STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285085	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport House	6798 N 67th Plaza Omaha, NE 68152

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. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, interview, and record review the facility failed to ensure food stored in the kitchen's refrigerators and freezers were labeled, dated and/or sealed. The facility census was 92.Findings are:A record review of the facility's Food Storage General Guidelines policy with a revision date of 3/8/2024 revealed the following:1) All foods are labeled and dated.9) Food is stored in clean, approved containers that are covered, labeled and dated. This includes foods stored in refrigerators, freezers, and pantries. A record review of the FDA Food Code 2022, revealed that food packages shall be in good condition and protect the integrity of the contents so that food is not exposed to adulteration or potential contaminants. An observation of the large reach-in freezer on 1/26/2026 at 7:15 AM revealed the following: 1 clear bag of small round brown substance was not labeled and sealed. 1 clear bag of large, flat, tan/brown substance was not labeled and sealed. 2 brown bags of yellow, elongated substance was not sealed. 1 brown bag of tan round substance was not sealed. An observation of the walk-in refrigerator on 1/26/2026 at 7:15 AM revealed the following: 1 package of open sliced cheese that was not sealed. An observation of the walk-in freezer on 1/26/2026 at 7:15 AM revealed the following: 1 large sheet pan with round, colorful, tan substance that was not labeled, dated, or sealed. In an interview on 1/27/2026 at 12:20 PM the Sous Chef (SC) confirmed the following: 1 clear bag of small round brown substance was not labeled or sealed and should have been. 1 clear bag of large, flat, tan/brown substance was not labeled or sealed and should have been. 1 brown bag of yellow, elongated substance that SC referred to as French fries was not sealed and should have been. 1 brown bag of tan round substance that SC referred to as Tator tots was not sealed and should have been. 1 box of tilapia was not sealed and should have been. 1 box of open wild Alaskan seafood was not sealed and should have been. In an Interview on 1/27/2026 at 12:20 PM the Team Lead Food Nutrition Services (TLFNS) confirmed the following: 1 large sheet pan of round, colorful, tan substance in the walk-in freezer that was not labeled, dated, or sealed and should have been. 1 package of open sliced cheese in the walk-in refrigerator that was not sealed and should have been.

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 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** Licensure Reference Number 175 NAC 12.006.18(B)Licensure Reference Number 175 NAC 12.006.18(D)Licensure Reference Number 175 NAC 12.006.19(A)(i)Licensure Reference Number 175 NAC 12.006.18(C)(i) Based on observation, interview, and record review, the facility failed to ensure Hoyer lifts (mechanical full body lifts) were sanitized before or after each use, gowns were worn during high contact cares on Resident 14, Resident 7's nebulizer (neb)(a machine used to deliver aerosolized medications to the lungs) administration kit was cleaned after each use, handle linens used for perineal (peri)(area between the genitals and rectum) care in a manner to prevent the potential for cross contamination for Resident 84, failed to perform hand hygiene with glove changes during perineal care for Resident 84, store oxygen tubing and a Bilevel Positive Airway Pressure Device (BiPAP)(a machine used to treat apnea or high carbon dioxide levels) mask in a manner to prevent the potential for cross contamination, and failed to ensure the nebulizer kit and oxygen humidification were labeled with a date for Resident 9. The facility census was 92. Findings are:A. A record review of the facility's undated Transmission-Based Precautions Guidelines revealed equipment handling for standard precautions was to disinfect equipment before and after each use. An observation on 01/27/2026 at 10:22 AM revealed that Registered Nurse (RN)-H and Nursing Assistant (NA)-G entered Resident 7's room to transfer the resident from the wheelchair to the bed. NA-G exited the room and got the Hoyer lift from the hallway and brought it into the resident's room without disinfecting the Hoyer lift. NA-G and RN-H transferred the resident from the wheelchair to the bed using the Hoyer lift and then NA-G took the Hoyer lift from the room and placed it against the wall in the 200 hallway. NA-G then removed gloves, went to the nurse's station and performed hand hygiene. Observation between 10:22 AM and 10:45 AM revealed the Hoyer lift had not been disinfected. An observation on 01/28/2026 at 9:41 AM revealed that NA-I and NA-J retrieved the Hoyer lift from the 200 hallway and took it into Resident 7's room without disinfecting the Hoyer lift. NA-I and NA-J used the Hoyer lift to transfer Resident 7 from the bed to the wheelchair. NA-A then took the Hoyer lift back into the 200 hallway without disinfecting it. An observation on 01/28/2026 at 10:07 AM revealed NA-I and NA-J took the Hoyer lift that was used on Resident 7 and had not been disinfected into resident room [ROOM NUMBER], Resident 70's room, and transferred that resident without disinfecting the Hoyer lift. In an interview on 01/28/2026 at 10:24 AM, NA-I confirmed that the Hoyer lift was not disinfected prior to or after using it to transfer Resident 7 or prior to using it on Resident 70. In an interview on 01/28/2026 at 9:54 AM, RN-H confirmed there were 3 residents on the 200 hall that required Hoyer lift transfers. In an interview on 01/28/2026 at 3:27 PM, the Director of Nursing (DON) confirmed the staff should have disinfected the Hoyer lift before or after use. B. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's undated Transmission-Based Precautions Guidelines revealed that for standard precautions a gown should have been worn if soiling was likely and that if a resident was in Enhanced Barrier Precautions (EBP), staff should have applied a gown prior to high-contact resident care activities such as dressing, bathing, toileting, transferring, providing hygiene (cleaning), device care or use such as urinary catheter, feeding tube and any skin opening requiring a dressing. A record review of Resident 14's Care Plan with an admission date of 09/23/2024 revealed the resident had a Ileostomy (a surgically created opening in the stomach area that allows waste and gas to bypass damaged colon into an external bag) and a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube placed directly into the stomach to allow nutrients, fluids, and medications to be administered) for tube feedings. The Care Plan had a focus area that the resident was in EBP and an intervention that staff should have worn gowns and gloves during high-contact resident care activities. An observation on 01/27/2026 at 8:29 AM revealed a round EBP magnet on the right side of the door frame. RN-H entered Resident 14's room, performed hand hygiene, gloved, pulled back the PEG tube dressing and looked at the site, flushed the resident's PEG tube, removed gloves, exited the room and performed hand hygiene all without wearing a gown. An observation on 01/27/2026 at 11:44 AM revealed a round EBP magnet on the right side of the door frame. NA-K entered Resident 14's room and performed hand hygiene, checked Resident 14's Ileostomy, put on gloves, retrieved a graduate cylinder (a container used to measure fluid contents) and propped the graduate cylinder between resident's Ileostomy and NA-K's leg. NA-K then opened the Ileostomy bag and drained the waste into the graduate cylinder. NA-K emptied and rinsed the graduate cylinder, removed gloves, performed hand hygiene and exited the room, all without having a gown on. In an interview on 01/28/2026 at 7:56 AM, RN-H confirmed the resident was in EBP and RN-H did not wear a gown during Resident 14's PEG tube cares on 01/27/2026 at 8:29 AM, and RN-H and NA-K should have had a gown on with PEG tube and Ileostomy cares. C. A record review of the facility's Medication – Nebulizer Treatment policy dated 07/26/2017 revealed the staff should rinse the nebulizer administration kit pieces after each use. A record review of Resident 7's Medication Administration Record (MAR) dated January 2026 revealed that the resident had orders for Albuterol/Ipratropium (a medication used to relax the muscles in the lungs) nebulizer treatments twice daily and as needed (PRN). The MAR was marked that the resident received the nebulizer treatments twice per day, every day. An observation on 01/26/2026 at 10:31 AM revealed that Resident 7's nebulizer administration kit was laying on the bedside table with a residual (small, leftover) amount of liquid (presumed medication) remaining in the kit. An observation on 01/27/2026 at 7:04 AM revealed that Resident 7's nebulizer administration kit was lying on the bedside table with a residual amount of liquid (presumed medication) remaining in the kit. An observation on 01/27/2026 at 10:22 AM revealed RN-H removed the nebulizer administration kit (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from Resident 7's mouth and placed it on the bedside table prior to assisting NA-G with transferring the resident to bed. RN-H did not rinse the nebulizer administration kit. At 10:45 AM the kit was lying on the overbed table with a residual amount of medication still in the kit. An observation on 01/28/2026 at 6:27 AM revealed that Resident 7's nebulizer administration kit was laying on the bedside table with a residual amount of liquid (presumed medication) remaining in the kit. In an interview on 01/29/2026 at 7:18 AM, RN-F confirmed that staff should have cleaned Resident 7's nebulizer administration kit after each use. D. Record review of the facility policy titled Hand Hygiene and Glove Usage dated 03-09-2021 revealed it is the policy of the facility that hand hygiene for residents and staff will be performed to avoid the spread of pathogens. Hand Hygiene is required before putting on gloves and after removing gloves. Record review of Resident 84's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 11-17-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored at 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required total assistance with dressing, hygiene, toileting, bed mobility and transfers. -was frequently incontinent of bowel and bladder. An observation conducted on 01-28-2026 at 6:15 AM of Nursing Assistant (NA) C performing incontinence care for Resident 3 revealed NA C with gloved hands removed the soiled brief and performed perineal care (cleaning of the genital and anal area) then removed gloves and reapplied new gloves without performing hand hygiene. An interview conducted on 01-28-2026 at 6:50 AM with NA C confirmed hand hygiene was not performed in between glove changes and should have been. E. Record review of the facility policy titled Personal Laundry and Clean Linen dated 04-13-2022 revealed infection prevention principles was a key consideration related to procedures related to on-site laundry services. Linens will be collected following infection control standards. An observation conducted on 01-28-2026 at 6:15 AM of NA C providing facial hygiene for Resident 3 revealed NA C went to the bathroom turned on the sink, obtained a washcloth and held it under the running water, wringed it out and then placed it on the bedside table on top of Resident 3's belongings without a barrier and proceeded to wash Resident 3's face with the wash cloth. After completing facial hygiene, NA C went to the bathroom, placed the dirty washcloth in the laundry basket, obtained another washcloth, held it under the running water and then squeezed out the excess water by pressing the washcloth against the inside of the sink basin, then placed the washcloth on the bedside (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	table without a barrier and proceeded to perform perineal care. An interview conducted on 01-28-2026 at 6:50 AM with NA C confirmed the washcloth was placed on the bedside table without a barrier and confirmed the washcloths touched the inside of the sink basin. An interview conducted on 01-28-2026 at 7:00 AM with Registered Nurse (RN) F confirmed washcloths touching the bedside table without a barrier and washcloths touching the inside of the sink could cause cross contamination. F. Record review of the facility policy entitled Policy – Medication – Nebulizer Treatment dated reviewed 11/15/2021 revealed: -C. Change tubing and administration kit weekly. Record review of the facility policy entitled SOP – Medication Provision – Oxygen dated reviewed 08/10/2022 revealed: -c. Humidifiers -i. Care and use of prefilled disposable humidifiers: -8. Label humidifier with date and time opened. Bottle is good for 72 hours. Record review of Resident 9's Census List revealed the facility admitted the resident on 08/08/2023. Record review of Resident 9's Diagnosis Report revealed Resident 9 had conditions that included acute and chronic respiratory failure, interstitial pulmonary disease (chronic inflammation and scarring of the lung tissue), hypoventilation (breathing too slow or too shallow to meet the body's needs), and shortness of breath. Record review of Resident 9's MDS dated [DATE] revealed Resident 9 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. According to the MDS manual, a score of 15 indicated the resident was cognitively intact. Further review of Resident 9's MDS revealed Resident 9 used oxygen and a non-invasive mechanical ventilator (BiPAP). Record review of Resident 9's Order Summary Report (OSR) revealed the following orders: -ipratropium and albuterol solution one vial per nebulizer every four to six hours as needed for congestion dated 12/14/2025. -O2 (oxygen) at three liters per nasal cannula continuously for interstitial disease dated 06/04/2024. -Oxygen low flow nasal cannula bled into BIPAP while asleep dated 07/15/2025. -BiPAP settings at 6 centimeters (cm) CPAP (continuous positive airway pressure, delivers a steady stream of pressurize air to keep the airway open while asleep)/EPAP (expiratory positive airway pressure, the lower, baseline pressure provided during exhalation, designed to keep airways open) and 12 cm inspiratory positive airway pressure (IPAP, higher pressure during inhalation). Provide the device with heated humidification and mask to achieve best patient comfort and compliance. Oxygen 4 liters per minute per BIPAP device dated 07/15/2025. Observation on 01/27/2026 at 8:19 AM revealed a BiPAP mask lying on the resident's bedside table with no barrier beneath. Observation on 01/27/2026 at 10:50 AM revealed a BiPAP mask lying on the resident's bedside table with no barrier beneath. Further in-room observations revealed a nebulizer machine and nebulizer kit sitting in the windowsill with the nebulizer kit/tubing undated; an undated disposable O2 humidification bottle connected to the O2 concentrator; and the O2 bleed-in tubing for the BiPAP was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored on the floor. Observation on 01/28/2026 at 12:58 PM revealed the nebulizer kit and machine were sitting in the window and the nebulizer kit/tubing were undated; an undated disposable humidification bottle was attached to the O2 concentrator; the O2 bleed-in tubing for the BiPAP was stored on the floor; and a BiPAP mask lying on the resident's bedside table with no barrier beneath. An interview on 01/28/2026 at 1:02 PM with Licensed Practical Nurse (LPN)-L confirmed the nebulizer kit/tubing and O2 humidification bottle were undated, the O2 bleed-in tubing for the BiPAP was stored on the floor, and the BiPAP mask was stored on the bedside table with no barrier beneath. LPN-L confirmed the nebulizer kit and O2 humidification bottle should have been dated, the BiPAP bleed in tubing should have been stored off the floor, and the BiPAP mask should have been stored with a barrier beneath. An interview on 01/29/2026 at 11:38 AM with the Assistant Director of Nursing (ADON) who also acted as the facility's Infection Preventionist confirmed the undated nebulizer kit and humidification bottle, the O2 bleed-in tubing for the BiPAP stored on the floor, and BiPAP mask stored on the bedside table with no barrier created potential for cross-contamination.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Licensure Reference Number 175 NAC 12-006.04(F)(i)(5)Based on record review and interview, the facility failed to notify the medical practitioner of 10 consecutive days of refusal of scheduled bowel medications for 1 (Resident 4) of 1 sampled residents. The facility staff identified a census of 92.Findings are:Record review of a facility policy entitled Notification to Physician/ Family of Change in Resident Health Status dated reviewed 08/27/2018 revealed the following: - Policy Statement: The Care Communities will notify the resident's physician or designee the resident's legal representative when there is: - A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or ineffectiveness and/or need to implement a new form of treatment). - Definitions: - C. A need to alter treatment significantly such as a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or need to initiate a new form of treatment to deal with a problem (e.g., the use of any medical procedure or therapy that is not currently ordered. - Procedure: - A. Notification tool - SBAR [SBAR, a structured communication framework used in healthcare to provide clear, concise, and complete information. SBAR is divided into four parts situation (what is happening now), background (relevant history), assessment (professional evaluation), and recommendation (what action is suggested)] - 3. In non-emergent or non-urgent situations, such as notification of a fall without injury, the SBAR can be faxed to the physician's or designee's office. - 4. The SBAR serves as documentation of the information provided and is filed in the Physician's Order section of the chart. - B. Notification - 1. The Care Communities will attempt to contact the resident's physician or designee with changes in resident's health status. - a. If the resident has one or more consulting physicians, the primary physician or designee will be contacted unless there are other specific instructions. - b. After hours, the on-call physician or designee will be responsible for emergency care. - c. In the event that the on-call physician or designee is not available, the house supervisor/designee will contact the Medical Director or send the resident to the Emergency Department.Record review of Resident 4's Census List revealed the facility admitted the resident on 06/20/2022.Record review of Resident 4's Diagnosis Report revealed Resident 4 had conditions which included cerebral infarction (stroke), hemiplegia (total or partial paralysis on one side of the body that results from disease or injury to the motor centers of the brain) and hemiparesis (muscular weakness or partial paralysis restricted to one side of the body) following cerebral infarction affecting the right dominant side, and difficulty in walking.Record review of Resident 4's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/16/2025 revealed Resident 4 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 7. According to the MDS manual, a score of 7 indicated the resident had moderate cognitive impairment. Further review of the MDS identified Resident 4 had rejected care during one to three days of the assessment period and had constipation. Record review of Resident 4's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed the following interventions related to bowel elimination: -Monitor for constipation dated 08/29/2022. -Monitor bowel and bladder pattern every shift dated 08/29/2022. -Continue to educate importance of bowel management. Resident often states it's normal for them to go a lengthy amount of time between bowel movements dated 01/02/2023. -At times Resident 4 will refuse bowel protocol because of [gender's] past profession where it was necessary to go days without access to facilities where [gender] felt comfortable in moving bowels. Resident 4 understood the risk of doing this, dated 07/01/2024.Record review of Resident 4's Order Summary Report revealed the following orders: -Medical Director may visit, examine, and treat as indicated dated 06/20/2022. -Prune products for bowel needs as needed (PRN), (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every 12 hours PRN, and every 24 hours PRN dated 06/20/2022. - Document in nursing notes characteristic bowel sounds, abdomen characteristic if flat or distended and firm or soft daily, dated 02/12/2025. -Milk of magnesia suspension (saline laxative) 400 mg in 5 milliliters (mL) by mouth once daily as needed for constipation dated 07/28/2022. -Senna-time tab (stimulant laxative) 8.6 mg take 2 tablets by mouth every evening dated 07/08/2025. -Bisacodyl suppository (fast acting stimulant laxative) 10 milligrams (mg) insert 1 suppository per rectum once daily as needed for constipation dated 08/15/2025. -Motegrity tab (a medication that works by stimulating colon muscle contractions to relieve chronic idiopathic [unknown cause] constipation) 2mg take 1 tablet by mouth daily dated 11/12/2025. -Miralax powder (saline laxative), mix 17 grams with 8 ounces of water/juice and drink twice daily dated 12/03/2025.Record review of Resident 4's December 2025 and January 2026 Medication Administration Records (MAR) revealed Resident 4 refused docusate sodium 15 out of 20 scheduled administrations from 12/29/2025 through 01/07/2026: -12/29/2026 evening dose; -12/30/2026 morning and evening doses; -12/31/2026 morning and evening doses; -01/01/2026 morning and evening doses; -01/02/2026 morning dose; -01/03/2026 evening dose; -01/04/2026 morning dose; -01/05/2026 morning and evening doses; -01/06/2026 morning and evening doses; and -01/07/2026 morning dose.Further review of Resident 4's December 2025 and January 2026 MARs revealed Resident 4 refused Motegrity and Miralax 8 out of 10 scheduled administrations from 12/29/2025 through 01/07/2026: -12/30/2025, 12/31/2025, 01/01/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, and 01/07/2026.Further review of Resident 4's December 2025 and January 2026 MARs revealed Resident 4 refused senna-time tab 2 out of 10 scheduled administrations on 12/31/2025 and 01/04/2026.Record review of Resident 4' s Progress Notes (facility based) dated 12/29/2025 through 1/7/2026 revealed the following: -12/30/2025 resident refused docusate sodium, Registered Nurse (RN) educated on importance of taking bowel medications. Resident stated understanding and still refused. -12/31/2025 refused senna and docusate, was educated and verbalized understanding but still refused; -12/31/2025 resident refused docusate sodium - will not take bowel meds. RN educated on importance of having more frequent BM (bowel movements), resident stated understanding and still refused. -01/01/2026 Resident day 7 without BM and continue to refuse any bowel protocol order by provider. Denies pain and discomfort while palpating abdomen. Bowel sound Ax4 [active times 4 quadrants] at this time. -01/03/2026 Resident is going on day eight without having a BM. The nurse asked if Resident 4 would like something for bowels and Resident 4 refused despite education on bowel obstructions and other health concerns. Resident 4 had active bowel sounds in four quadrants. Resident 4 had no complaints of pain or discomfort. -01/04/2026 at 2:49 PM Resident 4 was administered ondansetron (a medication used to reduce nausea and vomiting) due to vomiting. -01/04/2026 at 3:33 PM the resident returned from an outing. Resident 4 had a large emesis of suspected root beer and noodles. Vital signs were obtained, resident had active bowel sounds on the right side, hypoactive left side and denied abdominal pain or feelings of constipation. The resident was believed to have a UTI and pink eye infection, but the facility was waiting on the provider's office as they had no on-call service.Record review of Resident 4's physician visit dictation dated 01/07/2026 and signed by Resident 4's medical practitioner revealed [gender] has not been taking (gender) bowel regimen as [gender] does not like to take the medications. Further review of the Progress Note revealed the following updated plan of care for chronic constipation: - Continue on Miralax twice daily, docusate daily, senna 2 tabs nightly, and Motegrity 2 mg daily. Previously was on linaclotide but unable to swallow capsule. Emphasized to [gender] the importance of taking (gender) medications as directed. I will also add magnesium citrate for (gender) to use as needed for intermittent constipation. Orders: Colonoscopy to schedule.Record review of Resident 4's progress notes, scanned documents, and physical chart did not reveal evidence of notification to Resident 4's medical practitioner regarding refusals of medications. Further review of the medical record to include physician's orders and the care plan did not identify parameters for notification of refusal of medications.An interview on 01/29/2026 at 1:00 PM with the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Team Lead (RNTL)-M with the Director of Nursing (DON) present revealed the facility did not have evidence that an SBAR communication form was sent to the provider regarding Resident 4's refusal of bowel medications from 12/29/2025 through 01/07/2026.An interview on 01/29/2026 at 2:35 PM with the DON confirmed the facility did not have evidence at the time of survey exit of notification to the provider for Resident 4's refusal of bowel medications from 12/29/2025 through 01/07/2026.

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	285085	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport House	6798 N 67th Plaza Omaha, NE 68152

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G) Based on interview and record review, the facility failed to ensure a rational (based on clear thought and reason) was provided to continue as needed (PRN) Lorazepam (a medication used to treat anxiety) greater than 14 days. This affected 1 (Resident 7) of 5 sampled residents. The facility census was 92. Findings are:A record review of Resident 7's Clinical Census dated 01/27/2026 revealed the resident was admitted to the facility on [DATE] and elected to receive hospice services on 10/03/2025. A record review of Resident 7's Medical Diagnosis dated 01/27/2026 revealed the resident had diagnoses of Chronic Diastolic (Congestive) Heart Failure (CHF), Delirium Due To Known Physiological Condition (fluctuating disturbance in attention, awareness, and cognition), Depression, and Anxiety. A record review of Resident 7's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 01/06/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15, which indicated the resident was cognitively aware. The resident required setup or clean-up assistance with eating and oral hygiene (cleaning), partial/moderate assistance with personal hygiene, and was dependent on staff for toileting, bathing, dressing, footwear, and transfers. The resident did not have behaviors and was on antianxiety medications. A record review of Resident 7's Care Plan with an admission date of 11/27/2023 revealed the resident had a focus area of the resident took Lorazepam for Anxiety and Insomnia. Interventions were administer medications as ordered, inform hospice of changes in mood, behaviors, or side effects from the medication, and scheduled and PRN assessments. A record review of Resident 7's Clinical Physician Orders dated 01/27/2026 revealed the resident had orders for scheduled Lorazepam .5 milligram (mg) tablet at bedtime and Lorazepam Concentrate .25 milliliters, (ml) every hour as needed for Anxiety. A record review of Resident 7's Medication Administration Record (MAR) January 2026 revealed that the PRN Lorazepam Concentrate was administered 01/13/2026 and 01/23/2026. A record review of Resident 7's Progress Notes dated 01/13/2026 and 01/23/2026 revealed the resident was administered PRN Lorazepam for Anxiety and no behaviors or non-pharmacological interventions (some done to treat behavior other than administer medications) were documented. A record review of Resident 7's Pharmacist's Recommendation To Prescriber dated 10/08/2025 revealed that the resident had an order for PRN Lorazepam Concentrate and the Center for Medicare and Medicaid Services required a 14 day stop on all PRN psychotropic (mind altering) medications unless the prescriber documented clinical rational for continued use and provided a new duration for use on the continued order. The recommendation from the pharmacy was to continue the PRN Lorazepam for a period of 6 months for Anxiety. The prescriber's response was an X on agree, a check mark beside the recommendation, and signed as CHI Hospice/(MD name) with illegible initials dated 10/17/2025. It did not reveal a clear rational for the continued use of the PRN Lorazepam. In an interview on 01/29/2026 at 8:05 AM, the Director of Nursing (DON) confirmed that the rational for Resident 7's continued PRN Lorazepam greater than 14 days was Anxiety and for a normal resident, not on hospice, there should have been a rational for continued use documented on the Pharmacist's Recommendation To Prescriber.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.09(E)(i). Based on record review and interview, the facility failed to implement a comprehensive care plan to prevent the potential for altered nutrition for 1 (Resident 3) of 2 residents sampled. The facility census was 92. Findings are:Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-weight on admission was 173 pounds (lbs).-Brief Interview of Mental Status (BIMS) was scored as 0. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.-required extensive assistance with eating.-required total assistance with hygiene, dressing, bed mobility, transfers, toileting and bathing. Record review of Resident 3's Electronic Health Record (EHR) revealed a baseline care plan dated 12-31-2025 indicating Resident 3 was on a regular mechanical soft diet and required assistance with eating. Record review of Resident 3's Nutrition Assessment (NA) dated 01-04-2026 revealed the following care plan goal:-provide adequate nutrition and hydration.-improve oral intake to 75% or greater at 2 meals daily.Further review of the NA dated 01-04-2026 revealed the nutritional evaluation summary section revealed Resident 3 had no edema, was averaging 50 % of meal intake, and would follow for the need of oral nutritional supplements and had no skin breakdown. Record review of Resident 3's EHR revealed a Comprehensive Care Plan dated 01-05-2026 revealed no plan of care for altered nutrition. An interview conducted with Registered Dietician (RD) A on 01- 28-2026 at 1:00 PM confirmed a comprehensive care plan for altered nutrition should have been implemented on or before 01-20-2026 and was not implemented until 01-26-2026.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(J)(i)(1). Based on observation, interview and record review the facility failed to evaluate, monitor and implement interventions for a significant weight loss for 1(Resident 3) of 2 residents sampled. The facility census was 92. Findings are:Record review of the facility policy titled Weight Management dated 10-10-2023 revealed it is the policy of the facility to maintain acceptable parameters of nutritional status by recognizing, evaluating, and addressing the needs of the residents at risk or experiencing impaired nutrition and hydration, unless the resident's clinical condition demonstrates that this is not possible or residents' preference indicates otherwise. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-04-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-weight on admission was 173 pounds (lbs).-Brief Interview of Mental Status (BIMS) was scored as 0. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment.-required extensive assistance with eating.-required total assistance with hygiene, dressing, bed mobility, transfers, toileting and bathing. Record review of Resident 3's Comprehensive Care Plan (CCP) printed on 01-26-2026 revealed no care plan for nutrition. Record review of Resident 3's Hospital Inpatient Dietary Consult (HIDC) dated 12-30-2025 revealed Resident 3 was having poor oral intake, was having trouble with a regular diet and family was assisting Resident 3 with eating. Further review of the HIDC revealed the hospital dietician recommended a soft diet and Ensure (nutritional supplement) with meals three times a day. Record review of Resident 3's Order Summary (OS) printed on 01-26-2026 revealed no orders for Ensure or any other nutritional supplements. Record review of Resident 3's Medication Administration Record (MAR) for January 2026 revealed no orders for Ensure or a nutritional supplement. Record review of Resident 3's Electronic Health Record (EHR) under the section weights and vitals revealed the following weights:-01-03-2026 weight was 172.2.-01-09-2026 weight was 166.0, a loss of 6.2 lbs. or 3.6 % compared to the weight on 01-03-2026.-01-12-2026 weight was 162.0, a loss of 10.6 lbs. or 6.15 % compared to the weight on 01-03-2026, which signified a significant weight loss within 30 days.-01-23-2026 weight was 161.3, a loss of 10.9 lbs. or 6.32 % within 30 days of admission. Record review of Resident 3's Nutrition Assessment (NA) dated 01-04-2026 revealed the following care plan goal:-provide adequate nutrition and hydration.-improve oral intake to 75% or greater at 2 meals daily.Further review of the NA dated 01-04-2026 revealed the nutritional evaluation summary section revealed Resident 3 had no edema, was averaging 50 % of meal intake, and would follow for the need of oral nutritional supplements and had no skin breakdown. Record review of Resident 3's EHR, including nutritional notes, care plan, and physician's orders revealed no evaluation or implementation of interventions to address Resident 3's significant weight loss on 01-12-2026. Record review of Resident 3's Dietary Progress Note (DPN) dated 01-26-2026 revealed Resident 3 had multiple meal refusals, had lost 10.8 lbs. (6.2 %) since admission due in part to the resolution of lower extremity edema (swelling caused by excess fluid trapped in the body tissues) and in part due to oral intake and the dietician recommended Ensure twice a day. Record review of Resident 3's Progress Notes (PN) from 12-31-2025 to 01-27-2026 revealed no documentation of edema. Record review of Resident 3's PN dated 01-05-2026 revealed Resident 3 required assistance with meals and a decrease in fluid intake was noted. Record review of Resident 3's PN 01-08-2026 revealed Resident 3 had a decrease in fluid intake, had a change in appetite, and had difficulty swallowing at times. Record review of Resident 3's PN dated 01-17-2026 revealed Resident 3 had received new orders to encourage fluids, monitor for decreased appetite, weight loss, and worsening kidney function. An observation conducted on 01-27-2026 at 9:00 AM revealed Resident 3 was in bed with the head of bed elevated and Resident 3's daughter was there helping Resident 3 eat breakfast. Resident 3 ate a couple of bites of scrambled eggs and a couple of bites of toast with jelly. An interview conducted with the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Dietician (RD) A on 01-29-2026 at 8:45 AM confirmed Resident 3 loss of 10.8 lbs. or 6.2% in 1 month was a significant weight loss that was not identified until 01-23-2026 and interventions were not put into place until 01-26-2026 and confirmed Resident 3 had not had edema.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.09(D). Based on observation, interview and record review the facility failed to ensure a medication error rate of less than 5% as evidenced by 2 medication errors out of 25 opportunities for error. The facility medication error rate was 8 %. The facility census was 92. Findings are:Record review of the facility policy titled Medication Administration dated 03-08-2022 revealed it was the facility policy to store and administer medications and treatments in a safe and effective manner. Professional standards of medication administration are followed including the 6 rights of medication administration:-right resident-right drug-right dose-right time-right route-right documentation. An observation conducted on 01-28-2026 at 9:00 AM of Registered Nurse (RN) E administering medications to Resident 84 revealed Resident 84 was given the following medications while eating breakfast:Riluzole 50 milligram (mg) 1 tabletTylenol 500 mg 2 tabletsAspirin 81 mg tabletCyclobenzaprine hydrochloride 10 mg tabletFamotidine 20 mg tabletMultivitamin 1 tabletOxybutynin chloride 5 mg tabletVitamin D3 25 microgram (mcg) tablet Record review of Resident 84's Order Summary (OS) printed on 01-27-2026 revealed an order for Riluzole 50 mg tablet, take one tablet by peg tube twice a day, give 1 hour before or 2 hours after a meal. An interview conducted with RN E on 01-28-2026 at 12:15 PM confirmed the Riluzole 50 mg tablet was not given 1 hour before or 2 hours after a meal and should have been. An observation conducted on 01-28-2026 at 9:30 AM of RN D administering medications to Resident 52 revealed Resident 52 was given the following medication while eating breakfast:-apixaban 2.5 mg tablet-Vitamin D3 50 mcg tablet-amlodipine 10 mg tablet-omeprazole 20 mg tablet-furosemide 40 mg tablet-lacosamide 150 mg tablet Record review of Resident 52's OS printed on 01-28-2026 revealed an order for omeprazole 20 mg tablet by mouth daily, take 60 minutes before meals. An interview conducted on 01-28-2026 at 11:30 AM confirmed Resident 52 was given an omeprazole 20 mg tablet with breakfast and it should have been given 60 minutes prior to the meal.