| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285071 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heritage Estates | 2325 Lodge Drive<br>Gering, NE 69341 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Licensure Reference Number 175 NAC 12-006.1(A)(i)Based on observation, record review, and interview the facility failed to ensure that residents were served the approved menu serving sizes. This affected 11 observed residents served food from the facility kitchen (Residents 77, 73, 19, 7, 65, 41, 92, 10, 60, 79, and 85). The facility census was 99.Findings are:<br><br>A.<br><br>Record review of the facility Resident Policies dated 12/2020 revealed that the facility will provide the resident with a diet that their physician has ordered. The menu selections are served to meet their orders and have been approved by a qualified dietitian.<br><br>Record review of the undated Questions & Answers from the undated facility admission packet revealed that the facility serves three meals a day. A dietician oversees dietary needs.<br><br>Record review of the recipe for Pureed Beef Soft Tacos (pureed is a cooked food item that has been ground with a blender into a smooth pudding-like consistency for residents with difficulty chewing or swallowing) dated 2026 revealed that the portion (serving size) was two #6 scoops (a total of 10.68 ounces). (One #6 scoop equals 5.34 ounces).<br><br>Record review of the recipe for Spanish [NAME] dated 2026 revealed that the serving size was one #8 scoop (4 ounces).<br><br>Record review of the recipe for Pureed Spanish [NAME] dated 2026 revealed that the serving size was one #8 scoop (4 ounces).<br><br>Record review of the recipe for Refried Beans dated 2026 revealed that the serving size was one #8 scoop (4 ounces).<br><br>Record review of the recipe for Pureed Refried Beans dated 2026 revealed that the serving size was one #8 scoop (4 ounces).<br><br>Observation on 6/24/26 at 11:08 AM at the 100/200 kitchen revealed 5 blue #16 dishers (scoops for serving food items at a measured amount of ounces) on the steam table.<br><br>Observation on 6/24/26 at 11:49 AM in the 100/200 kitchen revealed that Dietary Aide-H (DA-H) performed handwashing at the sink. DA-H removed the covers from the pans of food items in the steam table. DA-H placed a blue handled #16 disher (2 ounces) in the steam pan of pureed tacos. DA-H placed a blue handled #16 disher (2 ounces) in the steam pan of regular rice. DA-H placed a blue<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | handled #16 disher (2 ounces) in the steam pan of pureed rice. DA-H placed a blue handled #16 disher (2 ounces) in the steam pan of refried beans. DA-H placed a blue handled #16 disher (2 ounces) in the steam pan of pureed refried beans. DA-H began to plate a meal for Resident 77. DA-H used the blue handled #16 dishers to plate 1 scoop of pureed rice (2 ounces served-only half of the 4 ounces that should be served), 1 scoop of pureed refried beans (2 ounces served-only half of the 4 ounces that should be served), and 1 scoop of pureed taco (2 ounces served- less than 1/5th of the 10.68 ounces that should be served) onto the divided plate. DA-H placed the plate of food onto the service window and staff delivered the meal to the resident. DA-H plated a meal for Resident 73. DA-H used tongs to place a taco onto the plate. DA-H used the blue handled #16 dishers to place 1 scoop of regular rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H placed the plate of food onto the service counter widow and staff delivered the meal to the resident. DA-H plated a meal for Resident 19. DA-H used the gloved hands to place a soft taco onto the plate. DA-H used the blue handled #16 dishers to place 1 scoop of regular rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate on the service window counter and staff delivered the plate to the resident. DA-H plated a meal for Resident 7. DA-H used tongs to place a taco on the plate. DA-H used the blue handled #16 dishers to place 1 scoop of rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H used the gloved hands to place a soft taco onto a plate for Resident 65. DA-H used the blue handled #16 dishers to place 1 scoop of rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H used the gloved hands to place a soft taco onto a plate for Resident 41. DA-H used the blue handled #16 dishers to place 1 scoop of rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H began to plate a meal for Resident 92. DA-H used the blue handled #16 dishers to place 1 scoop of pureed rice (2 ounces served-only half of the 4 ounces that should be served), 1 scoop of pureed refried beans (2 ounces served-only half of the 4 ounces that should be served), and 1 scoop of pureed taco (2 ounces served-less than 1/5th of the 10.68 ounces that should be served) onto the divided plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H used tongs to place a taco onto a plate for Resident 10. DA-H used a blue handled #16 disher to place 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H used tongs to place a taco onto the plate for Resident 60. DA-H used the blue handled #16 dishers to place 1 scoop of rice (2 ounces served-only half of the 4 ounces that should be served) and 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H used the gloved hands to place a soft taco onto a plate for Resident 79. DA-H used a blue handled #16 disher to place 1 scoop of refried beans (2 ounces served-only half of the 4 ounces that should be served) onto the plate. DA-H sat the plate onto the service window counter and staff delivered the plate to the resident. DA-H began to plate a meal for Resident 85. DA-H used the blue handled #16 dishers to place 1 scoop of pureed rice (2 ounces served-only half of the 4 ounces that should be served), 1 scoop of pureed refried beans (2 ounces served-only half of the 4 ounces that should be served), and 1 scoop of pureed taco (2 ounces served- less than 1/5th of the 10.68 ounces that should be served) onto the divided plate. DA-H sat the plate onto the service window counter and<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | staff delivered the plate to the resident.<br><br>Observation on 6/24/26 at 12:20 PM in the 100/200 kitchen with the Dietary Manager (DM) confirmed that the blue handled dishers were #16, 2 ounces. The DM confirmed that the scoops were the wrong size to provide the amount of the food items as directed by the menu recipe for each item. The DM told DA-H that 2 scoops of pureed taco should be served as 1 scoop was not enough. The DM revealed that there is usually a chart with the disher sizes posted in the kitchen but it was not there.<br><br>Interview on 6/24/26 at 12:20 PM with the Dietary Manager (DM) confirmed that the amounts of rice and beans served did not meet the required serving size per the menu recipes. The DM confirmed that the amount of pureed tacos did not meet the menu recipe required serving size.<br><br>B.<br><br>A record review of recipe lasagna revealed serving size is 3 x 3 inches 1 slice per cooking direction and pan size.<br><br>A record review of recipe puree lasagna revealed serving size is #6 scoop per cooking direction and pan size.<br><br>A record review of recipe breadsticks revealed serving size is 1 each portion.<br><br>A record review of recipe puree breadsticks revealed serving size is #12 scoop per cooking direction.<br><br>A record review of recipe Cesar salad revealed serving size is 1 cup per assembly and direction.<br><br>A record review of recipe chopped, soft chilled steamed vegetables revealed serving size is #8 scoop or 4 ounce or 1/2 cup per cooking direction.<br><br>A record review of puree chilled steamed vegetables revealed serving size is #12 scoop per cooking direction.<br><br>A record review of recipe fresh fruit cup revealed serving size is 1/2 cup per assembly and direction.<br><br>A record review of recipe puree soft canned fruit revealed serving size is #10 scoop per assembly and direction.<br><br>An observation on 6/23/26 at 11:32 AM with Dietary Aide (DA)-K in one of three satellite kitchens revealed the foods being served are: lasagna, salad, fresh fruit, canned vegetables, and breadsticks. DA-K placed all service wear items on top of the food containers prior to serving.<br><br>An interview on 6/23/26 at 12:00 PM with DA-K revealed they use the scoop that is required for the meal. DA-K continues to reveal (gender) the kitchen staff have a monthly meeting that reveals this information, the scoop size and correlation is listed on a form that is posted on the wall of the satellite kitchen.<br><br>Record review of an undated form titled, Common Measurements with scoop sizes listed:<br><br>-#6 Scoop = 2/3 cup (c) = 6 ounces (oz)<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -#8 Scoop = 1/2 c = 4 - 5 oz<br><br>-#10 Scoop = 3/8 c = 3 - 4 oz<br><br>-#12 Scoop = 1/3 c = 2 1/2 - 3 oz<br><br>-#16 Scoop = 1/4 c = 2 - 2 1/4 oz<br><br>-#20 Scoop = 3 1/5 tablespoon (tbsp) = 1 ¾ - 2 oz<br><br>-#30 Scoop = 2 1/5 tbsp = 1 – 1 1/2 oz<br><br>A record review of recipe crispy beef tacos revealed serving size is 1 taco per modified cooking direction.<br><br>A record review of recipe beef soft taco revealed serving size is 2 tacos per cooking direction.<br><br>A record review of recipe puree beef soft taco revealed serving size is 2 #6 scoop.<br><br>A record review of shredded lettuce and diced tomatoes revealed serving size is 1/2 cup of lettuce and 1/4 cup of tomatoes per portion.<br><br>A record review of recipe Spanish rice revealed serving size is #8 scoop per cooking direction.<br><br>A record review of recipe puree Spanish rice revealed serving size is #8 scoop per cooking direction.<br><br>A record review of recipe refried beans revealed serving size is #8 scoop per cooking direction.<br><br>A record review of recipe puree refried beans revealed serving size is #8 scoop per cooking direction.<br><br>A record review of recipe paprika rice revealed serving size is #8 scoop per cooking direction.<br><br>A record review of recipe seven up cake revealed serving size is 3 x 2 inches 1 slice per cooking direction and pan size.<br><br>A record review of recipe puree seven up cake revealed serving size is #10 scoop per cooking direction.<br><br>An observation on 6/24/26 at 11:30 AM with Dietary Aide (DA)-L revealed tacos were proportioned by the cooks. All scoops available for service were all #12 green scoops (1/3 cup scoop size), and 1 #16 blue scoop (1/4 cup scoop size).<br><br>An interview on 6/24/26 at 12:00 PM with DA-L revealed all green 1/3 cup scoops are for all food items, the blue 1/4 scoop is for all bird eaters. When asked what a bird eater is, DA-L revealed little (genders) who do not eat a lot of food.<br><br>An interview with the Dietary Manager (DM) on 6/24/26 at 1:00 PM revealed knowing the dietary aides are not certain which scoops to use during service and that some training needs to occur to get everyone on the same process of serving. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>License Reference Number 175 NAC 12-006.18(B)(D)Based on record review and interview, the facility failed to ensure that infection control measures for hand hygiene were followed while assisting residents with eating meals and when donning (putting on) and doffing (taking off) gloves. This affected 8 residents of 8 sampled (Residents 57, 99, 16, 47, 36, 2, 22, and 55.); and the facility failed to ensure that those who had indwelling catheters had catheter bags kept off the floor. This had the potential to affect all residents in the 500 hall (Residents 22, 93, 99, 15, 24, 28, 69, 46, 90, 78, 16, 76, 82, 58, 57, and 5). The facility census was 99. Findings were: Record Review of the Hand Hygiene Competency dated 12/2019 revealed when one is to wash their hands with working within the facility. Hands were to be washed:Before eating or drinkingBefore each resident contactAfter touching a resident or handling their belongingsAfter contact with any body fluidsAfter handling contaminated itemsBefore and after glovingWhenever indicatedHand Hygiene using hand sanitizer was to be completed: 1. Before or after direct contact with a resident 2. After contact with resident's intact skin 3. After removing gloves or between changing gloves 4. After contact with inanimate objects, such as medical equipment in resident's room or vicinity.Record review of the facility policy dated 9/12/2027 Policy for Infection Prevention and Control Surveillance is stated under Standard precautions that all blood and body fluids for ALL Patients shall be considered potentially infectious. Accordingly, appropriate precautions shall be followed when there is a possibility of exposure to body fluids of ANY Resident. Team members must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Hand Hygiene shall be done for a minimum of 20 seconds, before and after all patient care. When hands are visibly soiled or contaminated, wash hands with soap and water. An antimicrobial soap is indicated for contract with severely immuno-compromised patients. Alcohol-based hand rubs may be used for decontaminating hands if hands are not visibly soiled, if there is no evidence of certain microbial infections or if running water and soap is not available. Any contact with patient's body fluids should be washed off immediately with soap and water. Hand Hygiene shall be done after removing and disposing of gloves and other protective equipment.Observation of resident care in the dining room of the 500 hallways on 6/22/2026 at between 12:10 PM and 12:50 PM revealed the following: -12:10 PM Resident 57 was seated at the dining table with a catheter cover over the catheter bag but the catheter bag was lying on the floor. -12:20 PM Nurse Aide (NA-B) started serving Resident 16. -12:21 PM Nurse Aide (NA) B and began to assist both Residents 99 and Resident 16 with their meals at the same time. -12:22 PM NA-B donned gloves on both hands then held the hamburger for Resident 16 to take a bite of the hamburger. -12: 23 PM NA-B pulled the wheelchair of Resident 99 closer to self with gloved hands. NA-B then took chips out of the single serving chip bag and fed Resident 16 some of the chips without changing gloves. -12:26 PM NA-B took a napkin for Resident 99 and wiped crumbs from their face. NA-B then started feeding Resident 99 spoons of food with gloved hands. -12:27 PM NA-B cut the Salisbury steak into smaller bites and fed Resident 16 with one hand then served a spoonful of food to Resident 99 with the same hand. - 12:30 PM NA-B continued to assist both Resident 99 and Resident 16 without performing any hand hygiene between residents and without changing gloves. -12:31 PM A staff member brought a covered cup of juice from the kitchen for Resident 99. NA-B removed the paper from the straw with the gloved hands and inserted the straw into the cup and assisted Resident 99 while drinking juice. After Resident 99 took a drink, NA-B continued helping both Resident 99 and Resident 16 with their meals. -12:32 PM NA-B removed both gloves and went to the coffee pot to get a large cup of coffee for Resident 57. NA-B did not use hand hygiene after removal of both gloves. NA-B then returned to the table where they were seated, donned a new set of gloves without performing hand hygiene, and continued to assist Resident 99 and Resident 16 with their meals. -12:35 PM Resident 16 finished eating and NA-B took the paper menu on the table for this resident and asked Resident what they wanted to eat tomorrow. NA-B then gave<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 99 a drink of water. -12:42 PM NA-B continued assisting both residents and at 12:43 PM used a paper napkin to wipe the face of Resident 99 and then NA-B removed both gloves, took a pencil, and filled out the menu for Resident 16. -12:45 PM Resident 57 put (gender) catheter bag in (gender) lap and continued to sit at the table drinking coffee from a large mug. -12:49 PM NA-B pushed Resident 57 to (gender) room with urinary catheter sitting on top of (gender) lap. NA-B has not used any hand hygiene. -12:50 Resident 22 was pushed to their room in a wheelchair by Licensed Practical Nurse (LPN)-A. After leaving Resident 22's room, LPN-A returned to the dining area, took hold of the wheelchair of Resident 16, and started to go to that resident's room, but NA-B returned to the area and took over. LPN-A didn't use HH and returned to the nursing office. NA-B did not use hygiene. Interview with NA-B on 6/22/2026 at 1:15 PM revealed that both Resident 16 and Resident 99 were assisted with their meals at the time and NA-B did not at anytime use Hand Hygiene by washing hands with soap and water or by using alcohol based hand rubs while feeding the residents. NA-B confirmed they did not use hand hygiene after the use of the gloves. NA-B did know that Resident 57's catheter bag was on the floor but did not hang it on the wheelchair. NA-B did state that Resident 57 wants to do things the way they did it at home prior to entering the facility. NA-B thinks it is care planned because Resident 57 gets upset if things are not done the way (gender) wants with the catheter bag. NA-B did state that when Resident 57 was pushed to their room, that the catheter was in the lap of this resident. NA-B confirmed that they did not know that urinary drainage bags should be kept below the level of the bladder.Interview with Medication Aide (MA) C on 6/22/26 at 1:20 PM revealed knowing that the catheter bag was seated on the floor while Resident 57 was eating and then did see that this resident put the catheter on top of their lap. MA-C confirmed that they did not know that putting the catheter bag on top of ones lap can potentially cause infections. Interview on 6/22/26 at 2:10 PM with LPN-A revealed that the staff get their training as it pertains to the feeding of the elderly during their classes when they become a certified nursing assistant and not certain what training they get through the facility. LPN-A confirmed that they did not know that one could not feed two people at one time without using hand hygiene between each resident. When asked if a urinary catheter bag should be left on the floor, the response of LPN-A was, Absolutely not. LPN-A confirmed that a catheter bag cannot be put onto the lap if the resident as that urine would be above the level of the catheter and cause a backflow of urine into the system. LPN-A stated that Resident 57 wants to do things that way they were done at home and will not keep the catheter bag attached to the chair. LPN-A confirmed that the urinary catheter bag should have been hanging on, or underneath of, the wheelchair as it is an infection control issue as well as a dignity issue. Record review of an untitled document dated 6/24/2026 revealed the following information as it pertained to resident 57: On 5/26/2026 the resident was noted to have his own catheter bag carrier, which was placed on the floor next to them in the dining area during lunch. This nurse attempted to educate the resident about the importance of having the catheter drainage bag attached to the wheelchair to which Resident 57 replied this is how I have always done it, it's ok. That may be how you do it, but I will do it my way. And refused to allow this nurse to assist with attaching the drainage bag to the wheelchair. The document further revealed education that the staff had been given and other findings about the resident and not keeping the catheter drainage bag off the floor as well as the importance of keeping the catheter bag below the level of the catheter to prevent backflow of the urine back into the bladder. On 6/1/2026 it stated that Resident 57 had been educated about receiving a new and clean catheter drainage bag cover and to not store the catheter bag on the floor, but that the resident was unwilling to make changes at that time. Family members as well as Resident 57 had been educated.Interview on 6/24/26 at 1:25 PM with Minimum Data Set (MDS)-O (a standardized, federally mandated clinical assessment tool used in Medicare and Medicaid-certified nursing homes to evaluate every resident's functional, medical, and psychosocial status) who stated, I was asked to write and bring you a letter that describes the issues that we have had with Resident and the care of their catheter bag. We have had issues since Resident 57's arrival at the facility as (gender) wants to do<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | things the way that it was done at and prior to admission. The letter was dated 6/24/26. This describes all that we have done as far as education with the resident, the resident's family, and with our staff. When asked if any of this was documented in the chart or in the electronic medical record prior to the survey team asking for information, MDS-O confirmed there was no documentation in the chart that documented any behaviors for Resident 57. MDS-O further confirmed that it is important to the facility to let the resident have choices, but when those choices affect the safety of other residents within the facility, the staff must work more diligently to make sure Resident 57 is not putting others at risk. B.Observation on 6/23/2026 during the period of 7:57 AM to 8:26 AM in the dining room of the 400 hall. -7:57 AM LPN-E is seated at the table between Resident 47 and Resident 36 assisting each of them with their breakfast. LPN-E did not wear gloves and there was no alcohol-based hand sanitizer (ABHS) on the table during the meal service. LPN-E gave each resident a bite of food while speaking to each of them. -7:58 AM LPN-E moved to sit between Resident 36 and Resident 27. LPN-E did not perform hand hygiene. LPN-E then gave Resident 27 a bite of food. LPN then reached out to assist Resident 36, then turned back to Resident 36. LPN-E continued to speak to all of the residents at the table. - 8:00 AM LPN-E arose from the table and walked to alcohol dispenser on the wall and used AHBS and returned to the chair seated between Resident 36 and Resident 27 and assisted Resident 27 with a bite of food. LPN-E then turned to Resident 36 and gave Resident 27 a bite of food. LPN-E consistently changed which silverware was used. No hand hygiene was performed. A second Nurse Aide (NA) F sat at the table to assist the residents while they ate. -8:04 AM - LPN-E reached out to Resident 36, took a napkin, wiped food off of lap of Resident 36, then reached back to Resident 27 and used a second napkin to wipe food off the clothing protector before serving another bite of food. Neither LPN-E or NA-F used any hand hygiene between residents as they assisted the residents. -8:11 AM MA-D sat at the table between Resident 47 and Resident 36 -8:26 AM MA-D removed their clothing protector after assisting Resident 47, put it in the dirty linens, then went to Resident 36 and removed the clothing protector, and then took Resident 36 to the resident's room. No ABHS was used between the residents while assisting with feeding the meals or after the clothing protectors were removed.In a confirmation interview with LPN-E at 10:05 AM, LPN-E revealed that all nursing staff go through a competency fair each year. There are 10-11 stations on infection control They also do assigned net learning each month where 3-5 learns are assigned. LPN-E confirmed that staff try not to feed more than one person at a time at the dining tables and further confirmed that neither LPN-E nor the other staff helping the Residents at the table used any hand hygiene during the meal process. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E) Based on record review and interview the facility failed to obtain complete consents for psychoactive medications for 2 of 5 residents (Residents 28 and 46), and failed to ensure that the resident power of attorney (POA; a legal document that allows a person to designate someone else to make decisions or act on their behalf regarding financial, legal, or medical matters) provided informed consent for use of psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) as required for 1 of 5 residents reviewed (Resident 51). The facility census was 99. Findings are:Record review of a facility document titled, Psychoactive medication and medication regimen review standard, dated 6/2026, revealed a policy for managing residents' medication regimens, as well as guidelines for psychoactive medications. The policy also revealed a consent for the use of psychoactive medications must be completed prior to initiating any psychoactive medication.<br><br>A.<br><br>Record review of a facility document titled, admission record, revealed Resident 46 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a progressive lung disease which causes restricted breathing), anxiety, major depressive disorder (mood disorder that can cause persistent feelings of sadness, hopelessness, and loss of interest in activities, bipolar disorder, and cervical spondylosis with radiculopathy (the degeneration of bones and disks in the neck which results in nerve pain).<br><br>A record review of Resident 46's medication orders in Point Click Care (PCC, an electronic medical record system), revealed that Resident 46 had orders for the following psychoactive medications:<br><br>- Alprazolam (an antianxiety medication) 0.5 milligrams (mg) by mouth 2 times daily for anxiety with an order date of 11/6/25.<br><br>-Divalproex (Depakote, a medication for bipolar, epilepsy - a seizure disorder, and migraine headaches) 125 mg twice daily, for major depressive disorder, with an order date of 6/12/26.<br><br>-Paroxetine (an antidepressant) 10 mg tablet at bedtime every other day for major depressive disorder, with an order date of 3/28/26.<br><br>-Quetiapine (Seroquel, an antipsychotic, used to treat schizophrenia, bipolar disorder, and major depressive disorder) 25 mg at bedtime every other day for major depressive disorder, with an order date of 3/16/26.<br><br>A record review of the Resident 46's electronic medical record (EMR) revealed the following facility documents each titled, Informed consent for use of psychotropic medications:<br><br>-A consent for Resident 46's paroxetine 10 mg at bedtime signed on 11/6/25 without a checkmark to select the antidepressant section or any side effects, and in the section, Statement of consent, neither box was checked to select if the medication had been consented to or not.<br><br>-A consent for Resident 46's Seroquel 25 mg every other day signed on 11/6/25 without a checkmark to select the antipsychotic section or any side effects, and in the section, Statement of consent,<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | neither box was checked to select if the medication had been consented to or not.<br><br>-A consent for Resident 46's alprazolam 0.5 mg twice a day signed on 11/6/25 without a checkmark to select the antianxiety section side effects.<br><br>-A consent for Resident 46's divalproex signed on 6/12/26 revealed no diagnosis for which the medication was prescribed, and in the section, Statement of consent, neither box was marked to indicate whether the medication had been consented to or not.<br><br>A record review of Resident 46's progress notes included a note dated 6/11/26, which revealed Resident 48 had been prescribed Depakote for 30 days, ending on 5/25/26. Resident 46's medical provider had noted during a visit on 6/10/26 the medication was no longer on the resident's medication list and wanted to restart it.<br><br>A record review of the EMR revealed no evidence Resident 46 or their representative had consented to the administration of Depakote for the 30 days ending 5/25/26. The facility did not provide evidence that consent had been obtained.<br><br>B.<br><br>Record review of a facility document titled, admission record, revealed Resident 28 was admitted on [DATE] with diagnoses of Type 2 diabetes mellitus (a chronic disease in which the body does not use insulin correctly, which can lead to high blood sugar levels and severe complications), chronic respiratory failure, and major depressive disorder.<br><br>A record review of Resident 28's medication orders in PCC revealed an order to administer mirtazapine (an antidepressant) 7.5 mg tablet at bedtime for major depressive disorder, with an order date of 6/17/26.<br><br>A record review of the Resident 28's EMR revealed a facility document titled, Informed consent for use of psychotropic medications, signed on 6/1/26 revealed a consent for Resident 28's mirtazapine 7.5 mg. No diagnosed condition was selected on the form to indicate why the medication was prescribed and, in the section, Statement of consent, no option was marked to indicate whether the medication had been consented to or not.<br><br>An interview on 6/25/2026 at 8:45 AM with the Director of Nursing confirmed the psychoactive medication consents for Residents 46 and 28 were not filled out completely and should have been.<br><br>An interview on 6/25/26 at 8:34 AM with the Facility Administrator confirmed the psychoactive medication consents for Residents 46 and 28 were not filled out completely and should have been.<br><br>C.<br><br>Record review of the facility policy titled Psychoactive Medication and Medication Regimen Review Standard dated 6/26 revealed that consent for use of psychoactive medication form must be completed prior to initiating and with the increase of any psychoactive medication. It must be reviewed/updated quarterly in conjunction with the care planning process and as needed (PRN). Completion of this form is required for every resident that receives routine or prn psychoactive medication.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 51 dated 5/6/26 revealed that Resident 51 had a diagnosis of depression and non-Alzheimer's dementia (a diverse group of brain disorders causing cognitive and functional decline). The MDS revealed that Resident 51 received an antipsychotic (a psychotropic medication) 7 days of the 7-day MDS lookback period.<br><br>Record review of the current care plan for Resident 51 dated 6/7/24 revealed that Resident 51 used medications with black box warnings (alerts to healthcare providers and patients to serious, life-threatening, or permanently disabling adverse effects). Additional review of Resident 51's care plan reveals resident's (family member gender) is resident's POA and HPOA (healthcare power of attorney).<br><br>Record review of the Order Summary (a listing of all physician orders for a resident) for Resident 51 dated 6/24/26 revealed that Resident 51 had an order for Abilify (an antipsychotic medication) 2 milligrams (mg) daily for depression. The order date was 5/4/26.<br><br>Record review of the medical record for Resident 51 revealed no evidence of a consent for use of psychotropic medications with acknowledgement of the POA.<br><br>Interview on 6/24/26 at 11:18 AM with the nurse manager licensed practical nurse (LPN)-N for Resident 51 confirmed that the facility is required to receive a psychotropic consent form for the resident or the POA as required.<br><br>Interview on 6/24/26 at 12:58 PM with the facility Staff Development Nurse (SDN) revealed that the nurse manager is responsible for receiving a psychotropic medication consent form when a medication is ordered from the physician, signed either by the resident or the resident's POA. |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>Licensure Reference Number 175 NAC 12-006.05(E)(F)Based on record review and interview, the facility failed to ensure that Resident Rights, which are presented to the residents and resident representatives at the time of admission, are honored and followed as written. This affected one resident of one sampled, Resident 22. The facility census was 99. Record review of the Resident Rights (federally protected rights that ensure a safe, dignified, and respectful life which guarantee freedom from abuse, the ability to make personal choices, and the right to proper medical care. Facilities must fully inform residents of these rights upon admission.) received from the Facility Administrator (FA) had a copyright date of 2017 and revealed the document is to inform you of your rights as a resident of this facility. Federal law requires that we provide these rights in writing, in a language and format you understand, upon admission and throughout your stay. Carefully review these rights by yourself and / or with your responsible party. During your stay, if any of these change, you will be given a revised copy. In addition, these rights are posted in the facility. Understanding your rights is important, and it helps us provide you with the highest level of care. Included were the following rights:Your Right: To be information of all your rights upon admission and during your stay in the facility (F572)Your Right: To review and make changes to your own plan of care (F553)Your Right: To make choices about aspects of your life in the facility that are significant to you, the resident.Your Right: To be informed of your health status medical condition. TO be given information about the type of care that will be provided during your stay. To participate in planning you own care. Record review of the Quarterly Care Plan Conference Summary for Resident 22 dated 10/14/2025 revealed that Resident 22 was not invited to the care plan conference and did not attend the care plan conference. A family member or the resident's responsible party did attend. The summary revealed that during the meeting, nursing concerns, dietary intake, life enrichment participation and social service concerns were reviewed. It was also determined that Resident 22 would start meetings with a telehealth physician or nurse, and that the resident had started participating in more life enrichment opportunities. Record review of the Care Plan Acknowledgement Form dated 10/14/2026 revealed that the care plan had been conducted over the phone with the Power of Attorney (POA) - a trusted person who cares for financial and legal affairs) and Healthcare Power of Attorney (HPOA) - a trusted person who makes medical decisions for you. This person only steps in to make choices if you become too sick or hurt to speak for yourself. It ensures your doctors follow your exact wishes of Resident 22. There was no signature for Resident 22 and no indication that Resident 22 had attended nor was there evidence that Resident 22 was invited to the conference. The signature line of the Representative of Resident 22 was marked with an X and stated phone call with (POA) and then form was signed by the facility Director of Nursing (DON)Record review of the Care Plan Acknowledgement Form dated 11/4/2025 revealed that the family had declined the care conference and the Interdisciplinary Team (IDT) held a meeting (a collaborative meeting where professionals from different healthcare or service disciplines come together to plan, coordinate, and review a patient's care) to discuss the resident cares and Resident 22 was not in attendance nor was there evidence that Resident 22 was invited to the conference. Record review of the Care Plan Acknowledgement Form dated 1/6/2026 revealed that the family had declined the care conference and the IDT held a meeting to discuss the resident cares and Resident 22 was not in attendance nor was there evidence that Resident 22 was invited to the conference. Record review of the Care Plan Conference Summary dated 3/3/2026 revealed that Resident 22 had not been invited to the Care Plan conference.Record review of an undated and untitled note from the facility Administrator presented to the surveyors for review stated the following: Annually Resident Rights are sent out via mail to first Emergency Contact/POA or handed out to resident who are cognitively intact. Resident Rights Letters in our facility are sent out every January; Brief Interviews for Mental Status scores (BIMS Score - a quick,<br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 15-point cognitive screening test used primarily in nursing homes and post-acute care settings to evaluate a patient's memory, ability to learn, and orientation. 13 to 15 Points (Cognitively Intact): Normal thinking and memory; the patient can generally function independently with minimal tailored cognitive support. 8 to 12 Points (Moderate Cognitive Impairment): Noticeable memory and thinking issues. The patient may require extra assistance with certain daily tasks and tracking cognitive decline. 0 to 7 Points (Severe Cognitive Impairment): Significant difficulties in orientation and memory.) are reviewed and sent out at that time. January 2026 Resident Rights Letter for Resident 22 was sent via mail to their Resident Representative. At that time, Resident 22 had a recent health decline and had increased confusion. BIMS Score on 12/30/2025 was 6/15. Residents Rights reviewed with POA during care conference on 3/3/2026. Resident Rights are reviewed monthly at Resident Council Meetings. Resident rights letter and Resident Right Packet were signed and provided to Resident 22 in 2025.A blank form letter accompanied this undated and untitled note from the FA which revealed the following: Enclosed you will find a copy of the Residents' Rights according to law. It is important that you are aware of these rights, and it is out obligation to provide them to you on an annual basis.Interview on 06/22/2026 at 1:35 PM with Resident 22 revealed that when asking about care and treatment within the facility, Resident 22 was knowledgeable about hospitalizations, cares, staff, meals, some medications but not all, activities in the facility and those Resident 22 preferred to attend, some specific past medical history pertaining to infections, knowledge of other diagnoses, but had no knowledge of care plans or what care plan meetings were. When an explanation of what care plan meetings were and who is allowed to attend care plan meetings, Resident 22 stated they still had no knowledge of care plan meetings or having attended any in the past.Interview on 06/23/2026 at 2:57 PM with the Medical Records and Social Services Nurse (MR) who stated that Resident 22's Power of Attorney (POA) that used to live in town passed away last year (March 2025). After that, the new POA appointed was another family member who resides out of state. The POA was enacted. Because the POA was enacted, we (the facility staff) usually have a care conference over the telephone and just leave it at that. So even though Resident 22 could be invited to come to the care conference, we don't always have the residents who have a POA enacted come to those conferences or have any input since we have a phone call. When asked at what point residents give up their resident rights to attend care plan conferences to discuss their plans of care, MR stated that residents do not give up their rights to attend care conferences. When asked if the staff speak to the residents about their cares, MR stated that staff do talk to them but most input is from the Resident Representative or POA. We usually invite residents to the Care Plan meetings based on their BIMS score, MR stated that anyone with a BIMS score over 3 should be invited to the care plan meetings. When asked to confirm this, the MR again stated that anyone with a BIMS score over 3 should be invited to the care plan meetings so that they had some input into the plans of care for that individual. There are individuals whose BIMS scores change because they were sick one month and now, they are back to their normal baseline. Even though we usually just check in with the family, there is really no reason we couldn't have the residents come to the care plan meetings to visit or listen to the plans especially if they are able to speak to us. If there is something that we discuss that may upset them such as they are no longer able to go home and this is going to be their permanent home or other serious matters, we could take the residents back to their rooms and then finish the meetings with the POA. Yes, I do think that going forward we probably should bring the residents to the meetings if they are able to attend, or they want to attend, so they can talk to all of us.Interview on 6/24/26 at 9:00 AM with the Social Services Director (SSD) revealed At no point do residents give their rights away to participate in care plan meetings, it has more to do with their ability to understand what the care plan meeting is about. Interview on 6/24/26 at 9:08 AM with Medical Records and Social Services nurse (MR) revealed residents never give up their rights to be able to attend a care plan meeting. So I guess, all of them need to be invited to the care plan whether the family wants them there or not. If we get to a point in a meeting when it may be upsetting to the resident and the family<br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | would like to discuss part of the care plan without the resident in attendance, we could probably remove the resident from the situation at the time. Interview on 6/24/26 at 11:00 AM with the FA, it was revealed after record review of the undated and untitled note about the information pertaining to Resident Rights sent to Resident 22's POA also had a copy of the Resident Rights presented to surveyors with the admission packet. The FA further stated that residents who have a lower BIMS score are not invited to the care plan meetings either because family has asked that they not be there or because they have a lower BIMS score and would not understand. For those who have a BIMS score that changes due to health status, if the BIMS score is 6 and changes to an 11, we would not invite them if the score was 6 but if it changes and it is now an11, they would be invited. Invitations to the care plan meetings are dependent upon the BIMS score. We do send the resident representative a copy of the Resident Rights in the mail each year. Surveyors were given a copy of the resident rights. When asked if the resident rights says that residents have the right to participate in their care plans depending upon their BIMS score, the FA agreed that it states Residents have a right to participate in their care plan. Residents have a Resident Council and Resident 22 attends the Resident Council meetings frequently. In the council meetings they discuss the resident rights at that time, so all of the residents should know they have a right to go to their care plan meetings. When asked if the Residents ever give up the right to attend care plan meetings, the FA again stated that residents are invited to the care plan meetings if their BIMS score is high enough which would indicate whether they would understand what they are discussing in the meeting.In a confirmation interview with the Director of Nursing (DON) on 6/24/26 at 11:00 AM, the DON confirmed that all residents had a right to be invited to the care plan meetings, that residents do not give up this right, and this is not being done by the facility. There was also no documentation in the resident records that confirm the resident had been invited and that the resident had chosen either not to attend or did not want to attend. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to submit accurate Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) for the medication regimen for 1 (Resident 5) of 5 sampled residents. The facility identified a census of 99 residents. Findings are:Record review of a facility document titled, admission record, revealed Resident 5 was admitted on [DATE] with diagnoses of Type 2 diabetes mellitus (a chronic disease in which the body does not use insulin effectively, leading to irregular blood sugar levels and medical complications), acute respiratory failure, lymphedema (tissue swelling caused by extra fluid that is usually drained by the body's lymphatic system), and chronic lymphocytic leukemia (CLL, a type of cancer that affects the blood and bone marrow).Record review of Resident 5's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) dated 1/14/26, Section N revealed Resident 5 had received 2 insulin injections in the 7 days prior to the assessment. Record review of Resident 5's quarterly MDS dated [DATE], Section N revealed Resident 5 had received 1 insulin injection in the 7 days prior to the assessment.A record review of Resident 5's medication orders in Point Click Care (PCC, an electronic medical record system), revealed an order for an injection of semaglutide (Ozempic) 1 milligram at bedtime weekly for weight loss related to Type 2 diabetes. The orders also revealed no order for insulin.A record review of Resident 5's electronic Medication Administration Record (MAR) for January 2026 revealed they did not receive any insulin products. A record review of Resident 5's MAR for February 2026 revealed they did not receive any insulin products. A record review of Resident 5's MAR for March 2026 revealed they did not receive any insulin products. A record review of Resident 5's MAR for April 2026 revealed they did not receive any insulin products. A record review of the prescribing information for Ozempic last revised May 2026, revealed semaglutide reduces blood sugar by stimulating insulin secretion (Section 7 Drug interactions and Section 12 Clinical pharmacology). The prescribing information also revealed Ozempic did not contain insulin, can be administered while also taking insulin, and the ingredients did not list insulin.An interview on 6/24/26 at 11:08 AM with the MDS Coordinator (MDS-O) confirmed the facility reported the resident as receiving insulin injections for the January and April MDS assessments, and that Resident 5 did not receive insulin, they received Ozempic. MDS-O revealed the facility's corporate home office had previously advised them to report that way, but on 6/5/26 MDS-O was notified in writing that the facility should begin reporting Ozempic as insulin. The interview also revealed no corrections or modifications had been submitted for Resident 5's January or April 2026 MDS assessments. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Licensure Reference Number 175 NAC 12-006.05 (E)Licensure Reference Number 175 NAC 12-006.09 (E)(i)Licensure Reference Number 175 NAC 12-006.09 (F)(ii) Based on record review and interview the facility failed to ensure that residents , as well as their resident representatives, were invited to the care plan meetings on a quarterly basis for 1 of 4 residents reviewed (Resident 22); and failed to revise the care plan to meet the needs of the resident when an antipsychotic was initiated for 1 resident (Resident 51) of 5 residents sampled. The facility census was 99. Findings are:Record review of the policy Comprehensive Care Plans dated 11/28/2026 revealed that the facility will develop and implement a comprehensive care plan (a detailed, step-by-step guide used in long-term care (LTC). It lists a resident's exact medical, physical, and emotional needs. The goal is to help the resident stay as healthy and happy as possible) for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.<br><br>The policy explanation and compliance guidelines stated that person centered care means to focus on the resident as the center of control and support and the resident in making their own choices and having control over the daily lives. The care plan would include an assessment of the resident's strengths and needs and would incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>The comprehensive care plan would be developed within 7 days after completing the comprehensive Minimum Data Set (MDS) (a standard, required health form used by nursing homes. The Centers for Medicare and Medicaid Services (CMS) requires staff to use it to evaluate a resident's physical, mental, and emotional health) assessment.<br><br>The comprehensive care plan would be prepared by an interdisciplinary team that includes but it not limited to:<br><br>- the attending physician,<br><br>-a registered nurse,<br><br>-a nurse aide,<br><br>-a member of dietary,<br><br>-the resident and the resident's representative when practicable,<br><br>-other staff as needed or requested.<br><br>The comprehensive care plan would include measurable goals and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The goals would be utilized to monitor the resident's progress.<br><br>Record review of the Quarterly Care Plan Conference Summary for Resident 22 dated 10/14/2025 revealed that Resident 22 was not invited to the care plan conference and did not attend the care plan conference. A family member, the resident's responsible party, did attend. The summary revealed that (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | during the meeting, nursing concerns, dietary intake, life enrichment participation and social service concerns were reviewed. It was also determined that Resident 22 would start meetings with a telehealth physician or nurse, and that the resident had started participating in more life enrichment opportunities.<br><br>Record review of the Care Plan Acknowledgement Form dated 10/14/2026 revealed that the care plan had been conducted over the phone with the Power of Attorney (POA) - a trusted person who cares for financial and legal affairs) and Healthcare Power of Attorney (HPOA) - a trusted person who makes medical decisions for you. This person only steps in to make choices if you become too sick or hurt to speak for yourself. It ensures your doctors follow your exact wishes of Resident 22. There was no signature for Resident 22 and no indication that Resident 22 had attended nor was there evidence that Resident 22 was invited to the conference. The signature line of the Representative of Resident 22 was marked with an X and stated phone call with (POA) and then form was signed by the facility Director of Nursing (DON).<br><br>Record review of the Care Plan Acknowledgement Form dated 11/4/2025 revealed that the family had declined the care conference and the Interdisciplinary Team (IDT) held a meeting (a collaborative meeting where professionals from different healthcare or service disciplines come together to plan, coordinate, and review a patient's care) to discuss the resident cares and Resident 22 was not in attendance nor was there evidence that Resident 22 was invited to the conference.<br><br>Record review of the Care Plan Acknowledgement Form dated 1/6/2026 revealed that the family had declined the care conference and the IDT held a meeting to discuss the resident cares and Resident 22 was not in attendance nor was there evidence that Resident 22 was invited to the conference.<br><br>Record review of the Care Plan Conference Summary dated 3/3/2026 revealed that Resident 22 had not been invited to the Care Plan conference.<br><br>Record review of the Comprehensive Care Plan schedule list from 7/8/2025 revealed that the family had been notified of the care plan but no indication an invitation had been sent to Resident 22. Family member was coming to town in July and wanted to set up a conference on July 18th if possible.<br><br>Record review of the Comprehensive Care Plan schedule list from 8/12/2025 revealed that there was a Care Plan meeting at 10:45 AM with the family only. There was no indication that the resident had attended the Care Plan conference.<br><br>Record review of the Comprehensive Care Plan schedule list from 10/7/2025 revealed that there was a Care Plan meeting scheduled with Resident 22's family/POA on 10/14/2026 at 10:00 AM. There was no indication that the resident had attended the Care Plan conference.<br><br>Record review of the Comprehensive Care Plan schedule list from 10/14/2025 revealed that there was a Care Plan meeting at 10:00 AM with the family only over the phone.<br><br>Record review of the Comprehensive Care Plan schedule list from 11/4/2025 revealed the POA did not want to schedule a Comprehensive Care Plan conference as the POA of Resident 22 had been in close contact with the Nursing staff while this resident had been ill. There was no indication as to whether Resident 22 had been invited or attended the care plan meeting.<br><br>Record review of the Comprehensive Care Plan schedule list from 6/2/2026 revealed a message had (continued on next page) |

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|---|---|---|---|
| | 285071 | A. Building<br>B. Wing | 06/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Heritage Estates | 2325 Lodge Drive<br>Gering, NE 69341 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | been left with the POA. It was unknown what the date of the care plan meeting was to be and no indication that Resident 22 had been invited to the care plan meeting to discuss preferences or concerns about cares.<br><br>Record review of the Progress Notes about Resident 22 revealed that throughout the past year:<br><br>10/3/2025 at 12:44 PM revealed Social Services review note that started Resident 22 had started having some pain that was interfering with their ability to function. Resident 22 also had osteoporosis and osteoarthritis. Continues to be able to express themselves sufficiently.<br><br>10/14/2025 at 10:09 revealed a care plan conference in which the family was invited by telephone and the resident did not attend the conference with the IDT present for the call. The resident started participating in more activities at the facility.<br><br>1/6/2026 at 8:34 PM Social Services review for a quarterly Social services review revealed Resident 22 had no advanced directive in place to tell the staff what to do in the event if Resident 22's heart stopped beating or Resident 22 stopped breathing. Information was obtained from Resident 22 who revealed they only wanted selective treatment with artificial nutrition and nothing further. Cognitively, Resident 22 was able to express themselves sufficiently and able to make wants and needs known to staff as well as make all daily choices. Resident 22 was involved in activities, currently showed no signs of depression or anxiety, was able to talk to staff and other residents, and liked to watch television and talk to family on the phone weekly. Family was invited to the care plan.<br><br>3/2/2026 at 11:52 AM a note as entered by social services revealed Resident 22 had no advanced directive in place to tell the staff what to do in the event if Resident 22's heart stopped beating or Resident 22 stopped breathing. Information was obtained from Resident 22 who revealed they only wanted selective treatment with artificial nutrition and nothing further. Cognitively, Resident 22 was able to express themselves sufficiently and able to make wants and needs known to staff as well as make all daily choices. Resident 22 was involved in activities, currently showed no signs of depression or anxiety, was able to talk to staff and other residents, and liked to watch television and talk to family on the phone.<br><br>3/3/2026 10:46 that a care plan meeting was held by the IDT including the POA/Resident Representative for Resident 22 by phone care. Resident 22 did not attend the meeting. It was noted that Resident had a new medication which they refused to take due to making them feel nauseated.<br><br>Interview on 06/22/2026 at 1:35 PM with Resident 22 revealed that when asking about care and treatment within the facility, Resident 22 was knowledgeable about hospitalizations, cares, staff, meals, some medications but not all, activities in the facility and those Resident 22 preferred to attend, some specific past medical history pertaining to infections, knowledge of other diagnoses, but had no knowledge of care plans or what care plan meetings were. When an explanation of what care plan meetings were and who is allowed to attend care plan meetings, Resident 22 stated they still had no knowledge of care plan meetings nor did Resident 22 recall having attended any in the past.<br><br>Interview on 06/23/2026 at 2:57 PM with the Medical Records and Social Services Nurse (MR) who stated that Resident 22's Power of Attorney (POA) that used to live in town passed away last year (March 2025). After that, the new POA appointed was another family member who resides out of state. The POA was enacted. Because the POA was enacted, we (the facility staff) usually have a care conference over the telephone and just leave it at that. So even though Resident 22 could be<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | invited to come to the care conference, we don't always have the residents who have a POA come to those conferences or have any input since we have a phone call with the POA. When asked at what point residents give up their resident rights to attend care plan conferences to discuss their plans of care, MR stated that residents do not give up their rights to attend care conferences. When asked if the staff speak to the residents about their cares, MR stated that staff do talk to them but most input is from the Resident Representative or POA. We usually invite residents to the Care Plan meetings based on their BIMS score, MR stated that anyone with a BIMS score over 3 should be invited to the care plan meetings. When asked to confirm this, the MR again stated that anyone with a BIMS score over 3 should be invited to the care plan meetings so that they had some input into the plans of care for that individual. There are individuals whose BIMS scores change because they were sick one month and now, they are back to their normal baseline. Even though we usually just check in with the family, there is really no reason we couldn't have the residents come to the care plan meetings to visit or listen to the plans especially if they are able to speak to us. If there is something that we discuss that may upset them such as they are no longer able to go home and this is going to be their permanent home or other serious matters, we could take the residents back to their rooms and then finish the meetings with the POA. Yes, I do think that going forward we probably should bring the residents to the meetings if they are able to attend, or they want to attend, so they can talk to all of us.<br><br>An interview on 6/24/26 at 9:00 AM with the Social Services Director (SSD) revealed Resident do not give their rights to participate in care plan meetings, it has more to do with their ability to understand what the care plan meeting is about.<br><br>Interview on 6/24/26 at 9:08 AM with Medical Records and Social Services nurse (MR) revealed residents never give up their rights to be able to attend a care plan meeting. So I guess, all of them need to be invited to the care plan whether the family wants them there or not. If we get to a point in a meeting when it may be upsetting to the resident and the family would like to discuss part of the care plan without the resident in attendance, we could probably remove the resident from the situation at the time.<br><br>Interview on 6/24/26 at 11:00 AM with the Facility Administrator (FA), it was revealed after record review of the undated and untitled note about the information pertaining to Resident Rights sent to Resident 22's POA also had a copy of the Resident Rights presented to surveyors with the admission packet. The FA further stated that residents who have a lower BIMS score are not invited to the care plan meetings either because family has asked that they not be there or because they have a lower BIMS score and would not understand. For those who have a BIMS score that changes due to health status, if the BIMS score is 6 and changes to an 11, we would not invite them if the score was 6 but if it changes and it is now an11, they would be invited. Invitations to the care plan meetings are dependent upon the BIMS score. We do send the resident representative a copy of the Resident rights in the mail each year. Surveyors were given a copy of the resident rights. When asked if the resident rights says that residents have the right to participate in their care plans depending upon their BIMS score, the FA agreed that it states Residents have a right to participate in their care plan. Residents have a Resident Council and Resident 22 attends the Resident Council meetings frequently. In the council meetings they discuss the resident rights at that time, so all of the residents should know they have a right to go to their care plan meetings. When asked if the Residents ever give up the right to attend care plan meetings, the FA again stated that residents are invited to the care plan meetings if their BIMS score is high enough which would indicate whether they would understand what they are discussing in the meeting.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In a confirmation interview with the Director of Nursing (DON) on 6/24/26 at 11:00 AM, the DON confirmed that all residents had a right to be invited to the care plan meetings, that residents do not give up this right, and that residents are not being given an opportunity to attend the care plan conferences by the facility. We are inviting the Resident representatives or [NAME] of Attorney, but we are not inviting the Facility Residents themselves to the care plan meetings. Some may get invited just in passing as we visit them, but there is no written invitation and it is not documented in the chart. There was no documentation in the resident records that confirm the resident had been invited and that the resident had chosen either not to attend or did not want to attend.<br><br>C.<br><br>Record review of the facility policy titled Psychoactive Medication and Medication Regimen Review Standard dated 6/26 revealed that if a resident is on psychoactive medication, there should be a separate care plan in place (separate problem/need, goal, and interventions).<br><br>Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) for Resident 51 dated 5/6/26 revealed that Resident 51 had a diagnosis of depression and non-Alzheimer's dementia (a diverse group of brain disorders causing cognitive and functional decline). The MDS revealed that Resident 51 received an antipsychotic (a psychotropic medication) 7 days of the 7-day MDS lookback period.<br><br>Record review of the current care plan for Resident 51 dated 6/7/24 revealed that Resident 51 used medications with black box warnings (alerts to healthcare providers and patients to serious, life-threatening, or permanently disabling adverse effects). Additional review of Resident 51's care plan reveals no reference to an antipsychotic medication, the residents goals or interventions.<br><br>Record review of the Order Summary (a listing of all physician orders for a resident) for Resident 51 dated 6/24/26 revealed that Resident 51 had an order for Abilify (an antipsychotic medication) 2 milligrams (mg) daily for depression. The order date was 5/4/26.<br><br>An interview on 6/24/26 at 1:45 PM with MDS-P revealed that when an antipsychotic is initiated and the medication falls within the MDS lookback period, this will be added to the care plan. MDS-P agreed that the care plan for Resident 51 was missing the antipsychotic problem/need, goal, and interventions needed to care for the resident. |