STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285067	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holdrege Memorial Homes, Inc	1320 11th Avenue Holdrege, NE 68949

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175NAC 12-006.05(E) Based on record review, and interview the facility failed to ensure that the risk versus benefit information for 2 of 5 sampled residents, (Resident 50 and 72), were discussed to the resident and resident representative for any psychotropic medications and prior to starting any psychotropic medications which describe in plain language the risks, benefits, options, and alternatives of the medication being prescribed. The facility census was 73. Findings are:Based on record review and interview, the facility failed to ensure that the risk versus benefit information for 2 of 5 sampled residents, (Resident 50 and 72), was given to the resident and resident representative for any psychotropic medications and prior to starting any psychotropic medications (medications are drugs that affect the mind, emotions, and behavior) which describe in plain language the risks, benefits, options, and alternatives of the medication being prescribed. Findings are: A. Record review of the Doctor Appointment Sheet dated 02/12/2025 revealed Resident 50 received a new order for Buspar (a medication for anxiety). Review of the 04/22/2025 quarterly MDS Assessment data revealed Resident 50 had a Brief Interview for Mental Status (BIMS - is a cognitive screening tool used in long-term care (LTC) facilities to assess the cognitive function of residents) score of 15 (13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment) displayed no behaviors, rejection of cares, or wandering behaviors. Resident 50 used a walker and a wheelchair and needed supervision while eating and moderate to maximum assistance with dressing, toileting, bathing, sitting, standing, and walking, was occasionally incontinent of urine and frequently incontinent of bowel, had complex diagnoses of breast cancer, diabetes, hypertension (high blood pressure) and coronary artery disease and received daily insulin injections, and prescribed antianxiety and antidepressant medications as well as opioid medications for pain. Review of the working care plan (a comprehensive plan to address the support and services needed by individuals who can no longer perform daily activities independently due to chronic illness, disability, or aging) last reviewed and revised on 07/30/2025 revealed that Resident 50 had been admitted to the facility on [DATE] with orders for Zoloft and Trazodone (medications for depression and insomnia), received a new order for the medication Buspirone 5 milligrams for anxiety on 02/12/2025 which was increased to 10 milligrams with an order on 06/11/2025, received a new order for Ativan (a medication for anxiety) on 04/30/2025, and an order for Hydroxyzine on 06/11/2025 for anxiety. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Doctor Appointment Sheet dated 04/30/2025 revealed Resident 50 received a new order to Ativan 0.5 milligrams (mg) orally as needed for anxiety. Record Review of the progress notes dated 4/30/2025 for Resident 50 revealed information is noted about the medication changes. The final sentence stated, Called and updated son, (son’s name). Record review of the May 2025 medication administration record (MAR) of Resident 50 revealed that the resident started taking Ativan (lorazepam - a psychotropic medication for anxiety) the first week of May 2025 (first dose of the medication was given on May 6, 2025) on an as needed only basis. Record review of the Doctor Appointment Sheet dated 06/11/2025 revealed Resident 50 received new orders to discontinue the use of the Ativan (medication for anxiety), start Hydroxyzine (medication used for anxiety), and to increase the Buspar (medication for anxiety) to 10 mg twice a day. Record review of the progress notes dated 6/11/2025 for Resident 50 revealed: “(Resident 50) was seen again by physician on Nursing home rounds. Medications were changed. Son updated on visit today. Record review of the June 2025 MAR of Resident 50 revealed that Resident 50 stopped taking the Ativan the first week of June 2025 (last dose received was 06/07/2025). Record review of the medical record documents revealed there were no risk and benefit documents related to psychotropic medications which explained the risks, benefits, options and alternatives of the medications that were prescribed for Resident 50, who was admitted on [DATE]. Interview on 07/31/2025 at 11:12 AM with the Minimum Data Set (MDS - a key component of the Resident Assessment Instrument (RAI) and helps identify residents' functional capabilities and health problems, forming the basis for their individualized care plans) Coordinator revealed that when doing resident assessments and adding risks and benefits of medications to care plans (plans used to prepare for and manage the potential need for ongoing care due to chronic illness, disability, or aging), there are no “Risk and Benefits” of medications or other treatments used in the facility. We do not have the residents or the resident representatives sign anything. Confirmation interview on 08/05/2025 at 10:15 AM with the Director of Nursing (DON) who confirmed the facility has never had anything that they reviewed with residents or resident representatives to discuss the risks and benefits of psychotropic medications. We do not go over the risks and B. Record review of a “Resident Face Sheet” dated 08/04/2025 for Resident 72 revealed: An admission date of 04/15/2025; Diagnoses of: 1. Alzheimer's disease with late onset (a progressive decline in memory and cognitive function, including challenges with language, problem-solving, and spatial reasoning) (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 72’s Medication Administration Record (MAR) for April 2025 revealed the following medications were administered as scheduled: -Celexa 20 milligrams (mg) once a day (a medication used to treat depression) with an indication of depression -Keppra 500mg twice a day (a medication to aide in controlling certain types of seizures) with an indication of convulsions -Seroquel 50mg once a day (a medication used to treat the symptoms of schizophrenia, bipolar disorder and major depressive disorder) with an indication of Unspecified dementia, unspecified severity, with agitation -Trazadone 50mg once a day (a medication used to treat depression, anxiety, and insomnia) with an indication of depression Record review of Resident 72’s MAR for July 2025 revealed the following medications were administered as scheduled: -Buspirone 10mg twice a day (a medication used to treat generalized anxiety and relieve the symptoms of anxiety) with an indication of Alzheimer’s disease for anxiety/agitation -Celexa 20mg once a day -Keppra 500mg twice a day -Trazadone 50mg once a day Record review of Resident 72’s Comprehensive Care Plan (CCP, 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) with a last revision date of 07/31/2025 revealed the following non-pharmacological interventions for the high-risk medication use and target behaviors: Utilizes Celexa for depression - 1-1 time to voice concerns Utilizes Buspar PRN daily for anxiety/agitation - data collection for agitation Utilizes Trazodone to assist with sleep - Observe for side effects of trazodone: drowsiness, dizziness, fatigue, headaches, nausea/vomiting, and stuffy nose Record review of a risk versus benefit information form provided to the resident/resident representative revealed the information is not available. An interview with the Director of Nursing (DON) on 08/05/2025 10:15 AM; confirmed there are no psychotropic risk and benefit forms that are reviewed with the resident or the resident representatives stating We (the facility) have never done anything like that before. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	benefits of medications. Do we need to have a form that they sign? All we do is chart that we have contacted the family in our progress notes. We do not chart what is discussed, just that there were updates to the medications, etcetera. So, like with Resident 50, when there were medication changes, we just charted in the progress notes that we called and notified the resident representative. The residents do not sign anything either.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensure Reference Number 175NAC 12-006.04(A)(iii)(2)(c)Licensure Reference Number 175NAC 12-006.04(A)(iii)(3)Based on record review and interview the facility failed to ensure that required registry checks (Child/adult abuse and neglect central registry checks, maintained by the Nebraska Department of Health and Human Services (DHHS), identify individuals with substantiated cases of abuse or neglect) were completed for new staff prior to working in the facility for 5 of 6 sampled staff. This had the potential for residents to be at risk of abuse and neglect. The facility census was 73. Findings are: A.Record review of the facility policy titled Abuse and Neglect Prevention Protocol dated 1/10/19 revealed that it is the facility policy to prohibit and prevent abuse, neglect, and exploitation from occurring. The section titled Screening revealed that the facility will not knowingly employ or otherwise engage individuals who have been found guilty of abuse, neglect exploitation, misappropriation of property, or mistreatment by a court of law; have a finding entered into the State Nurse Aide Registry concerning abuse; or that have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse. In order to screen potential employees for a history of abuse, neglect or mistreating residents as defined by law, the facility will follow the following procedure. Human Resource personnel will inform applicant of requirement for background checks upon application. Contact both the Adult Abuse and Child Abuse Registry for all new potential employees. Conduct an online search for the applicant on the Nebraska License Information System. Search for the applicant on the National Sex Offender Public Registry. All applicants who are initially offered employment following the application and interview process are hired contingent on the satisfactory return of the above checks and reference information. In cases where agency response indicates that an individual's name was found on a registry or there is an assault conviction or disqualifying criminal history present, the applicant will not be hired or any contingent offer of employment will be withdrawn. Record review of the undated facility policy titled Employee Orientation and Training revealed that employee orientation will be provided in two stages for new hires. General Orientation will be provided to complete facility and regulatory employment information and forms. Department Orientation will be used to provide employees with information related to their specific department, position, and job tasks. All newly hired personnel must attend general orientation prior to working in their respective department and position. General orientation will be made available to department employees on a twice per week basis where there is a need. All facility employment is initially considered conditional employment (a job offer that is contingent upon the candidate meeting certain requirements or conditions before officially starting the job). Not-conditional employment (signifies that the employer is ready to hire the candidate, pending only standard paperwork like onboarding forms, and that the candidate has already met all necessary requirements including criminal and abuse screening) will be based on the satisfactory completion of the criminal background check, verification of the nurse aide registry, verification with adult and child protective service agencies (the Adult Abuse and Child Abuse Registry check), and completion of the health screening and testing. Once all areas have been satisfactorily completed, the employee will receive a non-conditional offer of employment from the facility. The General Orientation program content includes completion of the facility health screening information, vital signs testing, and tuberculosis testing. Copies of all verifications, checklist or test results will be maintained in each employee's individual personnel file. In addition to the general orientation program each department supervisor or designee will ensure that each new employee receives and satisfactorily completes orientation specific to their department and job tasks. Department orientation is initiated following general orientation. An orientation checklist will be used by the facility for the documentation of general orientation participation. The in-service coordinator will complete all sections related to general orientation and forward to the business office. A separate checklist will be used by the department supervisor or their designee for the completion of department orientation. Interview on 8/4/25 at 2:42 PM with the facility Business Office Manager (BOM) revealed that the BOM checks the Nurse Aide Registry (a state required record of a successful completion of training and competency to be a nurse aide and any findings of abuse, neglect, or misappropriation of property) of an applicant prior to offer of contingent employment. The BOM revealed that the Business Office Payroll (BOP) ensures that other background and registry checks are completed. The BOM revealed that on the one day general orientation the new hire does complete online basic training. The BOM revealed that the department orientation is sometimes completed the same week as the general orientation. The BOM confirmed that the criminal background checks and

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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** Based on record review and interview the facility failed to notify the ombudsman (a state appointed advocate for residents of nursing homes) of resident discharge for 1 of 2 residents reviewed (Resident 82) as required. The facility census was 73. Findings are:Record review of the undated facility policy titled Transfer and Discharge from the Facility Policy revealed that each resident has the right to remain in the facility and not transfer or discharge a resident. The facility forwards a copy of all discharge notices to the Office of the State Long Term Care Ombudsman and required state agencies. The facility staff will document in the resident's record the date that a copy of the discharge notice was sent to the representative of the Office of the State Long Term Care Ombudsman and identified state agencies per requirements. Record review of the discharge Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 82 dated 6/5/25 revealed that Resident 82 admitted into the facility on 5/7/25. The MDS revealed that Resident 82 had a discharge date from the facility of 6/5/25.Record review of the Discharge summary dated [DATE] for Resident 82 revealed a discharge date of 6/5/25. Record review of the medical record for Resident 82 revealed no documentation of discharge notice provided to the ombudsman.Interview on 8/4/25 at 12:01 PM with the facility Social Services Director (SSD) revealed that the SSD provides notification of resident hospital transfers and discharges to the ombudsman monthly by email. The SSD revealed that the Emergency Transfers From Facility form is attached to the monthly email notification to the ombudsman.Record review of the facility Emergency Transfers from Facility form for June 2025 revealed that the discharge of Resident 82 on 6/5/25 was not included in the ombudsman notification. Interview on 8/5/25 at 12:02 PM with the facility Social Services Director (SSD) confirmed that the SSD was not aware of the requirement to notify the state ombudsman of resident discharges. The SSD revealed that the SSD only notified the ombudsman of resident hospital transfers. The SSD confirmed that the facility did not notify the state ombudsman of the 6/5/25 discharge of Resident 82.

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	285067	A. Building B. Wing	08/05/2025

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. The facility failed to ensure that all Minimum Data Set transmissions for each resident were submitted within 14 days after completion. This affected 7 of 7 residents (Residents 20, 53, 8, 55, 62, 68 and 70) sampled. The facility census was 73. Based on record review and interviews, the facility failed to ensure that all Minimum Data Set assessments (MDS - information which provides a comprehensive overview of a resident's functional status, diagnoses, and treatments used for resident care planning and quality monitoring in the long term care setting) was submitted within 14 days of completing the resident assessments. This affected 7 residents (Residents 20, 53, 8, 55, 62, 68 and 70) of 7 residents sampled. The facility census was 73. Findings are: Record review of the undated facility policy MDS Policy (in regulation with CMS guidelines) revealed the purpose of the policy was to ensure accurate and timely completion of the MDS in compliance with federal and state regulations for all residents of the facility. The procedures were as follows; 1. Resident will be assessed per the MDS Schedule as outlines in CMS (Centers for Medicare and Medicaid Services) regulations 2. The MDS Coordinator and Interdisciplinary team will review all assessments for completeness and accuracy before submission 3. The facility will maintain documentation to support all MDS items in the resident's medical record 4. The Administrator and the Director of Nursing will ensure that MDS processes remain in compliance with all applicable regulations. Interview on 07/31/2025 at 9:45 AM with the MDS COORDINATOR (MDSC) who stated due to personal issues, the MDSC had been out of the office more than in the facility as of late. As the only person who is currently working with the MDS data, MDSC had gotten behind and realized these had not been sent for finalization after being completed at the facility. Nobody else had checked the MDS work load in the absence of the MDSC. In reference to the data, the MDSC explained that MDS data that has been Finalized means that the MDS DATA had been gathered but it had not been submitted. Production Batch means it was submitted but had not been reviewed and accepted. Interview on 07/31/2025 at 10:00 AM with the MDSC confirmed that the MDS's were not submitted on time for Residents 20, 53, 8, 55, 62, 68, and 70. A. Record review of the MDS data dated 06/24/2025 for Resident 20 revealed the data was finalized; gathered but not sent within the 14 day required time period. B. Record review of the MDS data dated 06/24/2025 for Resident 53 revealed the data was finalized; gathered by not sent within the 14 day required time period. C.Record review of the MDS data dated 06/24/2025for Resident 8 revealed the data was finalized; gathered by not sent within the 14 day required time period. D. Record review of the MDS data dated 06/24/2025 for Resident 55 revealed the data was finalized; gathered by not sent within the 14 day required time period. E.Record review of the MDS data dated 07/01/2025 for Resident 62 revealed the data was finalized; gathered by not sent within the 14 day required time period. F. Record review of the MDS data dated 06/24/2025 for Resident 68 revealed the data was finalized; gathered by not sent within the 14 day required time period. G.Record review of the MDS data dated 06/24/2025 for Resident 70 the data was in the Production Batch; submitted but not reviewed and accepted within the required time period of 14 days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175NAC 12-006.09(E)(ii) Licensure Reference Number 175NAC 12-006.09(E)(iii) Licensure Reference Number 175NAC 12-006.09(E)(iv) Based on Record reviews, observations, and interviews, the facility failed to ensure the comprehensive care plans had person-centered goals, measurable objectives, and interventions related to respiratory infections, nutrition, diabetes, resident choices, urinary tract infections and other infections, resident fluid restrictions, and self-directed care wishes for 4 of 18 sampled residents (Residents 68, 55, 9, and 2). The facility census was 73.Findings are:A. Review of the progress notes revealed that on 12/27/2024 Resident 68 was transferred to the emergency room via ambulance and admitted on [DATE] with a diagnosis of pneumonia. Resident 68 was readmitted to the facility on [DATE]. An entry on 01/10/2025 revealed that the primary care physician had changed the current antibiotic, Bactrim, to cefdinir to treat Resident 68’s pneumonia. An entry on 01/17/2025 revealed the antibiotic was changed once again to Augmentin (antibiotic) for another 10 days for the pneumonia. On 01/30/2025 the progress notes revealed that the nebulizer treatments were to be given routinely. On 03/12/2025 a new order for another antibiotic was ordered for the diagnosis of pneumonia. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed Resident 68 was admitted on [DATE] and had been readmitted on [DATE] after a short stay hospitalization. Resident 68 wore bilateral hearing aides and could communicate without difficulty, had a Brief Interview for Mental Status (BIMS, a brief screening aide to assist in detecting cognitive impairment) score: 15/15 with a score determining: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment; and had a complex medical history which included coronary artery disease, congestive heart failure, high blood pressure, pneumonia, and hypoxemia (low levels of oxygen in the blood stream). Furthermore, Resident 68 became short of breath when lying flat and took diuretics (medications that help remove fluids) and opioid pain medications. Record review of the March 2025 Medication Administration Record (MAR) for Resident 68 revealed a new order for Albuterol treatments on 03/13/2025 and was used everyday from 03/13/2025 to 03/31/2025 except on 03/18, 03/21, and 03/28/2025. Levaquin (an antibiotic for respiratory infections) was ordered and started on 03/13/2025 and continued daily through 03/22/2025. Record review of the April 2025 MAR for Resident 68 revealed a new order for dextromethorphan/guaifenesin (a cough medicine) was ordered for pneumonia on 04/11/2025. Resident 68 used this cough medicine on the following dates in April 2025; April 12, 13, 15, 18, 21, 22, 23, 25, 26, 27, 29 and 30. Resident 68 continued to use the albuterol breathing treatments at least once a day through the month of April 2025 except on; April 1, 5, 6, 16, 17, 19, 20, and 28. The MAR also revealed a new order for Augmentin (an antibiotic) was started 04/30/2025 for and upper respiratory infection and pneumonia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Doctor’s Appointment Sheet dated 04/16/2025 revealed the resident had been on Levaquin (an antibiotic for respiratory infections) during the month of March and had been on oxygen to keep oxygen saturations above 90% since that time and continued to have wheezing (a high-pitched, whistling sound that occurs when air flows through narrowed airways in the lungs) and a cough. Robitussin (cough medication) had been ordered on 04/11/2025. The physician ordered a respiratory lab panel to include checking for Mycoplasma (a laboratory test that detects multiple pathogens that can cause respiratory infections). Record review of the May 2025 MAR revealed Resident 68 continued receiving Augmentin twice a day to the stop date of 05/14/2025. A new order for Prednisone (a steroid medication) was started on 05/01/2025 (prednisone and antibiotics can be used together to treat certain bacterial and viral infections) and continued through 05/09/2025. Resident 68 also continued to take albuterol treatments throughout the month of May 2025 with the exception of the following dates in May of 2025: 8, 12, 14, 15, 17-23, 26, and 31. Record review of the “Summary of Care” record dated 05/14/2025 revealed the resident continued to have a chronic cough. The cough did not bother (Resident 68) but the nurses noticed it relatively frequently. Also noted was the fact that (Resident 68) had a history of basal cell lymphoproliferative disorder, hypothyroidism, chronic kidney disease stage 4 (severe), benign hypertrophy of the prostate and hypertension. Further past medical history included status post nephrectomy (removal of a kidney), colostomy (surgical revision of the bowel in which the resident now has an opening on the abdomen), congestive heart failure (a condition in which the heart doesn't pump enough blood to meet the body's need and can cause fluid buildup in the lungs causing shortness of breath and fatigue), and others. Due to the chronic cough, the orders were to discontinue Resident 68’s valsartan, have nursing staff check blood pressures daily, and other changes related to medications, and ordered lab work. Record review of the Doctor’s Appointment Sheet dated 05/14/2025 revealed the physician questioned whether the cough was related to medication valsartan and the valsartan was discontinued. The physician ordered several different labs which included the BNP - (Brain Natriuretic Peptide - primarily used to help diagnose and assess the severity of heart failure) which may have been causing the cough. Record review of the June 2025 MAR for Resident 68 revealed use of the prescribed cough medication on 06/02, 3, 5, 6, and 7. Resident 68 had used the albuterol treatments 11 days in the month of June; 2, 3, 6, 7, 8, 13, 17,23, 24, 28, and 29. Record review of the July 2025 MAR for Resident 68 revealed the use of the albuterol treatments on 07/06/2025 and 07/24-31, 2025. Resident was restarted on an Antibiotic 07/28 for the following 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285067	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the working care plan reviewed on 07/31/2025 for Resident 68 revealed a problem of Levaquin (antibiotic for upper respiratory infections) 500 mg daily. The goal, with a goal target date of 09/23/2025, to resolve after the antibiotic series was completed. Interventions were: monitor the vitals signs and condition of the resident, and monitor the signs and symptoms of adverse effects of the antibiotic. Also related to the respiratory system was the problem of oxygen, with a goal target date of 09/23/2025, to keep oxygen saturations of the blood above 90%. The interventions listed were: change the oxygen tubing monthly, clean the concentrator filter weekly, oxygen saturation every shift, and observe top of ears for signs of irritation, pad tubing as needed. There were no other care plan interventions related to Resident 68’s respiratory status. Observation of Resident 68 in this resident's room [ROOM NUMBER]/20/2025 at 2:10 PM revealed this resident had a coarse, wet cough. Observation of Resident 68 on 07/31/2025 at 12:15 PM in the dining room while seated for the noon meal. Coughed occasionally while partaking of the meal. Observation of Resident 68 on 08/04/2025 at 08:25 AM in the dining room while seated for breakfast. Coughs occasionally while eating. Interview with Resident 68 on 08/04/2025 at 08:25 AM in the dining room. Ya, I still have that cough, but I am still here. B. Record review of the MDS for Resident 55 revealed the resident was admitted on [DATE] from the hospital. Resident 55 wore glasses, had adequate hearing, had a BIMS of 15/15, had no behaviors either verbally or physically towards others and did not wander. Resident had functional impairment of both lower extremities related to amputations, needed maximum or total assistance with cares and dressing, needed set up assistance with meals, and was diagnosed with amputation of both lower extremities, coronary artery disease, congestive heart failure, hypertension (high blood pressure), peripheral vascular disease (a circulatory problem affecting blood vessels outside the brain and heart, often causing pain and other symptoms in the legs), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively, leading to a buildup of waste and fluid in the body), diabetes, and obstructive sleep apnea. Resident 55 had orders for an anticoagulant (a medication that interrupts blood clotting), diuretic (a medication that helps remove fluids), antiplatelet (a medication that interrupts blood clotting, hypoglycemic (a medication to reduce blood sugars), and an anticonvulsant. Record review of the Care Plan last reviewed and revised on 06/24/2025 for Resident 55 revealed a problem of Diabetes, with a goal to have no signs and symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) with the short term goal of 09/24/2025. The interventions listed were: Dexcom or one touch as ordered, Insulin and metformin as ordered, observe for signs and symptoms of hypo/hyperglycemia, blurred vision, hunger, shaky, headache, confused thinking, cold sweats, weak tired feeling, change in behavior, irritability, faint feeling, nausea and vomiting, excessive thirst, drowsiness, dry flaky skin, abdominal pain and cramping, fruity breath, rapid breathing, excessive urination. (continued on next page)

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	285067	A. Building B. Wing	08/05/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second Care Plan problem of nutritional status; Resident 55 is alert and oriented, able to demonstrate safety in drinking hot beverages without a lid. Has a bilateral above the knee amputation, uses adaptive equipment, and receives Bumex (a medication primary used to eliminate excess fluid and salt from the body by increasing urine production). The goal for 09/24/2025 was to consume more than 75% of meals and fluids. The interventions listed were: monitor weights, prefers to wear clothing protector to keep clothing clean, and provide a regular diet with small portions, built up silverware, divided plate, cooks cut meats, egg, and meat daily. Observation of Resident 55’s room on 07/30/2025 at 2:33 PM revealed 8 cans of Vienna sausages, 2 jars of nuts, and other snacks on his bedside table within arm’s reach. Interview 07/20/2025 at 2:33 PM with Resident 55 who stated my (spouse) brings me many snacks every week when here to visit. I lost both of my legs due to diabetes. But I am not on any particular diet, I just eat what I want to eat. I am on insulin and take metformin (an oral medication for diabetes) and I think my blood sugars are in the 150 to 200 range most of the time. Observation 07/31/2025 at 8:24 AM of Resident #55 was seated at the dining room table for breakfast who had no issues eating and ate 100% of the meal. Observation on 07/31/2025 at 8:40 AM of Resident #55 who ate 100% of breakfast. Observation on 07/31/2025 at 12:13 PM of Resident 55 who used silverware with larger handles, visited with table mates, and had edema wear on the left arm. Observation on 08/04/2025 at 8:11 AM in the room of Resident 55 who has a can of potato chips, a large box of whoppers candy, and 6 cans of Vienna sausages sitting on the bedside table in the resident room. Record review of Resident 55’s weights from admission revealed that on 03/21/2025 the resident weighed 214 pounds. On 07/20/2025 Resident 55 weighed 247.7 pounds. On 07/29/2025 Resident 55 weighed 254 pounds. This was a weight gain of 18.69% since admission and 2.54% weight gain in one week. Interview on 08/04/2025 at 9:48 AM with Resident #55 who stated “I keep snacks at bedside but don't eat too many. My (spouse) brings many things to eat on Saturdays as needed. I just keep the food on the bedside table so I can reach it. I have been educated and am knowledgeable about the effects of sugar and high blood sugar on the system. I feel my blood sugars are “pretty well maintained” in the normal range most of the time. Wounds not healing. They started me on an antibiotic for my left leg now. Record review of the care plans last revised on 06/24/2025 did not reveal any goals for Resident 55 related to nutritional choices, diabetic education, and interventions about healthy food choices. Although there was mention of monitoring Resident 55’s weights, there were no identified measurable goals for the weights. C. (continued on next page)

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	285067	A. Building B. Wing	08/05/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS dated [DATE] revealed Resident 9 was admitted to the facility on [DATE], wore glasses, had adequate hearing, a BIMS of 15/15 with a score determining: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment, had no issues with moods or behaviors, was wheelchair dependent and used an electric wheelchair, was totally dependent upon cares, was occasionally incontinent of bladder and always continent of bowel, had diagnoses for a progressive neurological condition of muscular sclerosis, anemia, hypertension, urinary tract infections, and depression, received pain medications occasionally, had no swallowing or dental issues, and received antibiotics, opioid, and anticonvulsants medications. Interview on 07/30/2025 at 11:38 AM Resident 9 revealed having had 2 urinary tract infections in the past 8 weeks and a yeast infection. Resident 9 stated the conditions seemed to be under control now. Record review of the care plan for Resident 9 revealed a problem of UTI (urinary tract infection with a start date of 06/27/2025. The goal, with a target date of 07/15/2025, stated the condition will resolve after antibiotic series is complete. Interventions included; condition monitored by checking vital signs and condition of resident. Update the primary care physician as needed. The second intervention listed was to monitor for signs and symptoms of adverse effects of antibiotic. There was no mention of this resident having had any other urinary tract infections or other infections in the past. Resident 9’s care plan also had a problem of “falls”. The care plan stated Resident 9 is at risk for falls related to a history of falls, immobility, weakness, and a diagnosis of muscular sclerosis. Resident 9 is dependent on staff for transfers, repositioning, and has been evaluated by Occupational Therapy with balance precautions in place, due to poor sitting balance, Resident 9 is at risk for falls. The goal written was that “Resident 9 will not sustain serious injuries if a fall occurs”. Interventions included but were not limited to “keeping frequently used items within reach. (Resident 9) has a special device attached to this resident’s bed in which the resident’s phone is on to ensure this is close to (Resident 9’s) reach when in bed. Also likes to have push call light on chest so Resident 9 is able to use chin to turn the call light on.” A third identified problem on the care plan was Resident 9’s Nutritional Status which revealed Resident 9 had a diagnosis of muscular sclerosis (MS) and edema. Resident 9 used adaptive equipment which included a lid for coffee. Resident 9 didn’t eat sugar - very aware of MS and monitors the diet closely. Resident 9 didn’t drink milk or juice. had a good intake, and was fed at meals. Didn’t want any interventions in place to gain weight. BMI (a screening tool used to estimate body weight status based on height and weight)= 17. There was no mention of the use of extended straws used by the resident to promote dignity while consuming meals. Interview on 07/30/2025 at 3:45 PM with Resident 9 who revealed an inability to move much of (Resident9’s) body except my head due to diagnosis of Muscular Sclerosis. The staff always answer my needs as soon as I ring the call light. The staff leave the soft call light right next to my head so if I need to call them staff, I just have to move my head to the side and they will answer the call light right away. “I just can’t use my arms anymore.” (continued on next page)

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	285067	A. Building B. Wing	08/05/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/31/2025 at 08:12 PM of Resident 9 seated at the dining table for breakfast. Resident 9 was seated at the table with table mates and an assistant who helped Resident 9 consume breakfast. The drinking glasses had a very long straw in the cup that allowed Resident 9 to bend at the neck and drink per self without the assistant always having to help. Observation on 07/31/2025 on 12:17 PM Resident 9 was seated at the dining table for the noon meal. An assistant was seated next to Resident 9 who helped Resident 9 while Resident 9 ate dinner. Medications were given to Resident 9 while seated at the table. Two large drinks were on the table each with a very long straw. Resident 9 was able to consume drinks per self. Record review of the April 2025 Medication Administration Record (MAR) revealed that there was an order for Levofloxacin 250 mg for 7 days ordered for Resident 9 due to a urinary tract infection. The medication was given the 19th through the 24th. Resident 9 only had 6 documented doses of the 7 ordered. Record review of the May 2025 MAR revealed Resident 9 was diagnosed with a yeast infection and miconazole was ordered for the infection. The resident received this medication on May 4, 5, 6, 7, 9, 10, 11, 13, and 19. Nystatin powder was also ordered to be used twice daily and was started on May 8th. Resident 9 received this medication twice a day starting on the 8th. Record review of the June 2025 MAR for resident 9 revealed the nystatin powder continued to be used until the discontinuation date of June 30th. There was a new order for Levofloxacin 250 milligrams daily for 7 days which had been ordered for a urinary tract infection. This medication was given on the 27, 28, 29, and 30th. Record review of the July 2025 MAR for Resident 9 revealed that the order for Levofloxacin continued into the month of July and was given on the 1,2, and 3 of July. D. A record review of an “Resident Face Sheet” revealed the facility admitted Resident 2 on 11/05/2024 with a diagnosis of stage 3 chronic kidney disease (a condition of moderate kidney damage and reduced kidney function where the kidneys filter blood less effectively leading to a buildup of waste products in the body), left toe amputation, and diabetes (a condition characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). Review of Resident 2’s “Care Plan” revealed a problem of nutritional status stating the resident was alert and orientated and can demonstrate safety in drinking hot beverages with out a lid. The resident received a therapeutic diet and had significant weight loss due to a decrease in edema with a start date of 11/06/2024. A goal was listed that the resident would consume more than 50% of meals and fluids dated 02/19/2025. Approaches were listed to monitor weights, the resident preferred to wear clothing protector to keep their clothing clean, and staff provide a regular diet with small portions, 8 ounces of a supplement twice daily yogurt at breakfast, to have an egg daily and fruit for dessert all dated 11/06/2025. A record review of Resident 2 physician orders revealed an diet order for a regular diet with 1400 milliliters a day fluid restriction dated 05/27/2025. (continued on next page)

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	285067	A. Building B. Wing	08/05/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview completed on 07/30/2025 at 3:10 PM with Resident 2 spouse they revealed that the resident was on a fluid restriction and was aware of how much fluid they could consume a day but often would consume more per their choice. The spouse stated facility staff and the resident’s provider were both aware of the resident’s noncompliance with the ordered fluid restriction. In an interview completed on 08/04/2025 at 2:32 PM with Nurse Aide L (NA-L), NA-L confirmed knowledge of Resident 2’s fluid restriction. In an interview completed on 08/04/2025 at 2:34 PM with Registered Nurse J (RN-J), RN-J stated the dietary department tracked fluid intake consumed by the resident at mealtime and nursing staff provided and 8-ounce cup of fluid in the resident’s room three times a day to encourage the resident to comply with their fluid restriction as prescribed. The RN confirmed that the resident often chose not to comply with the fluid restriction as ordered by their provider. In an interview completed on 08/04/2025 at 4:02 PM with the facility Director of Nursing (DON), the DON confirmed that the resident was on a fluid restriction and was often noncompliance with following the prescribed fluid restriction. The DON confirmed that this should be reflected on the resident’s care plan and was not. In an interview completed on 08/05/2025 with the facility Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident’s functional capabilities and helps nursing home staff identify health problems) Coordinator (MDSC), the MDSC confirmed that the resident’s fluid restriction and noncompliance should be reflected in the resident plan of care and was not. Based on record reviews, observations, and interviews, the facility failed to ensure the individualized and personalized comprehensive care plans had person-centered goals, measurable objectives, and interventions related to respiratory infections, nutrition, diabetes, resident choices, urinary tract infections and other infections, resident fluid restrictions, and self-directed care wishes for 4 of 18 sampled residents (Residents 55, 9, 68, and 2). Findings were: Review of the undated facility “Care Plan Policy” revealed the purpose was to ensure that all residents of (Facility name) have an individualized, comprehensive care plan (plans used to prepare for and manage the potential need for ongoing care due to chronic illness, disability, or aging),that reflects their current needs, goals, and preferences, and is maintained in compliance with federal and state regulations. The policy further stated; 1. Each resident will have a care plan developed and maintained by the interdisciplinary team (IDT) to address medical, nursing, psychosocial, and functional needs. 2. Care plans will be A.) Developed within required federal and state timeframes following admission and significant change in condition, B.) Reviewed and updated as residents’ conditions, physician orders or needs change, and C.) Revised whenever new assessments, physician orders , or changes in condition require adjustments in care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The care plan will guide staff in providing individualized care and will be accessible to all appropriate team members. 4. Residents and/or their representatives will be invited and encouraged to participate in care planning and updates. 5. All care plans and updates will comply with 42 CFR 483.21 (Federal regulation) and CMS (Centers for Medicare and Medicaid Services) and state guidelines. The procedure was as follows: 1. The IDT will develop the initial care plan per regulatory timelines. 2. Updates to the care plan will occur A.) following any change in condition, B.) with any new or changed physician orders, and C.) after completion of significant MDS (minimum data set assessments - a key component of the Resident Assessment Instrument (RAI) and helps identify residents' functional capabilities and health problems, forming the basis for their individualized care plans). 3. Nursing staff will ensure care plans accurately reflect current orders, treatments, and resident needs 4. Documentation supporting care plan changes will be maintained in the resident medical record. Interview with Minimum Data Set Coordinator (MDSC) on 7/31/2025 at 10:00 AM in the MDS office revealed that the care plans are updated when the resident assessments are completed. They are updated again at any time there are falls, changes in medications, and any other needs to care for the residents. The MDSC records all of the changes in medications and another individual records and updates all of the falls. Interview with the MDSC on 7/31/2025 at 11:12 AM in the MDS office. The care plans are revised as soon as the acute problem is resolved. The falls stay on the care plan, but the medications usually come off the care plans. Anything that is acute (short term) issue or problem, is usually removed once it is resolved because it goes away. The MDSC was also in agreement that the care plans are not very descriptive for the individual being cared for. Agreed that the comprehensive care plans are not very personalized to each individual. The MDSC was going to review the federal and state regulations to see what must be included on the care plans and make changes as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Confirmation interview with the Director of Nursing on 08/04/2025 at 11:10 AM revealed the care plans are updated as needed with the medication changes and falls. The fall information stays on the care plans. But information that is related to respiratory infections or urinary tract infections are deleted from the care plan once they are resolved. No, they do not leave a history of that illness on the care plan because maybe it only occurred one time. Agreed that an example listing a problem of “Resident is a diabetic with a goal to show no signs of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar)” did not personalize the comprehensive care plan or show the whole picture of a resident’s care in comparison to “The resident is a diabetic, with XYZ problems and issues related to diabetes and other co-morbidities, whose choice is to keep high carbohydrate (sugar filled) foods at the bedside which are not recommended for those with diabetes” The DON confirmed that the comprehensive care plans needed to be more detailed in order to create a more personalized, individual comprehensive care plan so that those individuals caring for that resident had a better understanding of each resident being cared for.

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	285067	A. Building B. Wing	08/05/2025

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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. (continued on next page)

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	285067	A. Building B. Wing	08/05/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number NAC 175 12-006.09(H)(iii)Based on interview and record review the facility failed to ensure wounds were comprehensively assessed on a routine basis and failed to ensure a wound had treatment orders for 1 resident (Resident 10) of 2 sampled residents. The facility census was 73.Findings are:A record review of a document titled Best Practices for Wound Assessment and Documentation dated 04/17/2025 by the Wound Care Education Institute revealed the foundational elements of wound assessment should include precise anatomical location, classification and etiology, accurate wound measurements, wound bed characteristics, wound edge and margin assessment, exudate (drainage) characteristics, peri wound (skin surrounding the wound) status, and pain and symptom reporting.A record review of facility's undated policy titled Skin Assessment and Treatment Policy revealed it is the policy of the facility to routinely monitor, assess, and manage residents' skin integrity. All assessments and treatments are conducted in accordance with physician orders, accepted clinical standards and facility procedures. A comprehensive skin assessment is completed weekly, and wounds are treated per physician orders and standards of practice.A record review of a Resident Face Sheet revealed the facility admitted Resident 10 on 05/29/25 with diagnoses of Multiple Sclerosis (a chronic often disabling disease that attacks the central nervous system which includes the brain and spinal cord).A record review of Resident 10's Care Plan revealed the resident was listed to have a problem of having the potential for skin breakdown with a denuded area to the left buttock dated 05/29/2025. An intervention was listed for the resident to have a weekly skin assessment dated [DATE]. No treatment interventions were listed for the denuded area to the left buttock.A.A record review of a Skin Condition Record labeled with Resident 10's name revealed:-Documentation dated 06/18/2025 a 1.0 centimeter (cm) X 0.2 cm open area to the residents left lower buttock. No other assessment information was documented.-Documentation dated 06/30/2025 the area did not have any drainage, and the area was cleaned, and the resident had no complaints of discomfort. No other assessment information was documented.-Documentation dated 07/07/2025 the area did not have any drainage, and the area was cleansed, and Vaseline gauze was applied to the area. No other assessment information was documented.-Documentation dated 07/14/2025 the area did not have any drainage, and the area was cleansed without the resident having complaints of discomfort. No other assessment information was documented.-Documentation on 07/28/2025 that the area is without drainage and it was cleansed. No other assessment information was documented.A review of Resident 10 Progress Notes revealed:-On 05/29/2025 documentation reflecting the resident's admission to the facility with left buttock discomfort complaints and an abraded area on the left buttock measuring 0.4cm in diameter. Calzinc was applied to the area.-On 06/13/2025 documentation reflecting the resident was noted to have scant amount of red drainage and had an deep open area. No documentation of where the open area was located or further assessment of the drainage or open area. Aquaphor and Vaseline gauze were applied.-On 06/18/2025 documentation reflecting the resident had and open area to the left lower buttock measuring 1.0cm x 0.2cm. Documentation stated the area was cleansed and Vaseline gauze was applied.-On 06/20/2025 documentation that the resident continued to have an open area and the dietician was requesting to start a protein supplement.A review of Resident 10 Physician orders from 05/29/2025 through 08/04/2025 revealed no physician orders for wound care.In an interview completed on 07/31/2025 with Licensed Practical Nurse K (LPN-K), LPN-K stated that all residents receive a weekly head to toe skin assessment that is signed off as completed in the resident treatment administration record. The nurse stated if there is an alteration in skin integrity it is documented in the residents Progress Notes or Skin Condition sheet. The area is measured and assessed weekly and documented on. If a resident has a wound or sore the provider is notified and treatment orders are obtained for the area and entered as a physician order. Documentation of the treatment being completed is signed off on the residents Treatment Administration Record.In an interview completed on 08/04/2025 at 3:48 PM with the facility Director of Nursing (DON), the DON confirmed that Resident 10 had a wound to their left buttock that was not completely assessed and documented on on a routine or weekly basis. The DON confirmed that there was no treatment orders in the residents medical record for this area.

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	285067	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holdrege Memorial Homes, Inc	1320 11th Avenue Holdrege, NE 68949

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure coordination of care of dialysis for 1 resident (Resident 2) of 1 sampled residents. The facility census was 73.Findings are:A record review of facility's undated policy titled Policy and Procedures revealed it was the policy of the facility to ensure that residents who require dialysis are monitored and have care needs related to dialysis. Under section 3, monitoring and observation is to occur upon return for dialysis and the resident was assessed for general condition and tolerance of dialysis. Under section 5, Nurses will document date and time of transport to and from dialysis, resident condition before and after dialysis and all communication with dialysis providers and physicians will be documented in the resident's chart.A record review of an Resident Face Sheet revealed the facility admitted Resident 2 on 11/05/2024 with a diagnosis of stage 3 chronic kidney disease (a condition of moderate kidney damage and reduced kidney function where the kidneys filter blood less effectively leading to a buildup of waste products in the body), left toe amputation, and diabetes (a condition characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production).A record review of Resident 2's Care Plan revealed a problem of Dialysis with a start date of 04/23/2025. A goal was stated that the resident will remain stable while receiving dialysis with a target date of 08/26/2025. Approaches were listed as daily weights, labs as ordered, and dialysis site will remain free from infection and to monitor the site daily all dated 04/23/2025.In an interview completed on 07/30/2025 at 3:10 PM with Resident 2's spouse they stated that Resident 2 received dialysis 3 times a week on Monday, Wednesday, and Friday and the facility assisted with the transportation to and from the dialysis center in [NAME].A record review completed on 07/30/2025 at 5:00 PM of Resident 2's physician orders revealed no orders for the resident to receive dialysis three times a week at the dialysis center in [NAME].In an interview completed on 07/31/2025 at 10:30 AM with Licensed Practical Nurse K (LPN-K), LPN-K confirmed that the resident received dialysis outside of the facility on Mondays, Wednesdays, and Fridays.A record review conducted on 07/31/2025 of Resident 2's Progress Notes for 06/01/2025 through 07/29/2025 revealed:-Documentation on 06/06/2025 stating resident was transported via facility transportation for dialysis appointment. No documentation present of assessment of resident prior to or post dialysis no documentation reflecting the resident returned from dialysis.-Documentation on 06/09/2025 that resident went out of facility for dialysis and returned at 5:00 PM. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/11/2025 that resident went out of facility for dialysis and returned at 5:36 PM. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/18/2025 that resident went out of facility for dialysis. No documentation present resident returned to facility from dialysis. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/23/2025 that resident went out of facility for dialysis. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/25/2025 that resident went out of facility for dialysis and returned at 5:42 PM. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/28/2025 that resident stated they went to dialysis and returned on 06/28/2025. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 06/30/2025 that resident went out of facility for dialysis and returned at 6:40 PM. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 07/02/2025 that resident went out of facility for dialysis and returned at 5:30 PM. No documentation present of resident condition prior to leaving the facility for dialysis. Documentation stated no change of condition upon return from dialysis.- Documentation on 07/07/2025 that resident went out of facility for dialysis. No documentation of resident returning from dialysis. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 07/11/2025 that resident went out of facility for dialysis. No documentation of resident returning from dialysis. No documentation present of resident condition prior to leaving facility for dialysis or upon return to facility from receiving dialysis.- Documentation on 07/16/2025 that resident went out of facility for dialysis. Documentation stated resident returned to the facility with family at 7:15 PM. No documentation present of

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interview the facility failed to ensure that the Direct Care Daily Staffing posting (a required daily posting of facility nurse staffing information) included the required actual hours worked for each staff category. The facility census was 73. Findings are:Record review of the undated facility policy titled Posting Direct Care Daily Staffing Numbers revealed that the facility will post the number of nursing personnel responsible for providing direct care to residents on a daily basis for each shift. The information recorded on the form shall include the actual time worked during that shift for each category and type of nursing staff. Observation on 7/31/25 at 8:23 AM on the wall between the facility Activity Room and Greenhouse Cafe revealed that the Report of Nursing Staff Directly Responsible for Resident Care was posted. The report was dated 7/31/25 and revealed a census of 74 residents. The report revealed day shift staff consisting of 1 Registered Nurse (RN), 3 Licensed Professional Nurses (LPN), and 10 nurse aides (NA). The report revealed evening shift staff consisting of 3 RNs, 1 LPN, and 9 NAs. The report revealed night shift staff consisting of 1 LPN and 5.5 NAs. The report did not contain the number of work hours for the RNs, LPNs, or NAs. Observation on 8/4/25 at 10:42 AM on the wall between the facility Activity Room and Greenhouse Cafe revealed that the Report of Nursing Staff Directly Responsible for Resident Care was posted. The report was dated 8/4/25 and revealed a census of 72 residents. The report revealed day shift staff consisting of 3 Registered Nurses (RN), 1 Licensed Professional Nurse (LPN), and 10 nurse aides (NA). The report revealed evening shift staff consisting of 2 RNs, 1 LPN, and 10 NAs. The report revealed night shift staff consisting of 1 RN and 5 NAs. The report did not contain the number of work hours for the RNs, LPNs, or NAs. Observation on 8/5/25 at 11:55 AM on the wall between the facility Activity Room and Greenhouse Cafe revealed that the Report of Nursing Staff Directly Responsible for Resident Care was posted. The report was dated 8/5/2025 and revealed a census of 74 residents. The report revealed day shift staff consisting of 1 Registered Nurse (RN), 3 Licensed Professional Nurses (LPN), and 9.5 nurse aides (NA). The report revealed evening shift staff consisting of 3.5 RNs, 0.5 LPN, and 9.5 NAs. The report revealed night shift staff consisting of 1 LPN and 5 NAs. The report did not contain the number of work hours for the RNs, LPNs, or NAs. Interview on 8/5/25 at 11:58 AM with the facility Director of Nursing (DON) confirmed that the facility Report of Nursing Staff Directly Responsible for Resident Care posted did not contain the actual hours worked by each staff category as required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Licensure Reference Number 175NAC 1-005.06(D) Licensure Reference Number 175NAC 12-006. 18(B)Licensure Reference Number 175NAC 12-006.18(C) Based on observation, record review, and interview the facility failed to ensure that pre-employment health screens were completed for 1 of 6 sampled staff to prevent the potential for communicable diseases, failed to maintain fingernails while working with exposed foods that affected all facility residents, failed to ensure oxygen delivery devices were stored in a sanitary manner for 2 of 3 sampled residents (Resident 37 and 46), and failed to ensure the required PPE (Personal Protective Equipment) was available and used during care for 2 of 2 sampled residents (Resident 2 and 85). The facility census was 73. Findings are:A. Record review of the undated facility policy titled Employee Orientation and Training revealed that employee orientation will be provided in two stages for new hires. General Orientation will be provided to complete facility and regulatory employment information and forms. Department Orientation will be used to provide employees with information related to their specific department, position, and job tasks. All newly hired personnel must attend general orientation prior to working in their respective department and position. General orientation program content includes completion of the facility health screening information, vital signs testing, and tuberculosis testing. Copies of all verifications, checklist or test results will be maintained in each employee's individual personnel file. Medical information will be maintained in each employee's individual medical file. Interview on 8/4/25 at 2:42 PM with the facility Business Office Manager (BOM) revealed that the Business Office Payroll (BOP) ensures that during the one day general orientation the new hire completes the health screening and a tuberculosis test (a test for a chronic bacterial infection caused by Mycobacterium tuberculosis bacteria that can be transmitted through the air when an infected person coughs, sneezes, or talks) is completed. Record review of the undated and untitled list of all facility staff revealed that Nurse Aide-A (NA-A) had a current hire date of 7/14/25. Record review of the individual employee personnel file for NA-A revealed no health screening for NA-A. Record review of the individual employee medical file for NA-A revealed an Employee Medical History Form dated 12/2/24. The file did not contain a health screening for NA-A’s current hire on 7/14/25. Interview on 8/4/25 at 3:08 PM with the Business Office Payroll (BOP) confirmed that NA-A originally worked in the facility from 12/2/24 to 5/31/25. BOP revealed that NA-A was only gone for a couple of months before being re-hired so the Infection Preventionist chose not to redo the health screen. Record review of the undated COBRA Coverage Details (Consolidated Omnibus Budget Reconciliation Act, is a federal law that allows eligible individuals to temporarily continue their employer-sponsored health insurance coverage after certain qualifying events, such as job loss that would otherwise cause them to lose coverage) for NA-A revealed a qualifying event of Voluntary Termination with a date of 5/31/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Application for Employment dated 7/14/25 for NA-A revealed that it was an application for full-time employment. Record review of the General Orientation Checklist dated 7/14/25 for NA-A revealed that NA-A had a date of hire of 7/14/25. Record review of the Time Card Report dated 8/4/25 for NA-A revealed that NA-A worked hours in the facility from 12/2/24 to 5/31/25. The Time Card Report revealed no hours worked by NA-A after termination of employment on 5/31/25 until the re-hire date of 7/14/25. Interview on 8/5/25 at 11:59 AM with the facility Infection Preventionist (IP) confirmed that the facility did not complete a health screen for Nurse Aide-A (NA-A) on hire 7/14/25. B. Record review of the undated facility policy titled Enhanced Barrier Precautions (an infection control intervention involving the use of gown and gloves during high-contact resident care activities for residents with Multi-Drug Resistant Organisms (MDROs) as well as residents at increased risk of MDRO acquisition such as residents with wounds) revealed it is the facility policy to implement Enhanced Barrier Precautions for the prevention of transmission of multidrug-resistant organisms (MDROs). The policy defined “wound” as including residents with chronic wound, and not those with only shorter lasting wounds such as skin tears covered with a Band-aid or similar dressing. Enhanced Barrier Precautions are recommended for residents with wounds. EBP is indicated for residents with wounds. Record review of the Face Sheet for Resident 85 revealed that Resident 85 admitted into the facility on 7/21/25. Resident 85 had a chronic ulcer (an open wound on the surface of your skin that takes a long time to heal) of the right foot with the fat layer exposed. Record review of the care plan dated 7/31/25 for Resident 85 revealed that Resident 85 had a skin issue of a diabetic ulcer (an open sore or wound on the foot of a person with diabetes, often caused by a combination of nerve damage and poor circulation-a chronic ulcer) to the right lower leg. The care plan did not include the intervention for Enhanced Barrier Precautions (EBP). Record review of the progress note dated 7/30/25 at 5:03 PM for Resident 85 revealed that Resident 85 had an appointment with the Doctor of Podiatry (medical professional specializing in the diagnosis, treatment, and prevention of disorders of the foot, ankle, and related structures of the lower leg) for wound care of the right lower leg. Keep the area dry and covered. Change if it soaks through. Record review of the Orders list (a listing of all physician orders for a resident) for Resident 85 dated 7/31/25 revealed that Resident 85 is to have an Unna Boot (a compression gauze dressing filled with Zinc paste) in place to the right lower extremity- if soaks through use iodosorb (an antimicrobial gel) followed by absorbent pads and ace wrap as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 7/31/25 at 9:04 AM at the facility East Dining Room revealed that Nurse Aide-M (NA-M) assisted Resident 85 from the dining room into the resident’s room per wheelchair. NA-M assisted Resident 85 from the wheelchair into the recliner. NA-M did not wear gloves or an isolation gown. Interview on 7/31/25 at 9:44 AM with NA-M revealed that Resident 85 is not on Enhanced Barrier Precautions. Record review of the undated list titled Current Residents in EBP received from the facility on 7/31/25 revealed that Resident 85 was not included on the list. Observation on 7/31/25 at 11:46 AM at the room of Resident 85 revealed that the room door contained no identifier for Enhanced Barrier Precautions (EBP) and no signage for EBP in the resident room. Observation of both closets in the room revealed no isolation gowns in the room. Two boxes of disposable gloves were in a rack on the wall inside the resident room door across from the bathroom door. Interview on 07/31/2025 at 2:28 PM with the facility Infection Preventionist (IP) revealed that residents on EBP were identified by a “Blue” dot adhered to the outside of the door to their room. The IP revealed that personal protective equipment (PPE) gowns are stored in the resident’s room in their individual closet along with a trash can for disposing of used PPE. Interview on 7/31/2025 at 3:28 PM with the facility Director of Nursing (DON) revealed that the facility identified that the previously provided list of Current Residents in EBP was missing 4 residents including Resident 85. The DON provided a handwritten list of the 4 residents that had been omitted. The handwritten list included Resident 85 as being on EBP. Observation on 8/4/2025 at 7:59 AM outside the room of Resident 85 revealed that the room door was closed. A blue dot indicating the need for use of EBP was now in place on the upper left door frame for Resident 85. Observation on 8/5/25 at 9:10 AM in the facility therapy room revealed Resident 85 exercising on exercise equipment with the therapist monitoring the resident. The right foot of Resident 85 had an ace wrap over the ankle and mid foot with white dressing material visible protruding from the front of the ace wrap. The resident toes were medium red in color and swollen. C. Record review of facility's undated policy titled “Handwashing” revealed: Policy: This facility considers hand hygiene the primary means to prevent the spread of infections. Procedures: 1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Hand hygiene products and supplies (sink, soap, towels, alcohol-based hand rubs, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial soap and water or alcohol-based hand rub under the following conditions: g. Before and after eating or handling food (hand washing with soap and water); h. Before and after assisting a resident with meals 8. The wearing of artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities and is prohibited among those caring for severely ill or immunocompromised residents. The Infection Control Coordinator maintains the right to request the removal of artificial fingernails at any time if he or she determines that they present an unusual infection control risk. Record review of a policy titled, “Food Safety Requirements-Use and Storage of Food and Beverage Brought in for Resident, Food Procurement” undated reveals: Policy: It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods including those brought to residents by family and other visitors. It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state or local authorities. The food service workers, cooks, dietary aides, dishwashers, food prep aides or any person(s) who are in the kitchen working with any type of food, are responsible to adhere to the food and safety requirements. Types of Food Contamination Food contamination falls into 3 categories as follow: 1. Biological Contamination-biological contaminants are pathogenic bacteria, viruses, toxins, and spores that contaminate food. The two most common types of disease producing organism are bacteria and viruses. Parasites may also contaminate food but are less common. 2. Chemical Contamination-The most common chemicals that can be found in a food system are cleaning agents, (such as glass cleaners, soaps, and oven cleaners) and insecticides. 3. Physical Contamination-Physical contaminants are foreign objects that may advertently enter the food. Examples include but are not limited to staples, fingernails, jewelry, hair, glass, metal shavings from can openers, and pieces of bones. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 08/04/2025 at 12:00 PM just prior to meal service residents were observed sitting at dining tables while Dietary Aide (DA)-N pushed a hand cart with salad items, bowls and drinks. DA-N picked up a serving spoon from the container of salad and placed the salad in a bowl and served the item to several residents. DA-N was observed pouring and serving drinks to the residents. While pushing a hand cart, DA-N poured several drinks into cups and placed them on the table for several residents, hand hygiene was not observed to occur between resident meal/drink delivery. Two additional dietary aides arrived to set up and serve hot cooked/prepared foods. One dietary aide scooped items from the steam table onto the plates and bowls, then placing the plates and bowls onto the hand cart along with a placard that detailed the specific residents’ choices and dietary restrictions. DA-N picked up the placard, plate/bowl of food and delivered the items to the resident, DA-N then returned placing the placard in a pile and waited for the next plate/bowl to be assembled. During service, DA-N was observed to have long artificial nails, not wearing gloves. After meals were delivered, DA-N pulled out of the freezer a container of homemade ice cream, placed the item on the hand cart, in addition to bowls, and other items to add to the ice cream. DA-N pushed the cart from table to table, scooped the ice cream into a bowl, and served the dessert to all residents requesting the item. Other pre-prepared bowls of fruit cocktail were served to residents not requesting ice cream. Hand hygiene was observed to not occur between drinks, salads, resident meal delivery and dessert delivery for the entirety of the meal service. An interview on 08/04/2025 at 1:42 PM, the Dietary Manager (DM) revealed they were aware that DA-N has long artificial nails. A review of the Nebraska Food Code and policy, the DM revealed, since DA-N only delivers food and does not cook, they did not agree that the artificial nails were a concern. When DM was interviewed about speaking with the Infection Preventionist (IP) about the policy that details it is at the discretion of the IP regarding artificial nail use, the DM revealed No. An interview on 08/05/2025 at 10:05 AM, the IP confirmed that artificial nails should not be worn in the dietary department and had communicated this previously as a concern. Record review of a dietary skill competency and annual performance review for DA-N dated 03/08/2024 revealed staff member demonstrates acceptable personal hygiene habits for the following areas: -Keeps fingernails short, unpolished and clean. -Washes hands as necessary -Uses and changes gloves as necessary D. A record review of an undated facility policy titled “Cleaning and Storage of Respiratory Devices” revealed oxygen tubing is changed monthly and this order will be on the treatment administration record as a nursing order. Resident oxygen tubing will be stored in a bag attached to oxygen concentrator. A review of a “Resident Face Sheet” revealed the facility admitted Resident 37 on 02/19/2019 with diagnoses that included Chronic Obstructive Pulmonary Disease (a condition that causes air flow blockage and breathing problems that is progressive). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 37 “Administration Record” from 07/05/2025 through 08/04/2025 revealed the resident received supplemental oxygen via a nasal cannula on a routine basis. The resident had direction entered to have oxygen tubing changed once a month and this was documented as completed on 07/15/2025. In an observation completed on 07/30/2025 at 11:05 AM, Resident 37 was observed to be sitting in their recliner with eyes closed. The resident had their oxygen placed in their nasal passage. There was no labeling on the oxygen tubing indicating when it had been changed or replaced. There was no storage for the oxygen tubing attached to the oxygen concentrator. The excess oxygen tubing was on the floor of the residents room from where the concentrator was sitting at the foot of the bed to where the resident was sitting in their recliner approximately 10 feet. In an observation completed on 07/31/2025 at 9:04 AM, Resident 37 was observed to be sitting in their recliner with eyes closed. The resident had their oxygen placed in their nasal passage. There was no labeling on the oxygen tubing indicating when it (tubing) had been changed or replaced. There was no storage for the oxygen tubing attached to the oxygen concentrator. The excess oxygen tubing was on the floor of the resident’s room from where the concentrator was sitting at the foot of the bed to where the resident was sitting in their recliner approximately 10 feet. In an observation completed on 08/04/2025 at 10:15 AM, Resident 37 was observed to be sitting in their wheel chair in front of their recliner. The resident had their oxygen placed in their nasal passage. There was no labeling on the oxygen tubing indicating when it (tubing) had been changed or replaced. There was no storage for the oxygen tubing attached to the oxygen concentrator. The excess oxygen tubing was on the floor of the residents room from where the concentrator was sitting at the foot of the bed to where the resident was sitting in their wheel chair approximately 10 feet. In an interview completed on 08/05/2025 with Licensed Practical Nurse K (LPN-K), LPN-K stated that oxygen tubing and supplies are changed once a month on the night shift. The LPN stated they were not aware if the tubing or storage bags for the oxygen tubing were labeled or dated indicating when they were placed or changed. The LPN confirmed that staff just assumed that this was completed on the once monthly basis. The LPN confirmed that Resident 37’s oxygen tubing should not be sitting on the floor and each resident was to have a bag hanging on the back of their concentrator for oxygen tubing storage. The LPN confirmed that Resident 37 did not have this present for storage of their oxygen tubing. In an interview completed on 08/05/2025 with the Director of Nursing (DON) the DON confirmed that there should be a storage bag hanging on the concentrator for oxygen tubing storage. E. A record review of a facility's undated policy titled “Cleaning and Storage of Respiratory Devices” revealed nebulizer masks are rinsed with clean water and allowed to dry prior to the next use and soaked daily in a diluted vinegar solution. After rinsing masks- is to be stored in a basin and allowed to air dry. Tubing, masks and storage basin are to be changed monthly and this direction will be placed on the administration record. A review of a “Resident Face Sheet” revealed the facility admitted Resident 46 on 04/26/2024 with diagnoses of unspecified circulatory and respiratory symptoms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 46's “Administration Record” from 07/05/2025 through 08/04/2025 revealed the resident received Ipratropium-albuterol solution inhalation via nebulizer three times a day every day and supplemental oxygen via nasal cannula at bed time every night. The resident had direction entered to soak nebulizer mask and cup in vinegar one time daily in the evening. There was no direction to change the resident’s oxygen tubing once a month or nebulizer equipment (mask cup and tubing). In an observation completed on 07/30/2025 at 11:31 AM Resident 46’s nebulizer equipment was observed to be sitting on the table behind the resident’s chair on top of magazine and a Kleenex box. The resident had an oxygen concentrator at the foot of their bed. A bag was attached to the back of the concentrator and was dated 02/11 and had unlabeled or dated oxygen tubing coiled and being stored in the bag. In an observation completed on 07/31/2025 at 1:25 PM Resident 46’s nebulizer equipment was observed to be sitting on the table behind the resident’s chair in a gray kidney shaped plastic basin lined with a paper towel. The basin was not labeled or dated. The resident had an oxygen concentrator at the foot of their bed. A bag was attached to the back of the concentrator and was dated 02/11 and had unlabeled or dated oxygen tubing coiled and being stored in the bag. In an interview completed on 08/05/2025 with Licensed Practical Nurse K (LPN-K), LPN-K stated that oxygen tubing, and supplies are changed once a month on the night shift. The LPN stated they were not aware if the tubing or storage bags for the oxygen tubing were labeled or dated indicating when they were placed or changed. The LPN confirmed that staff just assumed that this was completed monthly. The LPN confirmed that Resident 46 did not have directions placed in their administration record for the oxygen tubing to be changed monthly or for the nebulizer equipment to be changed monthly and should be. The LPN confirmed the gray kidney shaped plastic basin should not be labeled with the date of 08/15/2025 and was and that the storage bag on the oxygen concentrator had the date of 02/11 on it. In an interview completed on 08/05/2025 with the Director of Nursing (DON) the DON confirmed that directions for changing of the nebulizer equipment and storage basin should be in the resident’s administration record and was not. The DON confirmed that the resident also did not have direction for their oxygen tubing to be changed monthly and should. The DON confirmed that the basin present in the resident’s room should not be labeled 08/15/2025 and the tubing storage bag should not be dated 02/11. F. A review of a facility policy titled “Enhanced Barrier Precautions” Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices), revealed gowns and gloves will be available near or outside of the resident’s room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285067	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holdrege Memorial Homes, Inc	1320 11th Avenue Holdrege, NE 68949

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of an “Resident Face Sheet” revealed the facility admitted Resident 2 on 11/05/2024 with a diagnosis of stage 3 chronic kidney disease (a condition of moderate kidney damage and reduced kidney function where the kidneys filter blood less effectively leading to a buildup of waste products in the body), left toe amputation, and diabetes (a condition characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). A record review of Resident 2’s “Care Plan” revealed a problem of Enhanced Barrier Precautions with a start date of 02/06/2025. The goal was stated that the resident will remain free from infection and a target date of 09/01/2025. The approach of enhanced barrier precautions being in place and dated 02/06/2025 was the only listed approach for this problem. In an observation completed on 07/30/2025 at 2:45 PM it was observed that Resident 2 did not have any Personal Protective Equipment (PPE, includes clothing, gloves, face shields, goggles, facemasks, respirators, and other equipment to protect front-line workers from injury, infection, or illness) stored outside or near the outside of the resident’s room. There was no trash can near the exit of the resident’s room. In an observation completed on 07/31/2025 at 8:59 AM it was observed that Resident 2 did not have any PPE stored outside or near the outside of the resident’s room. In an interview on 07/31/2025 at 1:42 PM with Licensed Practical Nurse K (LPN-K), the nurse denied knowledge of what EBP was. When explaining the question further to the nurse the nurse was able to state 4 names of residents residing on the hall that staff were to use gowns when providing assistance to them. In an interview on 07/31/2025 at 2:28 PM with the facility Infection Preventionist (IP), the IP stated that residents on EBP were identified by a “Blue” dot adhered to the outside of the door to their room. The IP stated that personal protective equipment is stored in the resident’s room in their individual closet. In an observation completed on 07/31/2025 at 3:00 PM of Resident 2’s room. No gowns were in either of the residents’ closets or in the drawers of their room. In an interview completed on 07/31/2025 at 3:28 PM with the facility Director of Nursing (DON) the DON confirmed that the facility policy stated that personal protective equipment was to be available near or outside of the resident’s room and storing the items in the resident’s closet of their room did not comply with the facilities policy. The DON confirmed that there should have been always gowns in Resident 2’s closet for use.