STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Haven Nursing Home	309 North Madison Street Coleridge, NE 68727

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled:Number of residents cited:Licensure Reference Number 175NAC 12-006.11(E)Based on observation, record review and interview; the facility failed to ensure dishwasher temperatures were maintained at levels to ensure adequate sanitization to prevent potential food-borne illnesses. This had the potential to affect all residents that ate food out of the kitchen. The facility census was 21.Findings are:A. Review of the facility policy titled Nursing Home Dishwashing Policy, undated revealed the following:-The facility ensured sanitization either through high temperatures (180 degrees Fahrenheit rinse) or chemical sanitizers (50-100 parts per million (ppm) chlorine).-Sanitization requirements for a Chemical Sanitizing Machine consisted of the following:-Wash Cycle reached a minimum of 120 degrees Fahrenheit and Sanitizer Concentration was 50-100 ppm chlorine.B. Observation of dishwasher temperatures revealed the following:-On 4/6/26 at 9:17 AM the dishwasher temperature reached 100 degrees; the water temperature reached 110 degrees after 3 wash cycles were completed.-On 4/6/26 at 11:58 AM the dishwasher temperature reached 115 degrees after 2 wash cycles were completed.Review of the dishwasher temperature and sanitizer log for the months of March and April 2026 revealed the following:-On 3/2/26 the water temperatures were 118 degrees at the beginning of washing the breakfast and lunch dishes.-On 3/3/26 the water temperature was 118 degrees at the beginning of washing breakfast dishes.-On 3/4/26 the water temperatures were 118 degrees at the beginning of washing the breakfast dishes and 119 degrees at the beginning of supper dishes.-On 3/5/26 the water temperature was 118 degrees at the beginning of washing breakfast dishes.-On 3/6/26 the water temperatures were 117 degrees at the beginning of washing the breakfast dishes and 119 degrees at the beginning of supper dishes.-On 3/7/26 the water temperatures were 119 degrees at the beginning of washing the breakfast and lunch dishes.-On 3/8/26 the water temperature was 119 degrees at the beginning of washing breakfast dishes.-On 3/9/26 the water temperatures were 118 degrees at the beginning of washing the breakfast dishes and 119 degrees at the beginning of supper dishes.-On 3/11/26 the water temperatures were 119 degrees at the beginning of washing breakfast and lunch dishes and 118 degrees at the beginning of supper dishes.-On 3/12/26 the water temperature was 119 degrees at the beginning of washing lunch dishes.-On 3/13/26 the water temperature was 118 degrees at the beginning of washing breakfast dishes.-On 3/14/26 the water temperatures were 118 degrees at the beginning of washing the breakfast and lunch dishes.-On 3/15/26 the water temperature was 117 degrees at the beginning of washing breakfast dishes.-On 3/16/26 the water temperatures were 117 degrees at the beginning of washing breakfast and supper dishes and 119 degrees at the beginning of lunch dishes.-On 3/19/26 the water temperatures were 118 degrees at the beginning of washing breakfast and supper dishes and 119 degrees at the beginning of lunch dishes.-On 3/20/26 the water temperatures were 117 degrees at the beginning of washing breakfast dishes and 118 degrees at the beginning of lunch dishes.-On 3/22/26 the water temperature was 110 degrees at the beginning of washing lunch dishes.-On 3/24/26 the water temperature was 118 degrees at the beginning of washing supper dishes.-On 3/25/26 the water temperatures were 118 degrees at the beginning of washing breakfast and supper dishes.-On 3/27/26 the water temperatures were 119 degrees at the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	beginning of washing breakfast dishes and 118 degrees at the beginning of washing supper dishes.-On 3/28/26 the water temperature was 119 degrees at the beginning of washing supper dishes.-On 3/30/26 the water temperatures were 118 degrees at the beginning of washing breakfast dishes and 119 degrees at the beginning of washing lunch dishes.-On 3/31/26 the water temperatures were 118 degrees at the beginning of washing breakfast and lunch dishes.-On 4/1/26 the water temperatures were 112 degrees at the beginning of washing breakfast dishes, 118 degrees at the beginning of washing lunch dishes and 116 degrees at the beginning of washing supper dishes.-On 4/2/26 the water temperatures were 114 degrees at the beginning of washing breakfast dishes, 117 degrees at the beginning of washing lunch dishes and 118 degrees at the beginning of washing supper dishes.-On 4/3/26 the water temperature was 118 degrees at the beginning of washing lunch dishes.-On 4/4/26 the water temperatures were 112 degrees at the beginning of washing breakfast dishes, 115 degrees at the beginning of washing lunch dishes and 119 at the beginning of washing supper dishes.-On 4/5/26 the water temperatures were 116 degrees at the beginning of washing breakfast dishes and 115 degrees at the beginning of washing supper dishes.-On 4/6/26 the water temperature was 118 degrees at the beginning of washing breakfast dishes. An interview on 4/6/26 at 12:05 PM with the Certified Dietary Manager (CDM)-J confirmed that the dishwasher temperatures were not consistently at 120 degrees or above, however the sanitizer concentration was within the proper range.

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 175 NAC 12-006.05(E)Based on record review and interview; the facility failed to have comprehensive informed consent including timeliness of the consent (prior to medication given), medication doses and potential alternate treatment plans for the use of psychotropic (mind-altering) medications for Residents 2, 3, 4, 5, and 6. The sample size was 5 and the facility census was 21. Findings are: A. Review of the undated facility policy for Anti-psychotropic Drugs revealed the physicians and profession/direct care staff used psychotropic medication appropriately and worked with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. -The facility made every effort to comply with state and federal regulations related to the use of psychopharmacological (medications affecting mood, behavior, sensation, thinking, and behavior) medication in long-term care to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. -efforts to reduce dosage or discontinue psychopharmacological medications were ongoing as appropriate, for the clinical situation. -the facility documented discussion with the resident and/or responsible party regarding the risk versus benefits of the use of those medications including discussion and documentation of the presence of black box warnings (warnings for those medications with significant risks involving careful weighing of risks versus benefits) or off label use of the medication (use of medications prescribed for other than specifically approved groups (such as children or elderly), for which they were not specifically approved, affecting the prescribing of the medication to the resident. -the facility interdisciplinary team evaluated effects and side effects of psychoactive medication, within one month of initiating, increasing, or decreasing doses and during routine visits thereafter. B. Review of Resident 2's Minimum Data Set (MDS-comprehensive federally mandated assessment used to develop resident care plans) dated 2/2/26 revealed the resident has diagnoses including Anxiety and Depression. In addition, the resident had no signs or symptoms of depression when interviewed, and no documented behavior problems in the look back period. The resident took antianxiety and antidepressant medication. Review of Resident 2's Care Plan with a revision date of 2/25/26 revealed the resident used the psychotropic medications Mirtazapine (antidepressant), Sertraline (antidepressant) and Buspirone (antianxiety) for the treatment and management of the diagnoses of an Anxiety Disorder and Unspecified Depression. The medications were observed for side effects and effectiveness. The facility consulted with pharmacy, and the Medical Doctor (MD) to consider dosage reduction when clinically appropriate, at least quarterly and discussed with the family regarding the ongoing need for use of the medication. Review of Resident 2's Medication Administration Record (MAR) dated 4/1/26- 4/31/26 revealed orders for the following psychotropic medications: -Sertraline 100 mg give two tablets by mouth every day starting 10/3/25.-Mirtazapine 15mg 1 tablet daily at bedtime starting 1/5/26, and -Buspirone 7.5mg 1 tablet 3 times daily starting 2/17/26. Review of Resident 2's Psychoactive Medication Therapy Informed Consent Forms revealed no consent for the use of Buspirone and Sertraline (both with no stated dose and no alternative treatment plans to assist the resident/responsible party in making an informed decision regarding the medication) until 4/8/26 (6 months after the Sertraline was started and nearly 2 months after the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Buspirone was started. Additional review of the consent for the Mirtazapine dated 4/7/25 revealed no stated dose, no alternative treatment plan and no evidence the consent was for the current ordered dose. C. Review of Resident 3's MDS dated [DATE] revealed the resident had severe cognitive impairment and displayed physical, verbal, and other behaviors. In addition, the resident sometimes rejected care. The resident received substantial assistance with dressing, personal hygiene, and transfers. In addition, the resident was dependent for toileting hygiene and bathing. The resident had a diagnosis of Brain Dysfunction and Dementia and had received antipsychotic and antidepressant medications. Review of Resident 3's Care Plan with a revision date of 1/21/26 revealed the resident receive antidepressant medication for treatment of Depression and antipsychotic medications for treatment of Dementia with a Psychotic Disturbance. Review of Resident 3's MAR dated 4/1/26 through 4/31/26 revealed the resident receive the following psychotropic medication: -Sertraline (antidepressant medication) 25 mg 1 tab by mouth every day starting 10/29/25, -Sertraline 50mg 1 tab by mouth every day starting 8/8/25, -Risperdal (antipsychotic medication) 0.5mg 1 tablet 2 times daily starting 1/16/26, and-Lorazepam (antianxiety medication) 0.5mg 1 tablet every day as needed for anxiety starting 3/11/26 Review of Resident 3's Psychoactive Medication Therapy Informed Consent Forms revealed the following;-Lorazepam dated 2/6/26 consent signed; no dose of medication and no alternative treatment plan to consider.-Risperdal dated 2/6/26 consent signed; no dose of medication indicated and no alternative treatment plan to consider.-Sertraline dated 3/17/25 consent signed; no dose of medication indicated and no alternative treatment plan to consider. D. During an interview on 4/8/26 at 10:30 AM Licensed Practical Nurse (LPN)-D confirmed the facility had not obtained consent for the use of psychotropic medications prior to administering them and Resident 2's Sertraline, Mirtazapine, and Buspirone and Resident 3's Sertraline, Lorazepam or Risperdal did not include the dose of the medications being given, or potential alternate treatment plans with non-pharmacological interventions. In addition, LPN-D confirmed the facility was not obtaining signed consent with dose increases of the medications being implemented. E. Review of Resident 4's MDS dated [DATE] revealed the resident was admitted on [DATE]; had short and long-term memory problems; behaviors included wandering, hallucinations and delusions; required assistance with dressing, toileting, mobility and personal hygiene; had diagnoses of Non-Alzheimer's Dementia, Malnutrition, Anxiety, and Depression; and received Antipsychotic and Antidepressant medications. Review of Resident 4's Care Plan last revised on 2/27/26 revealed the resident required assistance with bed mobility, transfers, toileting, and dressing; had diagnoses of Depression and Anxiety; and received antianxiety, antipsychotic, antidepressant medications. Review of the MARs for September and December in 2025 and January and April in 2026 revealed the following regarding Resident 4's medications: -Risperidone(an antipsychotic medication) 0.25mg two times per day was ordered on 9/23/25 and was increased to 0.5mg two times per day on 3/24/26; (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mirtazapine (an antidepressant medication) 7.5mg at bedtime was ordered on 8/14/25, it was increased to 15mg on 12/5/25 and increased to 30mg on 1/10/26; -Lorazepam (an antianxiety medication) 0.5mg every 8 hours as needed was ordered on 9/17/25 and discontinued on 9/30/25, 0.5mg apply topically to inner wrist was ordered 9/29/25, and 0.5mg three times per day as needed was ordered on 2/16/26; and -Sertraline (an antidepressant medication) 25mg daily was ordered on 1/21/26 and increased to 50mg on 3/3/26. Review of the facility form Psychoactive Medication Therapy Informed Consent Form for Resident 4 revealed a consent was signed on 10/7/25 by the residents Responsible Party for Risperidone, Lorazepam and Mirtazapine. The form did not include the dosages of the medications and it did not include any alternative treatment options. There was no evidence the facility had new consents completed when the dosages of the medications were increased. Review of the facility form Psychoactive Medication Therapy Informed Consent Form for Resident 4 revealed consent was signed on 2/6/26 by the residents Responsible Party for Sertraline. The form did not include the dosages of the medications and it did not include any alternative treatment options and there was no evidence the facility completed a new consent when the medication was increased. Interview on 4/8/26 at 3:25 PM with LPN-D revealed the resident was taking Risperidone, Sertraline, Lorazepam and Mirtazapine. Further interview confirmed the Psychoactive Medication Therapy Informed Consents were not obtained prior to administering the medications or with dose increases and the forms did not include dosage amounts or alternative treatment options. F. Review of Resident 5's MDS dated [DATE] revealed the resident was admitted on [DATE]; was cognitively intact; was independent with dressing, personal hygiene, and transfers, required staff assistance with toileting; had diagnoses of Diabetes, Arthritis, Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety and Psychotic Disorder; and received antipsychotic, antianxiety, and antidepressant medications. Review of Resident 5's Care Plan last revised 3/17/26 revealed the resident was independent with mobility, dressing, personal hygiene, and transfers; required assistance with toileting; had diagnoses of Diabetes, Hypertension, Delusional Disorder, Anxiety, and Dementia; and received antipsychotic and antidepressant medications. Review of Resident 5's Order Summary with Active Medication Orders as of 4/8/26 revealed the resident received the following medications: -Fluvoxamine (an antidepressant medication) 50mg every day at bedtime for skin-picking behavior with an order date of 3/8/26; and -Quetiapine (an antipsychotic medication) 25mg every day at bedtime for dementia with an order date of 4/23/25 Review of the facility form Psychoactive Medication Therapy Informed Consent form for Resident 5 revealed it was signed by the Responsible Party on 4/17/25 for Quetiapine. There was no dosage documented and there wasn't any evidence of alternative treatment options. Further review of the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' Medical Record revealed there was no consent for Fluvoxamine. Interview on 4/7/26 at 12:50 PM with LPN-D confirmed there was no consent for Fluvoxamine and there wasn't any documentation related to alternative treatment options for the Quetiapine. G. Review of Resident 6's MDS dated [DATE] revealed the resident was admitted [DATE]; had short and long-term memory problems; had behaviors of wandering, delusions and verbal behaviors; required staff assistance with dressing, transfers, personal hygiene, and bed mobility; had diagnoses of Dementia, Anxiety and Depression; and received antipsychotic and antidepressant medications. Review of Resident 6's Care Plan last revised 1/14/26 revealed the resident required assistance with mobility, bed mobility, dressing, and personal hygiene; had diagnoses of Dementia, Anxiety, and Depression; and received antidepressant and antianxiety medications. Review of Resident 6's Order Summary with Active Medication Orders as of 4/8/26 revealed the resident received the following medications: -Clonazepam (an antianxiety medication) 0.5mg two times per day for anxiety with an order date of 7/13/25; -Quetiapine 100mg two times per day for dementia with an order date of 5/6/25; and -Venlafaxine (an antidepressant medication) 225mg every day for depression with an order date of 9/21/25. Review of the facility form Psychoactive Medication Therapy Informed Consent form for Resident 6 revealed it was signed by the Responsible Party on 3/5/25 for Quetiapine, Clonazepam, and Venlafaxine. Interview on 4/8/26 at 3:15 PM with LPN-D confirmed the consent for Resident 6 did not include the dosage of the medications or alternative treatment options. Further interview with LPN-D confirmed the facility did not obtain new consents when dosages of psychotropic medications were increased.

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on record review and interview; the facility failed to test symptomatic residents for Covid-19 for 1 (Resident 20) out of 16 sampled residents. The facility census was 21. Findings are: A. Review of the facility policy Covid-19 Policy and Procedure (undated) revealed the following:-all residents, families and staff would be educated regarding Covid-19;-the facility would report testing results per CMS (Centers for Medicaid and Medicare) guidelines;-residents, regardless of vaccination status with signs and symptoms of Covid would be tested; and-symptoms of Covid included cough and shortness of breath. B. Review of Resident 20's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 12/26/25 revealed the resident was admitted [DATE]; had moderate cognitive impairment; required assistance with dressing the lower body and needed supervision with toileting, personal hygiene and dressing the upper body; and had diagnoses of Chronic Lung Disease, Depression, Anemia, and Hypertension. Review of Resident 20's Care Plan last revised 12/29/25 revealed the resident was independent with ambulation, toileting and personal hygiene, and required assistance with dressing; the resident would be tested for Covid during an outbreak and per CMS regulations and for possible/suspected symptoms of Covid. Review of Resident 20's Progress Notes for February revealed the following entries:-on 2/12/26 at 6:07 AM and 12:30 PM the resident requested cough drops for complaints of a cough;-on 2/14/26 at 9:26 PM the resident was given cough syrup for a cough;-on 2/15/26 at 4:27 AM and 5:38 AM the resident was given cough syrup for a cough;-on 2/15/26 at 2:02 PM the resident requested to stay in the resident room for meals on this day due to coughing. The resident stated they did not want to spread germs with coughing at meals. Vital Signs were within normal limits and the resident stated the cough syrup was working well;-on 2/15/26 at 4:09 PM the resident refused a treatment due to not feeling well;-on 2/15/26 at 3:09 PM, 5:03 PM, 8:38 PM, and 9:46 PM the resident was given cough syrup for a cough;-on 2/16/26 at 4:08 AM the resident was unable to wear their Continuous Positive Airway Pressure (CPAP-a machine that uses mild, steady air pressure to keep breathing airways open during sleep for managing Obstructive Sleep Apnea) mask due to coughing;-on 2/16/26 at 4:25 AM the resident continued to have a frequent congested cough, was unable to sleep in bed and did not wear their CPAP because of frequent coughing. The resident slept in their recliner and was given cough medication. Vital Signs were within normal limits;-on 2/16/26 at 4:29 AM and 9:05 AM the resident was given cough syrup for a cough and continued to complain of coughing;-on 2/17/26 at 3:18 AM the resident refused to wear their CPAP mask due to coughing;-on 2/17/26 at 5:26 AM and 12:29 PM the resident was given cough syrup for a cough;-on 2/17/26 at 12:36 PM an order was received for the resident to have a Z-Pak (an oral antibiotic used to treat bacterial infections);-on 2/17/26 at 8:10 PM the initial dose of the Z-Pak was administered. The resident had a non-productive cough and a hoarse voice;-on 2/18/26 at 2:49 PM the resident continued to have an occasional dry cough but stated they were feeling better;-on 2/18/26 at 8:06 PM the resident stated the cough was improving;-on 2/19/26 at 21:59 PM the resident was given cough syrup for a cough;On 2/19/26 at 10:22 PM the resident continued on the Z-Pak for an upper respiratory infection, continued to have an occasional moist, non-productive cough and was given cough syrup as requested. The resident sleeps in the recliner and was not using their CPAP due to coughing. The resident was given a nebulizer treatment (a breathing treatment to help open the airway). Lung sounds had wheezes with breathing in and breathing out;-on 2/20/26 at 2:00 AM, 6:45 AM, and 9:48 AM the resident was given cough syrup for a cough;-on 2/20/26 at 6:01 PM the resident continued to have a non-productive cough, was taking the Z-Pak, and was complaining of not being able to sleep at night due to coughing;-on 2/20/26 at 10:06 PM the resident was given cough syrup for a cough;-on 2/20/26 at 10:17 PM the resident stated the cough was improving and was able to lay in bed with the CPAP on. The residents lungs continued to have wheezes;-on 2/21/26 at 12:09 AM the resident was given (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cough syrup for a cough;-on 2/21/26 at 3:33 PM the residents cough had improved. The resident had no requests for cough syrup this shift;-on 2/21/26 at 7:57 PM the last dose of the Z-Pak was administered and the resident did not report a cough; and-there was no documentation that the resident had been covid tested 2/12/26-2/21/26 (the length of the illness). Review of Resident 20's Lab Results Administration Record for February 2026 revealed the resident had an order for Covid-testing as needed. There was no evidence that the resident had been tested for Covid-19. Interview with the Infection Preventionist on 4/8/26 at 10:50 AM confirmed Resident 20 had symptoms of Covid-19 in February and staff were to be testing residents who had symptoms. Further interview confirmed the facility had no evidence that the resident had been tested for Covid during their illness.

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Licensure Reference Number 175 NAC 12-006.05(B) Based on record review and interview; the facility failed to issue the required Notice of Medicare Non-Coverage (NOMNC-the required Medicare information provided to residents being discharge from Medicare following a covered stay in which the facility is required to inform the resident 2 days in advance to allow for appeal of the facility decision if desired, and the cost for continued services within the facility) for Resident's 1 and 4. The sample size was 3 and the facility census was 21.Finding are: Review of Resident 1's Notice of Skilled Nursing Non-Coverage dated 2/19/26 revealed the resident would be responsible for the cost of care and services provided beginning on 2/25/26, however there was no evidence the resident had been informed of the right to appeal the facility decision to discontinue Medicare covered services, and no evidence of the cost of continued services in the facility. Review of Resident 4's Notice of Skilled Nursing Non-Coverage dated 9/22/25 revealed the resident would be responsible for the cost of care and services provided beginning 9/23/25, however there was no evidence the resident had been informed of the right to appeal the facility decision to discontinue Medicare covered services, and no evidence of the cost of continued services in the facility.During an interview on 4/9/26 at 8:29 AM the Social Service Director confirmed the facility initiated the discharges for Residents 1 and 4, however did not provide the required NOMNC forms to inform residents of their right to appeal the facility decision and the cost of continuing services in the facility.