STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Springs, LLC	3200 G Street South Sioux City, NE 68776

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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 notify the resident and/or their representative of potential risk or benefits prior to initiation of pf psychoactive medications for 3 (Residents 2, 5, and 8) of 5 sampled residents. The facility staff identified a census of 46.Findings are:A. Review of the facility policy Psychotropic Medication Use, last revised February 2025 revealed the following:-residents would not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record;-medications included antipsychotics, antidepressants, antianxiety, and hypnotics/sedatives were subject to prescribing, monitoring, and review requirements specific to psychotropic medications;-psychotropic medication management involved the resident, family and/or representative;-residents who had not used psychotropic medications were not prescribed or given those medications unless the medication is determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record;-prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and the physician would review the following with the resident/representative prior to obtaining documented consent or refusal: non pharmacological alternatives, the indication and rationale for the recommendation, the potential risks and benefits, and the representative right to accept or decline the treatment. B. Review of Resident 2's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 12/3/25 revealed the resident was admitted [DATE] with diagnoses of Cirrhosis (scar tissue of the liver which make it hard to function), Kidney Disease, Diabetes, and Anxiety; was cognitively intact; was independent with dressing, transfers, bed mobility, and toileting; and received antianxiety and antidepressant medications.Review of Resident 2's Care Plan, last revised 9/5/25 revealed the resident was independent with dressing, ambulation, bed mobility and toileting; received psychotropic medications for anxiety and insomnia; and had diagnoses of Diabetes, Chronic Kidney Disease, Insomnia, and Anxiety.Review of Resident 2's Order Summary Report with active orders revealed the resident was receiving Buspirone (an antianxiety medication) 5 milligrams (mg) three times daily for a diagnosis of Anxiety with a start date of 8/18/25; and Zolpidem (a sedative/hypnotic medication) 5mg at bedtime for a diagnosis of Insomnia with a start date of 8/18/25.Review of Resident 2's Consent for Use of Psychoactive Medications revealed no documentation that consent for the Buspar and the Zolpidem had been obtained by the facility prior to administration of the medications. C. Review of Resident 5's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Renal Disease, Bipolar Disorder (a brain disorder that causes changes in a person's mood, energy, and ability to function), Post-Traumatic Stress Disorder and Chronic Lung Disease; was cognitively intact; was independent with ambulation, dressing, and bed mobility, and required assistance with toileting; and received antipsychotic, antianxiety and antidepressant medications.Review of Resident 5's Care Plan last revised on 10/13/25 revealed the resident was independent with dressing, transfers, bed mobility and required assistance with toileting; received antipsychotic and antidepressant medications; and had diagnoses of Bipolar Disorder, Post-Traumatic Stress Disorder, Borderline Personality Disorder, and Insomnia.Review of Resident 5's Order Summary (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report with active orders revealed the resident was receiving Vraylor (an antipsychotic medication) 3mg at bedtime for a diagnosis of Bipolar Disorder with a start date of 3/25/25; and Amitriptyline 100mg at bedtime for a diagnosis of Depression with a start date of 4/16/25.Review of the facility facsimile (fax) dated 3/25/25 revealed Resident 5 received an increase of Vraylor to 3mg and Amitriptyline to 50mg.Review of Resident 5's Progress Note dated 4/17/25 revealed the resident had an increase in Amitriptyline to 100mg at bedtime and the resident (self-responsible) was aware (1 day after the start of the Amitriptyline, and not in advance).Review of Resident 5's Consents for Use of Psychoactive Medications revealed no documentation consent for the Vraylor and Amitriptyline increase on 3/25/25 had been obtained prior to administration. D. Review of Resident 8's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Anemia, Heart Failure, Bipolar Disorder, and Schizophrenia (a brain disorder causing disruptions in thought, emotions, and behaviors); had moderate cognitive impairment; required assistance with toileting, hygiene, dressing, and transfers; and received antipsychotic and antidepressant medications.Review of Resident 8's Care Plan last revised 1/6/26 revealed the resident required assistance with bed mobility, dressing, hygiene, toileting, and transfers; received psychotropic medications; and had diagnoses of Schizophrenia, Adjustment Disorder with Depressed Mood, and Obsessive-Compulsive Disorder.Review of Resident 8's Order Summary Report with active orders revealed an order for Fluvoxamine 100mg 1 tablet in the morning, and 2 tablets at bedtime for a diagnosis of Schizoaffective Disorder (combination of Schizophrenia symptoms and Bipolar Disorder symptoms) with a start date of 8/1/25.Review of Resident 8's Consents for Use of Psychoactive Medications revealed no documentation that consent for Fluvoxamine was obtained prior to administration. E. Interview on 1/14/26 at 2:10 PM with the Director of Nursing confirmed the facility did not have documentation to show consents for Resident 2's Buspar and Zolpidem, Resident 5's Vraylar and Amitriptyline, and Resident 8's Fluvoxamine were obtained prior to the medications being administered.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)Based on observations, record reviews, and interviews; the facility failed to maintain the cleanliness and condition of resident rooms/bathrooms in 3 (Rooms 206, 505 and 509) of 45 occupied rooms. This had the potential to affect 3 residents who resided in those rooms. In addition, the facility failed to clean and maintain bathhouses, and the windows, flooring and walls in corridors and the dining room. The total sample size was 17 and the facility census was 46. Findings are: A. Review of the undated Maintenance and Housekeeping Policy revealed the purpose of the policy was to ensure the facility was maintained in a safe, clean, functional, and hygienic condition through effective maintenance and housekeeping practices, thereby supporting operational efficiency, safety, and compliance with applicable standards and regulations. This applied to all buildings, infrastructures, equipment, utilities, common areas, and external premises of the facility. The following objectives were identified:-obtain a clean, safe, healthy environment.-prevent equipment and infrastructure deterioration.-ensure compliance with safety, health and environmental regulations.-minimize downtime and maintenance related risks.-promote accountability and continuous improvement.The following roles and responsibilities were identified for the maintenance team -perform preventative corrective and breakdown maintenance.-maintain records of inspections and repairs and servicing.-ensure safe operation of equipment and utilities.The following roles and responsibilities were identified for the housekeeping team:-maintain cleanliness of all designated areas per schedule. High touch and high risk areas were to receive priority cleaning. -use approved cleaning agents and equipment. -follow waste segregation and disposal guidelines.B. Review of the Deep Clean Check Off List revealed the following areas in the residents' rooms which were to be cleaned with documentation when cleaning was completed: -pull out the beds and sweep/vacuum under, wipe down the bed frames and springs.-pull out the dresser and sweep/vacuum underneath, wipe down sides.-dust and wipe down televisions. -clean ceilings, vents, and light fixtures.-clean windowsills and inside of windows.-clean and wipe down heater/radiator units, remove trash from inside of units. -clean and wipe down pictures/prints on the walls.-clean and wipe down garbage cans inside and out.-clean and wipe down all walls (clean out corners with scrapers if needed). -clean and wipe down doors, door jams, and door frames.-clean and wipe down closets and shelving inside and out.-clean and wipe down all tables, nightstands and rolling tables.-clean and wipe down all chairs. -clean and wipe down baseboards/edges.-clean and disinfect floors.-clean and disinfect toilets.-clean and disinfect vents (check for trash inside of vents).-clean and disinfect any wheelchairs in the rooms.inspect curtains for spills or damage and alert management to replace if needed. -clean and disinfect outside of refrigerators.-clean and disinfect phones, remotes, and anything else belonging in room. C. Environmental observations of the residents' rooms on 1/11/26 during the initial pool from 9:00 AM to 2:00 PM revealed the following:-resident room [ROOM NUMBER], the bathroom trash receptacle contained several pre-moistened cleansing cloths and an incontinent brief which were soiled with feces and the room had a feces odor. The window next to the resident's bed was covered with plastic and the window frame was paint chipped.-resident room [ROOM NUMBER], with a urine odor to the room. The mattress on the bed had brown discoloration, and an outline of a urine stain. The bed frame and headboard with heavy layer of dust/debris. The wheelchair in the room had brown spots which covered the wheels and handles of the chair. The vanity underneath the handwashing sink in the resident's room was missing the baseboard to the left side. In addition, there were brown colored stains on the ceiling which extended down the wall directly above the light fixture over the vanity/handwashing sink.-resident room [ROOM NUMBER], personal fan which blew directly across the resident's bed with heavy layer of dust/debris. The baseboard heater in the resident's room behind and to the side of the bed was missing the outside cover. The baseboard underneath the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handwashing sink/vanity was still intact but portions were pulled away from the wall. Observations of the facility shower/bathhouses on 1/12/26 at 9:25 AM revealed the following:-300 hall shower room, the ceiling directly above the shower chair had a 5 by 7 centimeter (cm) area of paint which had peeled away from the ceiling and was hanging. The remainder of the ceiling with areas of chipped paint.-500 hall whirlpool room, panel on the lower wall opposite of the tub with a heating/cooling unit. Two prongs extended from the panel which were to hold knobs for adjusting the temperature of the room. The panel with areas of brown discoloration which appeared to be rust. A window directly next to the whirlpool tub was covered with plastic and was secured with 2-3 inch blue masking tape around the perimeter of the window. A ceiling vent above the tub with a heavy layer of dust/debris. Interview with Bath Aide (BA)-A and BA-B on 1/12/26 at 9:35 AM verified the concerns related to the ceiling of the shower room. BA-A and BA-B confirmed the following regarding the whirlpool room:-there were no knobs for the heating/cooling unit in the whirlpool room. The staff would have to get someone from maintenance to come with pliers to adjust the temperature of the room. -the window did not close completely and the plastic wrap and tape helped to keep the cold out.-the ceiling vent above the whirlpool needed to be cleaned. During an environmental tour with the Assistant Social Service Director (SSD) /previous Administrator on 1/13/26 from 10:30 AM to 11:17 AM revealed the following:-room [ROOM NUMBER], the window frame remained paint chipped and was covered with plastic.-desk at the Nurse's Station between the 300 and the 500 corridors, with a wood veneer finish which was faded and worn completely away in areas. -the windows to bilateral sides of the corridor between the dining room and the 500 halls were spotted/soiled and required cleaning. The wall cover was peeled away on bilateral sides of the hall between the fire doors and the windows.-floor of the commons area leading to the 300 hall was scuffed with areas worn away/missing. -floor to the dining room with several scuffed areas underneath the residents' tables/chairs and at the entrance of the dining room by the 300 halls. During an interview on 1/13/26 at 11:20 AM the Assistant SSD/previous Administrator reported the following:-was aware on 1/11/26 the bathroom trash in room [ROOM NUMBER] contained soiled items and there was an odor in the room. The housekeeping staff were instructed to clean the room and remove the trash.-performed a daily check of the resident's room temperature and if a significant drop in temperature from the entrance of the room to the window, would then instruct the maintenance staff to cover the windows with plastic.-replaced the mattress in room [ROOM NUMBER] on 1/12/26 when notified of the strong urine odor.-the windows in the corridor required cleaning and indicated they had not been cleaned since the spring/summer months and the wall covering needed to be repaired. -flooring in the dining room and the hallways needed to be replaced.-desk at the Nurses' Station needed to be repaired. An interview with the Maintenance Supervisor on 1/14/26 at 8:00 AM confirmed the ceiling needed to be repaired in the shower room and knobs needed to be replaced on the heating/cooling unit of the whirlpool room. In addition, the baseboards needed to be repaired in rooms [ROOM NUMBERS] and the baseboard heater in room [ROOM NUMBER] needed a new cover. Interview with the head of House keeping on 1/14/26 at 8:30 AM confirmed the housekeeping staff were to clean the resident's bed frames, personal fans and the ceiling vents in the resident's rooms and the bath houses. If the housekeeping staff notice a resident's wheelchair was soiled then the staff should wipe down and notify nursing.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview; the facility failed to notify the ombudsman (a state appointed advocate for residents of nursing homes) of resident discharges as required for 3 (Residents 3, 4 and 48) of 3 residents reviewed. The facility census was 46.Findings are: A. Review of the facility policy Transfer and Discharge (undated) revealed it was the policy of the facility to permit each resident to remain in the facility and not transfer or discharge the resident from the facility, except in limited circumstances. The facility's transfer/discharge notice was to be provided to the resident and the resident's representative in a language and way they could understand. The notice was to include the name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care (LTC) Ombudsman. In addition, the notice was to be provided to the resident, the resident's representative if appropriate and the LTC Ombudsman as soon as practicable before the transfer or discharge. The Social Service Director (SSD) or designee was to provide copies of notices for emergency transfers to the Ombudsman, but they were to be sent when practicable, such as in a monthly list of residents, if the list met all requirements for content of notices. The facility was to then maintain evidence that the notice was sent to the Ombudsman. B. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 1/7/26 revealed the resident was admitted [DATE] with diagnoses of anemia, coronary artery disease, Non-Alzheimer's dementia, schizophrenia, anxiety, diabetes, bipolar disorder, and chronic obstructive pulmonary disease. Review of Resident's 4's Nursing Progress Notes revealed the following: -6/4/25 at 12:33 AM the resident was found in bed with a large, dark, foul smelling coffee ground emesis. The resident was sent to the emergency room for evaluation. -6/4/25 at 5:01 AM the emergency room was contacted and indicated the resident was admitted to the hospital. -9/4/25 at 7:15 AM the resident complained of weakness with difficulty standing/ ambulating and reported pain with breathing. The resident had a temperature of 102.2 degrees Fahrenheit with a pulse rate of 134 beats per minute. The resident was sent to the emergency room for evaluation. -9/4/25 at 2:16 PM the facility was notified the resident was admitted to the hospital with aspiration pneumonia. -11/24/25 at 4:38 PM the resident was unable to bear weight on the right leg with complaints of pain. The resident's right leg was swollen up to the thigh. The resident was sent to the emergency room for evaluation. -11/24/25 at 11:27 PM the resident was admitted to the hospital with weakness and leg pain. -1/4/26 at 6:40 PM the resident had an emesis and was lethargic. The resident's temperature was 104.4 degrees Fahrenheit and pulse was 122 beats per minute. The resident was sent to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emergency room for Evaluation. The resident was admitted to the hospital for a urinary tract infection. Review of the resident's medical record from 6/4/25 to 1/11/26 revealed no evidence that the Ombudsman had been notified of the resident's discharges to the hospital on 6/4/25, 9/4/25, 11/24/25 and on 1/4/26. Interview with the SSD on 1/13/26 at 8:26 AM confirmed the SSD was responsible for notification to the Ombudsman of resident discharges. The SSD further confirmed the Ombudsman had not been notified of Resident 4's discharges to the to the hospital. C. Review of Resident 48's Medical Record revealed the resident was admitted to the facility on [DATE] and discharged on 10/28/25. There was no evidence that the State Ombudsman was notified of Resident 48's discharge. Additional review revealed the facility had no evidence the facility was submitting a report to the State Ombudsman containing residents discharging from the facility. During an interview on 1/12/26 at 10:15 AM the SSD confirmed the facility had not been submitting the required discharge reports to the State Ombudsman including Resident 48. There was no evidence of reports being submitted in the past 6 months. D. Review of Resident 3's Medical Record revealed the resident was admitted to the facility on [DATE] and admitted to the hospital on [DATE]. There was no evidence that the State Ombudsmen were notified of the resident's discharge to the hospital on [DATE]. An interview on 1/13/26 at 11:30 AM with the SSD confirmed the facility had not notified the State Ombudsmen of the Resident 3 being discharged to the hospital.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(iii)Based on observations, interviews and record review; the facility failed to ensure insulin pens were labeled for all insulin dependent residents, failed to monitor the temperature of refrigerators containing medications, and failed to ensure expired medications were not available for resident use. In addition, the facility failed to ensure Resident 7's bedside medications were securely stored and failed to secure medications in Resident 31's room. The sample size was 17 and the facility census was 46. Findings are: A. Review of the facility policy Medication Storage dated 2024 revealed the following: -The facility ensured all medications housed on the premises were stored in the pharmacy or medication room according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. -All medications were stored in locked compartments (i.e., medications carts, cabinets, refrigerators, medication rooms) and under proper temperature controls,-All medications requiring refrigeration were stored in refrigerators with temperatures maintained within 36-46 degrees. Charts were kept on the refrigerators and temperature levels were recorded daily by the charge nurse or designee. B. Review of the facility information provided through the facility pharmacy dated April 2025 and titled Expired or Not Expired revealed the following: -expiration dating of many products change once the items are removed from their primary packaging and are in use -Once the products were opened, they needed to be used within a specific timeframe to avoid reduced potency and potentially reduced efficacy. -Expiry dates of all medications should be checked on a monthly basis. -Items to watch included insulins, as expiration dates could vary between pens and vials. C. Review of the undated facility list containing information regarding the stability of insulin stored at room temperature revealed the following: Novolog/Aspart (rapid-acting insulin made to control blood sugar in people with diabetes) was stable for 28 days if opened,Humalog/Lispro (rapid-acting insulin made to control blood sugar in people with diabetes) was stable for 28 days if opened,Basaglar (a long-acting insulin made to control blood sugar in people with diabetes) was stable for 28 days if opened, andLantus/Glargine (a long-acting insulin made to control blood sugar in people with diabetes) was stable for 28 days if opened.Revzoglar (a long-acting insulin injection used to improve glycemic control in adults and children with diabetes) was stable for 28 days if opened. Glargine-yfgn (a long-acting insulin made to control blood sugar in people with diabetes) was stable for 28 days once opened. D. During a tour of the facility medication carts and room on 1/12/26 at 2:40 PM the following were observed. -No insulin pens that were opened and on the medication carts, had the required opened (date when the medication was first opened) date to ensure the insulin was not being administered past the recommended use by date. -The following vial of insulin was observed: -Resident 35 had 1 vial of Lantus insulin that was opened on 11/30/25-The following insulin pens were found opened with no date indicating when they were opened: -Resident 19 had Basaglar (glargine) -Resident 23 had Humalog- 2 pens-Resident 31had Lantus- 2 pens and Novolog/Aspart-Resident 37 had Lispro and Lantus-Resident 39 had Aspart and Glargine-Resident 43 had Aspart and Rezvoglar-Resident 59 had Lantus and Rezvoglar (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. During an interview at 2:45 with Medication Aide (MA)-R reported being unsure how long insulin could be given once it was opened. The MA thought maybe 2-3 months but did not know for sure. MA-R confirmed that none of the insulins on the cart had dates when opened and thus staff would not know when to stop using them and/or open a new vial or pen. Further interview confirmed the MA had given undated insulin injections to residents. In addition, the MA confirmed giving insulin injections to residents. F. During an observation of a second medication cart revealed the following undated and opened insulin pens on 1/12/25 at 2:50 PM -Resident 2 had Lantus and Aspart-Resident 4 had Aspart and Rezvoglar-Resident 13 had Rezvoglar-Resident 21 had Aspart-Resident 22 had Basaglar-Resident 29 had Lantus-Resident 40 had Lantus (2 pens) and Lispro,and -Resident 54 had Glargine-yfgn G. During an interview on 1/12/26 at 2:55 PM with MA-T reported being unaware insulin pens were to be dated when opened, and in addition confirmed being unsure how long insulin pens could be used once opened I month I think. In addition, the MA confirmed giving insulin injections to residents. H. During a tour of the facility medication room on 1/12/26 at 2:58 PM the following was noted; -2 refrigerators containing resident medications and no evidence the facility had been completing daily temperature checks of the refrigerators to check to see if the medications were being held at appropriate temperatures.The following stock (used for whichever resident may need it) medications -an opened and undated vial of Tuberculin -5 Acetaminophen suppositories that expired on 9/2025-An unopened bottle of Acidophilous that expired on 4/28/25, and 12 unopened bottles of Antacid each containing 150 chewable tablets that expired on 10/2025. I. During an interview at 3:00 PM Registered Nurse (RN)-S confirmed the refrigerator temperature was to be checked daily, and the only temperature log completed was for December 2025, and there was no log for January 2026. In addition, RN-S confirmed that all outdated medications were to be destroyed so they were not available for use by residents. J. Review of the list of Residents taking subcutaneous (injections under the skin) antidiabetic medications revealed the following: -Resident 2 had orders for Lantus, inject 10 units twice daily and Novolog, inject 3 times daily based on the residents' current blood glucose levels. -Resident 4 had order for Lantus inject 15 units in the morning and 5 units in the evening.-Resident 19 had orders for Glargine inject 15 units at bedtime.-Resident 13 had orders for Rezvoglar 18 units at bedtime.-Resident 21 had orders for Aspart inject 13 units 3 times daily, and addition units based on the current blood glucose levels, and Lantus 20 units twice daily. -Resident 22 had orders for Glargine 5 units daily.-Resident 23 had orders for Humalog to be given based on the residents' current blood glucose levels. -Resident 29 had orders for Lantus inject 50 units daily.-Resident 31 had orders for Lantus inject 35 units daily.-Resident 35 had orders for Lantus inject 10 units daily.-Resident 37 had orders for Lantus inject 42 units daily and Lispro inject 3 times daily based on blood glucose levels. -Resident 39 had orders for Basaglar inject 20 units twice daily, and Novolog inject 3 times daily based on the residents' blood glucose levels. -Resident 40 had orders for Lantus inject 45 units daily and Lispro inject 12-16 units 3 times daily based on the resident's blood glucose levels. -Resident 43 had orders for Lantus inject 20 units in the morning and 5 units at bedtime.-Resident 54 had orders for Glargine inject 8 units at bedtime.-Resident 59 had orders for Lispro inject after each meal based on the residents' current blood glucose levels and Rezvoglar 28 units daily. K. During an interview on 1/12/26 at 3:05 PM the Director of Nursing (DON) confirmed that all insulins must be dated when opened, to prevent it from being used beyond manufacturers' recommendations to ensure effectiveness. In addition, all undated insulin present on the medication carts would be discarded and destroyed to prevent further use. In addition, the DON confirmed that the facility had information available to direct staff in how long all types of insulin could be given once opened and all medications that were expired should be discarded/destroyed in accordance with facility policy. Further interview with the DON confirmed the facility was to complete daily checks of the facility (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerators used for storing medications to ensure those medications requiring refrigeration were being held at appropriate temperatures. L. Review of the facility policy titled Self-Administration of Medications revised in February 2021 revealed the following: -Residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. -Self-administered medications were to be stored in a safe and secure place which was not accessible by other residents. If safe storage was not possible in the resident's room, the medications of residents permitted to self-administer were stored on a central medication cart or in the medication room. A licensed nurse would transfer the unopened medication to the resident when the resident requested. M. Record review of Resident 7's admission record revealed Resident 7 was admitted on [DATE] with a diagnosis of Emphysema (chronic lung disease). Record review of Resident 7's physician orders revealed on 12/30/25 an order for Albuterol Inhaler two puffs every four hours as needed for shortness of breath, cough or wheezing may be kept at bedside. A record review of Resident 7's assessments revealed a Medication Self-Administration Safety Screen was completed on 12/31/2025 revealing the Brief Interview for Mental Status (BIMS-interview used to determine cognition) was 13. According to the MDS (an assessment tool used for care planning) manual as score of 13 to 15 indicates a person is cognitively intact. The screen revealed Resident 7 was safe to self-administer the Albuterol Inhaler. Record review of Resident 7's January 2026 Medication Administration Record (MAR) revealed a physician's order for Albuterol inhaler, inhaling two puffs into lungs every four hours as needed for shortness of breath/cough/wheezing, may keep in room. The following observations were revealed of Resident 7's Albuterol Inhaler: On 1/11/26 at 11:20 AM the Albuterol Inhaler was sitting on top of resident's dresser, not locked up. On 1/12/26 at 9:15 AM the Albuterol Inhaler was sitting on top of resident's dresser, not locked up. On 1/12/26 at 2:15 PM the Albuterol inhaler was sitting on top of resident's dresser, not locked up. An interview on 1/13/26 at 2:45 PM with the DON confirmed that medications that were self-administered by the residents were to be stored in safe and secure place that was not accessible by other residents. N. According to Resident 31's admission record, Resident 31 was admitted to the facility on [DATE] with a diagnosis of Quadriplegia (a paralysis affecting both arms and legs, chest, abdomen, pelvis and back). Record review of Resident 31's January 2026 Medication Administration Record (MAR) revealed an (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for Enemeez Mini Enema 5 milliliters (ml) into the rectum at bedtime. The following observations of Resident 31's room revealed the following: -There were three Enemeez Mini Enema's on Resident 31's vanity on 1/11/26 at 9:20 AM making this available to any staff, visitor or resident. -There were three Enemeez Mini Enema's on Resident 31's vanity on 1/11/26 at 12:30 PM making this available to any staff, visitor or resident. -There were three Enemeez Mini Enema's on Resident 31's vanity on 1/12/26 at 8:30 AM making this available to any staff, visitor or resident. Review of Resident 31's assessments from 06/15/2023 through 01/13/2026 did not reveal evidence of an evaluation of Resident 31's ability to self-medicate. An interview on 01/12/26 with Licensed Practical Nurse (LPN-K) confirmed that Resident 31 does not self-administer medications and there should not be any medications in Resident 31's room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, record review and interview; the facility failed to change gloves and wash hands at appropriate intervals during food preparation and the meal service to prevent the potential for cross-contamination and food-borne illness. This had the potential to affect any resident that consumed food prepared/served by the kitchen. The facility census was 46. Findings are:A. Review of the facility policy Handwashing, undated revealed Dietary Staff would wash their hands before starting work, when returning to work, after smoking, eating, drinking, after visiting restrooms, after handling garbage or poisonous compounds, and at other times hands were soiled. Hand washing facilities should be readily accessible and equipped with paper towels and soap. B. Review of the facility policy Glove Use, undated revealed it was the policy to wear gloves to protect both patrons and employees from contagious and foodborne illnesses. Employees would do the following:-wash their hands thoroughly before and after wearing or changing gloves;-choose the correct size gloves to fit their hands;-change disposable gloves between tasks and not wear them continuously;-change gloves if they rip or become soiled;-change gloves after sneezing, coughing, or touching their hair and/or face;-not use food contact gloves for nonfood tasks including cleaning, handling money, etc.;-remove disposable gloves by grasping at the cuff and peeling them off inside out;-wear gloves with handling salad bar items, fruits, sandwiches, cooked foods, deli meats, cheese, breads, and ice;-wear disposable gloves at all times if they were wearing artificial nails or fingernail polish; and-find gloves conveniently located in racks at hand sinks and near workstations. C. Observation on 1/12/26 at 10:55 AM Cook-F was already wearing gloves when preparing ground meat and puree meal preparation for residents who required those consistency of meals. Cook-F obtained ham with pineapple from the metal container using tongs and placed a sufficient amount in the blender. Cook-F obtained a saucepan off the stove that contained gravy and placed a ladle of gravy in with the ham and pineapple then placed the lid on the blender, held it in place with their left hand and pushed the buttons of the blender with their right hand. When finished Cook-F removed the lid of the blender, Cook-F reached into the blender with their right hand while wearing the same gloves used to touch the food containers, tongs, saucepan handle, ladle, blender lid and buttons grabbed large chunks of ham and ripped them up with their gloved hands and placed them back into the blender. Continuing to wear the same pair of gloves, Cook-F placed the lid back on the blender and pushed the buttons on the blender. Cook-F, while continuing to wear the same pair of gloves opened the blender, then grabbed another chunk of ham with their gloved hands and ripped that piece up. Cook-F replaced the lid, continued to wear the same pair of gloves, and utilized the buttons to puree the ham further to the desired consistency. While still wearing the same pair of gloves, Cook-F transferred the puree ham into a clean metal container using a spatula, then Cook-F removed their gloves. No hand hygiene was observed to have been performed. Cook-F ran the blender container through the dishwasher, then put on new gloves without performing hand hygiene. Cook-F obtained a new pan from the shelf and used the same tongs to place ham into the blender. Cook-F placed the lid on the blender and held it in place using their left hand while pushing the buttons with their right hand. Cook-F removed the blender lid and grabbed large chunks of ham while continuing to wear the same gloves and ripped the ham up. Cook-F replaced the lid on the blender, held it in place and pushed the buttons with their right hand. While continuing to wear the same pair of gloves, Cook-F transferred the ground meat into a new metal pan and covered the pan with a lid. Cook-F removed their gloves and placed the ham containers on a cart. No hand hygiene was observed to have been completed.D. Observation on 1/12/26 at 11:50 AM Cook-F brought the food for the lunch meal from the main kitchen to the serve-out kitchen. Cook-F applied gloves without performing hand hygiene. Cook-F started serving the lunch meal at 11:55 AM. Cook-F placed the pureed ham in a microwaveable bowl and placed the meat in the microwave, then pushed the buttons (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to warm up the food, and then placed the food back on the steam table. While continuing to wear the same pair of gloves, Cook-F grabbed a loaf of bread from the counter, opened it and placed it on top of the steam table. Cook-F grabbed a slice of bread while continuing to wear the same pair of gloves and placed it on a plate to be served. While continuing to wear the same pair of gloves, Cook-F went to the refrigerator and took out sliced turkey and sliced cheese which were in ziplock bags. Cook-F obtained a plate, and while wearing the same pair of gloves, grabbed 2 slices of bread and placed them on a plate. Cook-F then opened the turkey, grabbed 2 slices and put them on the bread. Continuing to wear the same gloves, Cook-F then opened the cheese, grabbed a piece and placed it on the other slice of bread, then placed the two slices together. Cook-F served the sandwich. Cook-F went to the refrigerator, opened it and grabbed a bag of buns. Cook-F then grabbed a bun out of the bag with the gloved hand and placed it on a plate with ham and served the plate. Cook-F, while continuing to wear the same pair of gloves grabbed a can of chicken noodle soup from a plastic package. Cook-F opened the can and placed it in a bowl, then put it in the microwave, while touching the handle of the microwave and the buttons of the microwave while continuing to wear the same gloves. Cook-F resumed serving from the steam table. No observations of hand hygiene or glove changing was observed. E. Interview on 1/12/26 at 12:35 PM with Cook-F confirmed Cook-F did not perform hand washing and glove changing at appropriate intervals. F. Interview on 1/12/26 at 1:50 PM with the Certified Dietary Manager confirmed hand washing should be completed after removing gloves and gloves should be changed when touching non-food items to touching food items.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 175 NAC 12-006.18Based on observations, record reviews, and interviews: the facility failed to utilize Personal Protective Equipment (PPE-equipment such as gowns, gloves, masks, goggles, that creates a barrier against germs and hazards) when performing high contact cares for Residents 8 and 41 who were on Enhanced Barrier Precautions (EBP-an infection control measure involving the use of gowns and gloves for high contact care to prevent spreading organisms), failed to perform hand hygiene and glove changing at appropriate intervals during toileting for Resident 7, and failed to clean re-usable resident care equipment used for transfers for Residents 8, 30, and 52. The sample size was 10 and the facility census was 46. Findings are: A. Review of the facility policy Enhanced Barrier Precautions dated 2024 revealed the facility implemented EBP for the prevention of transmission of Multidrug-Resistant Organisms (MDRO's-organisms that are resistant to multiple antibiotics) that employed targeted gown and glove use during high contact resident care activities. The facility promptly identified need, and initiated EBP's which included the following: -all staff received training on EBP upon hire and annually and were expected to comply with all designated precautions.-The facility had gloves and gowns available near or immediately outside the resident's room.-PPE for EBP was necessary when performing high-contact care activities.-EBP were used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. B. During an observation on 1/11/26 at 8:00 AM a sign titled Enhanced Barrier Precautions (EBP) was posted on the wall directly outside Residents 8 and 41's Room (roommates) which indicated staff were to clean their hands before entering and leaving the resident room. In addition, Providers and Staff were to wear gloves and a gown for the following High-Contact Resident Care Activities; Dressing, Bathing, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting, Device care or use (central lines, urinary catheters, feeding tubes, or tracheostomy), and/or Wound care for any skin opening requiring a dressing. C. Review of Resident 41's Care Plan with a revision date of 9/2/25 revealed the resident had a diagnosis of the MRDO Methicillin Resistant Staphylococcus Aureus (MRSA), was incontinent at times and staff were to offer assistance as needed with toileting needs. During an observation of care for Resident 41 on 1/12/26 at 8:10 AM Nurse Aide (NA)-C entered the resident room and then bathroom. NA-C put on gloves but not a gown and proceeded to assist the resident in the bathroom with changing a soiled brief and providing peri-cares. NA-C performed hand hygiene and exited the room with the soiled brief in a garbage bag. D. Review of Resident 8's Care Plan with a revision date of 11/4/25 revealed the resident was Resistant to Vancomycin (VRE-antibiotic resistant bacteria). During an observation of the care for Resident 8 on 1/12/26 at 8:25 AM, NA-C entered the room, put on gloves, but no gown and assisted Resident 8 with changing of a soiled brief, while the resident was lying in bed. The brief was removed, placed in a garbage bag and a new brief was applied all while not wearing a gown. E. During an interview on 1/12/26 at 8:33 AM, NA-C revealed the NA was not aware Residents 41 and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8 were on Enhanced Barrier Precautions. In pointing out the sign on the outside of the room, NA-C continued to deny being aware either resident was on EBP because they don't have catheters, and or don't go to dialysis. NA-C was not aware of other criteria that would require the use of EBP. F. During an interview on 1/12/26 at 12:47 PM the Director of Nursing (DON) confirmed the facility expected staff to implement the use of gown and gloves during high contact care episodes for residents who had targeted MRDO's including VRE and MRSA. This included Resident's 41 and 8. G. Review of the facility policy Cleaning and Disinfection of Reusable Equipment, undated revealed the following: -the purpose was to ensure reusable equipment was cleaned and disinfected in a manner that reduced the risk of infection transmission and supported a safe environment for individuals served, staff, and visitors; -reusable equipment would be cleaned and disinfected between uses, and as needed, using approved methods to prevent cross contamination; -all cleaning practices would be performed in accordance with manufacturer's recommendations, accepted infection prevention standards, and organizational procedures; -reusable equipment were items intended for use on more than one individual or for repeated use (such as medical devices, assistive devices, shared equipment); -staff were responsible for cleaning and disinfecting equipment after use and prior to reuse; -reusable equipment would be cleaned and disinfected between individual uses, when visibly soiled, and according to routine schedules; and -clean equipment would be stored in a manner that prevents contamination. H. Review of Resident 8's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 12/18/25 revealed the resident was admitted on [DATE] with diagnoses of Heart Failure and Kidney Disease; the resident had moderate cognitive impairment; and required assistance with toileting, dressing, hygiene, and transfers. I. Review of Resident 8's Care Plan, last revised 1/6/26 revealed the resident required assistance with bed mobility, dressing, hygiene, toileting, and transfers and had diagnoses of Left Artificial Knee joint, Kidney Failure, Adjustment Disorder with Depressed Mood; Obsessive-Compulsive Disorder, Bipolar Disorder (a brain disorder that causes changes in a person's mood, energy, and ability to function), and Unspecified Mood Disorder. J. An observation on 1/13/26 at 8:15 AM with Medication Aide (MA)-I and NA-C wore PPE appropriately while dressing Resident 8 while the resident was lying in bed. Both MA-I and NA-C removed their PPE, performed hand hygiene and applied new gloves, but no gowns. MA-I and NA-C assisted the resident to sit on the edge of the bed and their clothing touched the bed linens. The aides applied the sit to stand lift pad behind the resident and hooked the pad to the machine, then transferred the resident to the wheelchair. NA-C removed their gloves, performed hand hygiene then applied new gloves. NA-C then made the resident's bed and the bed linens were touching NA-C's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clothes. MA-I moved the sit to stand lift into the hallway. The lift was not observed to be cleaned after use. There was a bag on the handle of the lift, but no cleaning materials were noted to be in the bag. MA-I removed the trash from the room, removed their gloves and performed hand hygiene upon leaving the room. MA-C removed their gloves, exited the room and performed hand hygiene upon exit. K. An interview with the DON confirmed Resident 8 was on EBP, PPE should be worn with high-contact care activities including transfers and bed-making and the sit to stand lift should be cleaned after each use to prevent cross-contamination. L. During an observation on 1/11/26 at 1:29 PM, NA-X assisted Resident 52 to the resident's room per the wheelchair. NA-X was wearing a sweatshirt over the staff's uniform. NA-X washed hands and placed on clean gloves then lifted the sweatshirt to reveal a gait belt. NA-X removed the gait belt from their person and placed it directly on the resident. The resident was pivoted transferred from the wheelchair into the bathroom. When the resident had finished toileting, staff stood the resident, completed hygiene cares, adjusted the resident's clothing and brief and transferred the resident back into the wheelchair. NA-X removed the gait belt from the resident and after lifting the staff's sweatshirt, placed the gait belt back onto their person. NA-X failed to clean and/or disinfect the gait belt prior to and after use with the resident. During an observation of toileting cares on 1/12/26 at 10:38 AM, NA-C and NA-D approached Resident 52 who was seated in a recliner in the front commons area. NA-D removed a gait belt the staff member was wearing around their waist and placed it directly on the resident. The resident was transferred into a wheelchair and was assisted to the resident's room and into the bathroom. Once Resident 52 was positioned on the toilet, NA-D removed the gait belt from the resident and draped the belt across the top of the tank of the toilet. The resident then had clothing changed before the gait belt was removed from the toilet and placed back onto the resident for the transfer into the wheelchair. After the resident was positioned safely in the wheelchair, NA-D removed the gait belt from the resident and placed the belt back onto NA-D's waist. NA-D failed to clean and/or disinfect the gait belt prior to and after use with the resident. During an interview on 1/12/2026 at 10:58 AM, NA-C and NA-D confirmed the direct care staff reuse the gait belt from resident to resident without cleaning/disinfecting. The staff wear the gait belt so that they always have available. M. During an observation of care for Resident 30 on 1/13/26 at 10:45 AM, NA-J and NA-D washed hands and put on a disposable gown and gloves and used the full lift (mechanical device designed to help care givers move a resident who are unable to bear weight) to transfer Resident 30 from the bed to the recliner. Once in the recliner, the staff removed the lift from the resident and proceeded to exit the room with the lift and positioned the device in the corridor for use with the next resident. Staff failed to clean and to disinfect the lift before and after use on Resident 30 who remained on EBP. During an interview on 1/13/26 at 11:30 AM, NA-J confirmed the following: -staff did not clean the lift before bringing it into the resident's room or when removing it from the room. -the lift was used for transferring multiple residents and was not exclusively used for transferring Resident 30. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 30 remained on EBP due to positive diagnosis of HIV. N. Review of the facility policy titled Handwashing/Hand Hygiene revised October 2023 revealed the following: -Hand hygiene was the primary means to prevent the spread of healthcare-associated infection. -Hand hygiene was to be completed for the following: - After contact with body fluids or contaminated surfaces. - After touching a resident and the resident's environment. - Before moving from work on a soiled body site to a clean body site on the same resident. - Immediately after glove removal. O. Record review of Resident 7's quarterly Minimum Data Set (MDS) (a federally mandated assessment utilized to determine a resident's functional capabilities and care) dated 12/07/25 revealed the following: -The resident was occasionally incontinent of urine. -The resident refused to transfer to the toilet and was dependent on staff for perineal hygiene. -The resident was dependent on staff for transferring from bed to chair and chair to bed. -The resident required extensive assistance with dressing upper and lower extremities and putting on shoes. An observation of provision of care for Resident 7 on 1/13/26 at 10:15 AM revealed Nurse Aide (NA)-D and NA-J completed hand hygiene and put on gloves. NA-D had a gait-belt around the waist. Resident 7 was lying in bed and requested to be dressed and complete perineal hygiene in bed. NA-J changed the residents socks and put on pants and shoes for the resident. NA-D completed perineal hygiene cares, removed the wet brief and wet sheet from the bed. NA-D (did not change gloves or wash their hands) and NA-J put a clean brief on the resident. NA-D changed gloves (did not wash hands), sat resident on edge of bed, assisted resident with putting on shirt, the gait-belt was removed from around NA-D's waist and put around the resident's waist. The resident was then transferred to the wheelchair. NA-D and NA-J removed the gloves and washed their hands with soap and water. An interview with the DON on 1/13/24 at 2:45 PM confirmed that staff were to wash their hands when gloves were removed and staff should change gloves and wash hands when going from a dirty task to a clean task. Further interview confirmed staff should not be wearing a gait belt around their waist. P. Record review of Resident 31's January 2026 Treatment Administration Record (TAR) revealed the following treatment orders: -Soak the right and left great toes in epsom salt-soaked gauze for 15 minutes daily, then cleanse with wound cleanser, swab with betadine, apply a strip of iodoform gauze (sterile, medicated gauze strips) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	packing to the wound bed, cover great toe's with gauze and secure with tape. -Cleanse the right and left posterior thighs with soap and water using wipes then pat dry. Combine 1 packet of collagen particles with 15 milliliters (ml) of A&D ointment, apply to open areas, cover with a silicone superabsorbent dressing and change daily. Record review of Resident 31's January 2026 Medication Administration Record (MAR) revealed the following treatment: -Cleanse abdominal folds and groin with soap and water, pat dry, apply Calmoseptine (ointment that protects, soothes, and promotes healing) then apply cornstarch over the Calmoseptine 2 times daily and as needed. -Cleanse the forehead and face rash with saline, apply Triamcinolone (steroid) ointment to rash twice daily and as needed for itching. An observation of provision of care revealed Licensed Practical Nurse (LPN)-L, washed their hands with soap and water, put on a gown and gloves and set up a table with a clean surface and treatment supplies. The treatment was completed to both great toes as ordered (LPN-L did not change gloves or wash hands) then washed the residents face with saline soaked gauze and applied Triamcinolone ointment to the rash. LPN-L mixed the A&D ointment with 1 packet of collagen particles, washed the groin and abdominal folds with soap and water, then patted skin dry and applied Calmoseptine to the abdominal folds and groin. LPN-L removed their gloves (did not wash their hands) and put cornstarch over the Calmoseptine. LPN-L changed gloves, (did not wash hands), positioned resident on their side and cleaned the residents bottom using wipes, changed their gloves (did not wash hands) cleaned wounds to back of right and left leg with use of wipes, soap and water, patted areas dry and applied cream mixture of A&D and collagen then covered wounds with a dressing. (LPN-L did not change gloves or wash their hands) Then removed the gauze from the residents great toes, cleaned great toes with wound cleanser and painted them with betadine, applied a strip of Iodoform gauze packing to the wound bed and secured packing with tape. An interview on 1/12/26 at 1:45 PM with LPN-K confirmed that LPN-L should have been washing hands when changing gloves and should have changed gloves and washed hands when going from one treatment area to another.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10 (A)(i)Based on record review, observation and interview, the facility failed to evaluate 1 (Resident 31) of 2 sampled residents for self-administration of bedside medications. The facility staff identified a census of 46. Findings are: A. Review of the facility policy titled Self-Administration of Medications revised in February 2021 revealed the following:-Residents had the right to self-administer medications if the interdisciplinary assessed resident's cognitive and physical abilities to determine whether self-administering medications were safe and clinically appropriate for the resident.-If it was deemed safe and appropriate for a resident to self-administer medications, this was documented in the medical record and the care plan. B.According to Resident 31's admission record, Resident 31 was admitted to the facility on [DATE] with a diagnosis of Quadriplegia (paralysis affecting both arms and legs, chest, abdomen, pelvis and back). Record review of a quarterly Minimum Data Set (MDS) (a federally mandated assessment utilized to determine a resident's functional capabilities and care) dated 11/19/25 revealed the Brief Interview for Mental Status (BIMS-interview used to determine cognition) was 15, which indicated the resident was cognitively intact. Record review of Resident 31's Care Plan dated 06/15/23 revealed there was no evidence of a focus issue, goal or interventions regarding self-administration of medication. Record review of Resident 31's January 2026 Medication Administration Record (MAR) revealed an order for Enemeez Mini Enema five milliliters (ml) into the rectum at bedtime. Review of Resident 31's assessments from 06/15/23 through 01/13/26 did not reveal evidence of an evaluation of Resident 31's ability to self-medicate. The observations of Resident 31's room revealed the following:-There were three Enemeez Mini Enema's on Resident 31's vanity on 1/11/26 at 9:20 AM making this available to any staff, visitor or resident.-There were three Enemeez Mini Enema's on Resident 31's vanity on 1/11/26 at 12:30 PM making this available to any staff, visitor or resident.-There were three Enemeez Mini Enema's on Resident 31's vanity on 1/12/26 at 8:30 AM making this available to any staff, visitor or resident. An interview on 01/12/26 at 1:45 PM with Licensed Practical Nurse (LPN)-K confirmed that the facility had not completed an evaluation for Resident 31's ability to self-administer medications and there was no physician order for Resident 31 to self-administer medication.

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	285082	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Springs, LLC	3200 G Street South Sioux City, NE 68776

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(iii)Based on record review and interview; the facility failed to ensure Residents 8 and 41's Care Plans accurately reflected the need to implement Enhanced Barrier Precautions (EBP- the use of Personal Protective Equipment (PPE) during high contact care) during the care of Residents 8 and 41 who had MDRO's (Multi-Drug Resistant Organisms), and the use of Antipsychotic (medication that is used primarily in the treatment of severe mental illness) for Resident 1. The sample size was 17 and the facility census was 46. Findings are: A. Review of the facility policy Care Plans, Comprehensive Resident Centered with a revision date of March 2022 revealed the following; -The facility developed and implemented a comprehensive, person-centered care plan that included objective and timetables to meet the resident's physical, psychosocial and functional needs, -described the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being,-reflected currently recognized standards of practice for problem areas and conditions,-and was updated for a significant change in the resident's condition. B. Review of the facility policy Enhanced Barrier Precautions dated 2024 revealed the facility implemented EBP to prevent the transmission of multidrug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. The facility promptly identified need and initiated EBP's which included the following: -all staff received training on EBP upon hire and annually and were expected to comply with all designated precautions.-The facility had gloves and gowns available near or immediately outside the resident's room. PPE for EBP's were necessary when performing high-contact care activities.-EBP's were used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that place them at higher risk. C. During an observation on 1/11/26 at 8:00 AM a sign titled Enhanced Barrier Precautions was posted on the wall directly outside Residents 8's room identifying staff were to clean their hands before entering and leaving the resident room. In additional Providers and Staff were to wear gloves and a gown for the following High-Contact Resident Care Activities; Dressing, Bathing, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting, Device care or use (central lines, urinary catheters, feeding tubes, or tracheostomy), and/or Wound care for any skin opening requiring a dressing. D. Review of Resident 8's Care Plan with a revision date of 11/4/25 revealed the resident was dependent on staff for meeting physical needs due to cognitive and physical limitations. This included assistance with toileting and related hygiene needs and changing of briefs. Further review revealed the resident was Resistant to Vancomycin (VRE-an MRDO) however, the was no evidence in the plan of care that staff were to use EBP (the use of gowns and gloves during all high-contact resident care). E. During an observation on 1/11/26 at 8:00 AM a sign titled Enhanced Barrier Precautions was posted on the wall directly outside Residents 41's room identifying staff were to clean their hands before entering and leaving the resident room. In additional Providers and Staff were to wear gloves (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and a gown for the following High-Contact Resident Care Activities; Dressing, Bathing, Transferring, Changing Linens, Providing Hygiene, Changing Briefs or assisting with toileting, Device care or use (central lines, urinary catheters, feeding tubes, or tracheostomy), and/or Wound care for any skin opening requiring a dressing. F. Review of Resident 41's Care Plan with a revision date of 9/2/25 revealed the resident had the MRDO Methicillin Resistant Staphylococcus Aureus (MRSA). Additional review revealed the resident had mild incontinence, wore a brief, and staff were to assist as needed with incontinence care. Further review revealed no evidence staff were to use EBP during all high contact resident care. During an interview on 1/12/26 at 8:33 AM, NA-C revealed the NA was not aware Residents 41 and 8 were on Enhanced Barrier Precautions. In pointing out the sign on the outside of the room, NA-C continued to deny being aware either resident was on EBP because they don't have catheters, and or don't go to dialysis. NA-C was not aware of other criteria that would require the use of EBP. G. Review of the facility policy Psychotropic Medication Use, last revised February 2025 revealed the following: -residents would not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record; -medications included antipsychotics, antidepressants, antianxiety, and hypnotics/sedatives were subject to prescribing, monitoring, and review requirements specific to psychotropic medications; -psychotropic medication management involved the resident, family and/or representative; -residents who had not used psychotropic medications were not prescribed or given those medications unless the medication is determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record; -prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and the physician would review the following with the resident/representative prior to obtaining documented consent or refusal: non pharmacological alternatives, the indication and rationale for the recommendation, the potential risks and benefits, and the representative right to accept or decline the treatment. H. Review of Resident 1's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 12/8/25 revealed the resident was admitted on [DATE]; was cognitively impaired; required assistance with dressing, hygiene, transfers, and toileting; had diagnoses of Kidney Disease and Non-Alzheimer's Dementia; and received antipsychotic and antidepressant medications. Review of Resident 1's Care Plan last revised 12/15/25 revealed the resident required assistance with dressing, bed mobility, toileting, and transfers; had impaired cognitive function due to Dementia; received antidepressant medications; and was on Hospice Care. There was no documentation that the resident was receiving an antipsychotic medication. Review of Resident 1's Order Summary Report with active medication orders revealed an order for Haloperidol (an antipsychotic medication) 2 milligrams (mg) every 6 hours for a diagnosis of Dementia with a start date of 10/23/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Medication Administration Record revealed the resident received Haloperidol 108 out of 120 administrations in November 2025, 108 out of 120 administrations in December 2025, and 51 out of 51 administrations in January 2026. I. Interview on 1/14/26 at 1:00 PM with the MDS Coordinator revealed Enhanced Barrier Precautions was not on the Care Plan for Resident 8 and 14, and the antipsychotic was not on the Care Plan for Resident 1. J. Interview on 1/14/26 at 1:20 PM with the Director of Nursing confirmed Enhanced Barrier Precautions was not on the Care Plan for Residents 8 and 14 and the antipsychotic medication for Resident 1 was not on the Care Plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(iii)(3)Based on observations, record review, and interview; the facility failed to thoroughly assess bruising and to implement interventions to prevent ongoing bruises for Resident 52. The sample size was 2 and the facility census was 46 Findings are: A. Review of a facility policy titled Pressure Ulcers and Skin Policy with a reviewed date of 8/22 revealed the nursing staff were to examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. When bruising was observed, staff were to ensure appropriate clinical assessment occurred. The assessment was to include the general location, appearance, resident comfort, reported concerns and any reasonable contributing factors. Documentation was to support continuity of care and demonstrate bruising was recognized and addressed with ongoing observation and appropriate follow-up when indicated. Additional follow-up may occur when there was a change in condition, increased bruising, resident concern, or other clinical indicators. B. Review of Resident 52's Nursing Admission/Screening History dated 1/6/26 at 9:27 AM revealed no skin issues were noted.Review of the resident's current Care Plan dated 1/7/26 revealed the resident was admitted [DATE] with diagnoses of spinal stenosis, atrial fibrillation, repeated falls, history of Transient Ischemic Attacks (brief interruption of blood flow to the brain leading to temporary symptoms like those of a stroke), anxiety, and depression. The resident was identified at risk for skin breakdown related to fragile skin and side effects from blood thinner medications. Interventions included the following:-avoid scratching, keep fingernails short and avoid excessive moisture to body parts.-identify/document potential causative factors and eliminate/resolve where possible.-encourage the resident to wear shirts with long sleeves or geri-sleeves (sleeves made with breathable material that contours to the shape of the arm which protects skin from bruising and skin irritation). -keep skin clean and dry, apply lotion to dry skin. Review of a Nursing Progress Notes revealed the following:-1/7/26 at 2:00 AM the resident was found seated on the floor of the resident's room. The resident was barefoot and the right great toenail was bleeding. No further areas of skin breakdown were identified.-1/8/26 at 9:20 AM the resident's skin without bumps, bruises or redness noted. Right great toe with no further bleeding.-1/8/26 at 5:00 PM the resident's skin was without any new bumps, bruises, or redness. The bump to the resident's temple had subsided.-1/8/26 at 9:40 PM the resident was observed laying on the floor of the resident's room. The resident reported striking head and a small bump was noted above/beside the left eye.-1/9/26 at 8:20 PM the resident's skin is without any new bumps, bruises or redness noted. Area above the left eye continues with bruising to small bump.-1/11/26 at 5:45 AM the resident was up all night, repeatedly attempting to get up out of the wheelchair and yelling/hitting at staff. -1/11/26 at 10:59 AM resident noted to have bruises scattered on bilateral arms from fall and bumping items from being active up and down all night. During an observation on 1/11/26 at 11:02 AM, the resident was seated by the Nurse's Station in a tilt-n-space wheelchair (chair which allows the entire seating system to tilt backward while maintaining the user's hip, knee, and ankle angles). Resident 52 was picking things out of the air and attempted to reach down to the floor to pick up items. Resident 52 was wearing a short sleeved shirt and pants were pulled up to the resident's mid shins. The resident had dark purple bruising visible to bilateral arms from mid-bicep to the wrist, bilateral lower legs from the resident's ankle to the mid shin area and a bruise was noted above the resident's left eye. No protective sleeves or long sleeves were observed on the resident's arms. Review of Nursing Progress Notes on 1/12/26 at 8:17 AM revealed a late entry for 1/10/26 (no time) which indicated the resident had been up throughout the day with increased anxiety and multiple attempts to exit seek. The resident was unbalanced and would run into doors/hand railings and was resistive with cares. Several discolored areas were noted to the residents' arms. During an observation on 1/12/26 at 10:38 AM, Nurse Aide (NA)-D and NA-C approached the resident who was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seated in a recliner in the front commons area. The resident was wearing gripper socks, a sleeveless night gown and a short sleeved t-shirt. No arm protectors or long sleeves were in place. A gait belt was placed on the resident who was then transferred into a wheelchair and assisted to the resident's room for cares. During an interview on 1/12/2026 at 11:48 AM, Registered Nurse (RN)- AA reported the direct care staff were to notify the Charge Nurse of any new areas of skin breakdown and then the Charge Nurse was responsible for completing and documenting an assessment. The RN further reported typically measuring any new areas of breakdown, including bruising so that the staff can define if the areas are healing or not. Review of a Facsimile (Fax) Communication Sheet dated 1/13/26 at 1:31 PM revealed the resident's Primary Care Provider was notified the resident had scattered bruising to bilateral arms and requested a review of the resident's current medications. Further review of the fax revealed no evidence the bruising to the resident's left eye or bilateral lower legs being identified. During an interview with the Director of Nursing (DON) on 1/12/26 at 11:51 AM, the DON confirmed the Charge Nurses were responsible for completing assessments of any areas of skin breakdown. The DON indicated Resident 52's bruising was extensive and would not expect the staff to measure the areas but would expect to have documentation of all areas of breakdown with descriptions regarding exact location, color, and extent of the bruising to measure if bruises were healing. The DON did verify the resident's care plan identified use of long sleeves or geri-sleeves to be placed on the resident's arms to protect the resident's skin and to potentially prevent further bruising.