was also confirmed that a full investigation was completed into this event, including training with all staff, but was not reported to APS. During an interview on 3.11.2026 at 11:20 AM with Resident 1, it was confirmed the facility initiated CPR on 2.23.2026 against physician orders and resident wishes. Resident 1 confirmed being happy to be alive but would not want CPR to be initiated again and continues to be a DNR.