STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Hills Manor	1720 North Spruce Ogallala, NE 69153

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.11(E) Based on observations, interviews, and record review, the facility failed to ensure outdated food items were not available for use, items were labeled correctly, and failed to perform proper hand hygiene and change gloves while preparing food to prevent the potential for cross contamination and food-borne illness. The facility identified a census of 32. This had the potential to affect all residents who ate out of the kitchen.Findings are: A.Record review of a policy titled Food Safety Requirements, undated, revealed under Policy Explanation and Compliance Guidelines number 1 states Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements include the following: b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms. c. Preparation of food, including thawing, cooking, cooling, holding, and reheating. f. Employee hygienic practices. The policy revealed under number 3, c. iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers. During initial tour on 5/18/2026 from 9:48 AM until 11:25 AM, the following concerns were identified:-A cart in the prep area was found to have individual jelly and butter packages on the bottom level of the cart. These packets were in trays with no dates located.-The walk-in refrigerator was found to have a gallon bottle of lime juice dated with an expiration date of 3/25/2026. A gallon bottle of [NAME] French dressing was found to have black fuzzy spots scattered on label on the side of bottle. A gallon jar of sweet pickle relish was found with no open date. A clear prep tub with a sealed lid and labeled as marinated chicken was found with contents of raw chicken in a red liquid and was dated for 5/8.-The walk-in freezer was found to have an opened, sealed bag of breaded frozen balls with no label of contents or opened date. A clear bag of breaded strips was opened, not sealed, and had no label of contents or opened date.-In dry storage, a bottle of dark corn syrup was found with the lid crooked, not sealed, and with no open date on the bottle. A clear sealed bag of individual syrup cups was found with no label or expiration date. A box of Cream of Rice that was not opened was labeled best if used by 6/30/2025. A clear sealed bag of shell shaped items was found with no label of what item was or an expiration date written on bag. A bag of classic bowtie noodles was found with no open date. A bag of egg noodles was found with no open date. Interview with the Dietary Manager (DM) on 5/18/2026 at 10:52 AM confirmed undated individual jelly and butter packs, expired lime juice and French dressing, undated sweet pickle relish, marinated chicken in fridge for 10 days, undated and unlabeled breaded items in freezer, undated bag of individual syrups, unlabeled and undated shell-shaped items, undated bag of classic bowtie noodles, undated bag of egg noodles, unsealed and undated dark corn syrup, and expired cream of rice. B.Additional record review of the policy Food Safety Requirements, undated, revealed under number 6, c. Staff shall wash hands prior to handling clean dishes, and shall handle them by outside surfaces or touch only the hands of utensils. Under number 7, a. Staff shall wash hands according to facility procedures. b. Staff shall not touch food with (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bare hands, exhibiting appropriate use of gloves, tons, deli paper, and spatulas. f. Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection. Record review of a policy titled Handwashing Guidelines for Dietary Employees, undated, revealed under number 6. Frequency of Handwashing b. After hands have touched anything unsanitary e. After handling chemicals and beginning to work with food. f. While preparing food, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. h. Before donning gloves for working with food. Under number 7. Handwashing Procedure d. Rub together vigorously for at least 20 seconds. g. Rinse thoroughly under clean, running warm water. During an observation of meal prep on 5/19/2026 from 9:30 AM until 10:27 AM, DM washed their hands with soap and water for 15 seconds, rinsed and then continued holding their hands under running water for an additional 7 seconds. DM measured out 1 quart of rice using a clean measuring scoop and rinsed the rice with water in a strainer in the sink located on the prep counter. DM dumped the rice into a pot, added 2 quarts of rice into the pot, and placed the pot on stove. They grabbed a box of yellow squash and placed the yellow squash into the sink located on the prep counter, scrubbed, washed, and placed yellow squash on a clean cutting board. DM then washed their hands with soap and water for 10 seconds, rinsed and then continued holding their hands under running water for an additional 10 seconds. DM put on gloves and cut the squash. When finished cutting squash, they used a rag out of a red bucket with sanitizer to sanitize the knife and counter and placed the rag back in the bucket. DM placed saran wrap on the bowl of squash and labeled it with the contents and date and placed the bowl in the fridge. DM then washed their hands with soap and water for 5 seconds, rinsed and then continued holding their hands under running water for an additional 20 seconds. They prepared cornbread with a boxed mix, whisked the ingredients together, and scraped the contents into a baking pan with a spatula. DM washed their hands with soap and water for 4 seconds, rinsed and then continued holding their hands under running water for an additional 22 seconds. They grabbed a new cutting board and slid 2 halved onions out of a bag onto the cutting board without touching the onions with their hands. DM washed their hands with soap and water for 22 seconds, rinsed, put on gloves, and proceeded to chop the onions. DM removed the pot of rice from the stove, dumped the rice into a steam table pan, and placed that pan on the steam table. DM used the rag out of the red bucket to wipe the cart where the cutting boards and mixer are located, wiped the hand-washing sink, wiped the front of the stove and front of the oven doors, and wiped the knobs on the front of the oven. DM washed their hands with soap and water for 8 seconds, rinsed and then continued holding their hands under running water for an additional 20 seconds. Additional observation during this meal prep on 5/19/2026 from 9:30 AM until 10:27 AM revealed that Dietary Aide (DA)-B washed their hands with soap under running water for 14 seconds. They loaded dirty dishes into the dishwasher trays. DA-B then washed their hands with soap and water for 7 seconds, rinsed them and then continued holding their hands under running water for an additional 10 seconds. Additional observation of food prep and meal service on 5/19/2026 from 11:15 AM until 1:00 PM revealed DM had gloves on and dumped a bowl of brown and red coated raw shrimp onto a sheet pan and used a spoon to spread them out on the pan. DM removed their gloves and stirred the squash that was on the stove. They poured canned chicken broth onto the vegetables and placed saran wrap on the can of chicken broth. DM washed their hands with soap and water for 6 seconds, rinsed and then continued holding their hands under running water for an additional 10 seconds. DM put on new gloves, sliced a half stick of butter, placed the slices over the shrimp, and poured lemon juice over the shrimp. DM moved 2 hot dogs from the griddle into a steam table pan with a spatula. They cleaned the counter with the rag from the red bucket, placed the rag back into the bucket, and took it out to clean off the knife. DM removed their gloves then applied new gloves. They opened sliced cheese, grabbed 3 slices, and cut them on a new cutting board. DM grabbed ham from a bag and sliced it on the same cutting board. They placed the ham and cheese slices on a plate, covered with saran wrap, and labeled it with the contents and date. DM touched fridge handle with (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gloved hand to open fridge and walked in to place the plate in the fridge. DM grabbed a bag of lettuce, a bag of tomatoes, and a jar of pickles out of the fridge and placed these items on the counter. They removed their gloves and put hot mitts on. DM dumped the squash into a steam table pan using a spoon. DM removed the hot mitts and used the rag out of the red bucket to clean off the knife then flipped the cutting board over. DM washed their hands with soap and water for 7 seconds, rinsed and then continued holding their hands under running water for an additional 13 seconds. DM put on gloves and proceeded to slice onions. With gloved hands, DM grabbed the bag of tomatoes and took out 4 quartered tomatoes and sliced them. They grabbed 2 clean plates with their gloves on and did not touch the tops of the plates. With the same gloved hands, DM opened the bag of lettuce, grabbed the lettuce with their gloved hands, and placed it onto the plate. With the same gloved hands, they placed the tomatoes and onions onto the plate. With the same gloved hands, they opened the pickle jar, set the lid on the counter, opened a drawer and grabbed tongs out, and grabbed pickles out of the jar with the tongs and placed them on the plate. DM grabbed a clear bag and put 2 halves of onions into the bag using the same gloved hands. DM opened the fridge and placed the bags of onion, tomato, and lettuce and jar of pickles in there with their gloves still on. They proceeded to open sliced cheese and grabs cheese slices with their same gloved hands. With the same gloves on their hands, DM grabbed a bag of bread from dry food storage, opened the fridge, and grabbed a stick of butter. DM placed the stick of butter in a plastic bowl without touching the butter with their hands and placed the bowl in the microwave. DM removed their gloves and washed their hands with soap and water for 11 seconds, rinsed and then continued holding their hands under running water for an additional 15 seconds. DM put on gloves pureed the shrimp in a food processor with chicken broth, scraped the contents into steam table pan, and put that food processor bowl on the dishwasher tray. DM used the rag from red bucket to wipe off the food processor. DM washed their hands with soap and water for 9 seconds, rinsed and then continued holding their hands under running water for an additional 13 seconds. DM put gloves on and used a new food processor bowl to puree the squash with chicken broth. They poured that into a steam table pan and placed the food processor bowl on a dishwasher tray. They removed their gloves and washed their hands with soap and water for 5 seconds, rinsed and then continued holding their hands under running water for an additional 20 seconds. DM grabbed a pie cutter out of a drawer and set it on top of a prepackaged, unopened pie. They opened the lid to another pie and cut the pie with the pie cutter. DM washed their hands with soap and water for 7 seconds, rinsed and then continued holding their hands under running water for an additional 10 seconds. DM put on gloves and began plating food for lunch. With same gloved hands, they obtained 2 potatoes from the dry food storage and scrubbed them clean in the sink located in the prep counter. They pierced the potatoes with a fork and placed them in the microwave. DM removed their gloves and washed their hands with soap and water for 10 seconds, rinsed and then continued holding their hands under running water for an additional 10 seconds. They put on gloves and continued to plate lunch trays. With same gloved hands, DM grabbed 3 buns out of a bag, buttered the top and bottom half, and placed them on the griddle buttered side down. They used tongs to place 3 hamburger patties on the griddle. DM opened the fridge with their same gloved hands, grabbed a tub of sour cream, obtained a scoopful of sour cream, and placed the scoop of sour cream onto the cutting board. With the same gloved hands, DM grabbed a hot potato out of the microwave, placed it on a plate, and brushed it with butter. They added that scoop of sour cream on top of the potato and smashed the potato down with a fork. DM added a bun and hamburger patty to the plate with tongs and spatula. Using the same gloved hands, DM grabbed a slice of cheese from the cutting board and placed it onto the hamburger patty. With same gloved hands, they grabbed 2 slices of bread from a bag, brushed butter on them, and placed them on the griddle. DM added sliced cheese on top of the bread using the same gloved hands. DM opened the fridge with same gloved hands and grabbed the bag of lettuce, bag of onions, bag of tomatoes, and pickle jar and placed them on the counter. With same gloved hands, DM removed lettuce from the bag, removed onion from the bag, removed tomato from the bag, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	added them to a plate. DM used a spoon to remove pickles from jar. DM opened the fridge with same gloved hands and returned to the prep counter to add a baked potato to a plate with same gloved hands. An interview with DM on 5/20/2026 at 8:19 AM confirmed that the expectation for washing hands is 20 seconds. DM confirmed hand washing during meal prep did not meet recommended length of time to wash. DM confirmed that gloves should be changed when touching other items or finishing projects. Confirmed that gloves should have been changed more often, especially when DM was making alternative meals.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(B)(ii) Based on record review and interview, the facility failed to ensure 1 of 5 sampled nurse aides completed 12 hours of in-service educations and 4 hours of dementia training as required.Findings Are: A record review of an untitled facility-provided document revealed a list of current employees of the facility with name, department, job title, and hire dates. The document also revealed Nurse Aide - A (NA-A) was hired on 2/1/2022. Record review of facility staffing documentation revealed that Nurse Aid (NA)-A completed 1.55 training hours between 2/1/2025 and 2/1/2026 which included the following training, completion dates, and hours:-Basics of Tuberculosis Self-Paced, completed 5/15/25, 0.25 hours.-HIPAA documents review, completed 5/15/25, 0.25 hours-HIPAA Do's and don'ts of social media and electronic communication self-paced, completed 5/15/25, 0.25 hours-Infection control: Handwashing, completed 5/15/25, 0 hours-[NAME] compliance and ethics program overview, completed 5/15/25, 0.3 hours-Personal protective equipment-ALL, completed 5/19/25, 0 hours-Safe patient handling training videos, completed 5/15/25, 0.5 hours-Safe patient handling, lifts skills checklist 10/17/19, completed 5/19/25, 0 hours An interview at 12:43 PM on 5/21/26 with the Administrator (ADM) and the [NAME] President of Operations (VPO) confirmed that NA-A did not complete 12 continuing education hours as required and did not complete the 4 hours of required dementia training as required.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on record review and interview, the facility failed to ensure the consultant pharmacist completed a Medication Regimen Review every month as required for 3 of 5 sampled residents (Residents 2, 6, and 25). The facility identified a census of 32.Findings Are: Record review of a facility policy dated 11/2022 labeled Medication Regimen Review revealed the following information: - The requirements associated with the Medication Regimen Review (MRR) apply to all residents, whether short or long stay - The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed - Each MRR shall be signed by the pharmacist - The consultant pharmacist shall schedule at least one monthly visit to the facility and shall allow for sufficient time to complete all required activities. A. A record review of Resident 2's admission Record dated 5/20/2026 revealed Resident 2 was admitted to the facility on [DATE] and had the following diagnoses: -Hyperlipidemia (high cholesterol) -Hypertension (high blood pressure) -Type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels) -Unspecified dementia (condition characterized by a decline in cognitive function, affecting memory, thinking, behavior and the ability to perform everyday activities) -Obstructive and reflux uropathy (blockage in the urinary system that prevents urine from flowing through the ureters) -Paroxysmal atrial fibrillation (episodes of a fast, chaotic heart rhythm) A record review of Resident 2's medication list dated 5/19/2026 revealed the following active medication orders: -Apixaban (a prescription medication used to thin blood to prevent strokes and treat blood clots) -Seroquel (a prescription medication used to treat various mental health conditions) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review conducted on 5/20/2026 of Resident 2's electronic medical records (EMR) revealed there was no evidence of any medication regimen reviews being completed in 2025 or 2026. B. A record review of Resident 6's admission Record dated 5/20/2026 revealed Resident 6 was admitted to the facility on [DATE] and had the following diagnoses: -Hypertensive heart disease without heart failure (a condition that arises from the chronic effects of high blood pressure) -Hyperlipidemia (high cholesterol) -Hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone) -Gastro-esophageal reflux disease (GERD) (a chronic condition where stomach acid flows back into the esophagus) -Major depressive disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities and various emotional and physical problems) -Iron deficiency anemia (when the body lacks sufficient iron which is essential for producing hemoglobin, a protein in red blood cells that carries oxygen) -Type 2 diabetes mellitus (chronic condition characterized by insulin resistance and high blood sugar levels) -Bipolar disorder (a mental health condition characterized by significant mood swings) A record review of Resident 6's medication list dated 5/21/2026 revealed the following active medication orders: -Abilify (a prescription medication used to treat mental health conditions including bipolar disorder) -Insulin lispro (injectable prescription medication used to manage blood sugar levels in individuals with diabetes) -Fluoxetine (prescription medication used to treat various mental health conditions) -Glucagon (prescription medication crucial in regulating blood glucose levels) -Humalog (fast-acting injectable prescription medication used to manage blood sugar levels in individuals with diabetes) -Insulin glargine (long-acting injectable prescription medication used to manage blood sugar levels in individuals with diabetes) -Insulin detemir (long-acting injectable prescription medication used to manage blood sugar levels in individuals with diabetes) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Levothyroxine (prescription medication used to restore normal thyroid hormone levels) -Midodrine (prescription medication used to treat low blood pressure) -Insulin aspart (fast-acting injectable prescription medication used to manage blood sugar levels in individuals with diabetes) -Ozempic (prescription medication used to manage Type 2 Diabetes Mellitus) -Risperdal (prescription medication used to treat mental health conditions including bipolar disorder) -Insulin degludec (long-acting injectable prescription medication used to manage blood sugar levels in individuals with diabetes) -Dulaglutide (prescription medication which helps the pancreas release insulin with blood sugar levels are high) -Wellbutrin (prescription medication used to treat major depressive disorder) A record review conducted on 5/20/2026 of Resident 6's electronic medical records (EMR) revealed a medication regimen review had been completed by the pharmacist on 2/9/2026 and on 3/16/2026. There was no evidence in the EMR of any additional medication regimen reviews being completed in 2026. C. A record review of Resident 25's admission Record dated 5/20/2026 revealed Resident 25 was admitted on [DATE] and had the following diagnoses: -Essential hypertension (high blood pressure) -Benign prostatic hyperplasia (BPH) (enlarged prostate – an accessory gland of the male reproductive system) -Obstructive sleep apnea (common sleep disorder characterized by repeated interruptions in breathing during sleep) -Hyperlipidemia (high cholesterol) -Polymyalgia rheumatica (an inflammatory condition that causes pain and stiffness in the muscles) A record review of Resident 25's medication list dated 5/21/2026 revealed the following active medication orders: -Fentanyl transdermal patch (opioid pain medicine used to treat moderate to severe chronic pain) -Levothyroxine (prescription medication used to restore normal thyroid hormone levels) -Hydrocodone-acetaminophen (an opioid pain reliever used to relieve moderate to severe pain) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mirtazapine (prescription medication used to treat major depressive disorder) A record review conducted on 5/20/2026 of Resident 25's electronic medical records (EMR) revealed a medication regimen review had been completed by the pharmacist on 3/1/2026 and on 4/27/2026. There was no evidence in the EMR of any additional medication regimen reviews being completed for Resident 25 in 2026.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(A)Based on record review and interview, the facility failed to ensure 3 of 5 sampled residents (Residents 14, 21, 25) had received or declined influenza and pneumococcal immunizations as required. The facility identified a census of 32 residents. A. Record review of Resident 14's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 14's Electric Medical Record (EMR) revealed no evidence of Resident 14 receiving or refusing the Pneumococcal immunization, or being medically ineligible to receive it. B. Record review of Resident 21's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 21's EMR revealed no evidence of Resident 21 receiving or refusing the pneumococcal immunization, or being medically ineligible to receive it. C. Record review of Resident 25's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 25's EMR revealed no evidence of Resident 25 receiving or refusing the pneumococcal immunization, or being medically ineligible to receive it. Further record review of Resident 25's EMR also revealed no evidence of influenza immunization, education, or refusal for the most recent influenza season. Interview with [NAME] President of Operations (VPO) on 5/21/2026 at 11:30 AM confirmed that the facility did not have any vaccination records for Resident 25. An interview on 5/21/26 at 9:07 AM with the Director of Nursing revealed the facility documented the immunizations for each resident in the EMR when residents received those immunizations at the facility. The DON revealed they did not document the immunizations received outside the facility in the EMR or have influenza or pneumococcal immunizations/declinations documented for Residents 14, 21, and 25.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(A)Based on record review and interview, the facility failed to ensure 3 of 5 sampled residents (Residents 14, 21, 25) had received or declined COVID-19 (coronavirus disease 2019, a highly contagious respiratory illness caused by the SARS-CoV-2 virus) immunizations as required. The facility identified a census of 32 residents. A. Record review of Resident 14's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 14's Electric Medical Record (EMR) revealed no evidence of Resident 14 receiving or refusing the COVID-19 immunization, or being medically ineligible to receive it. B. Record review of Resident 21's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 21's EMR revealed no evidence of Resident 21 receiving or refusing the COVID-19 immunization, or being medically ineligible to receive it. C. Record review of Resident 25's face sheet revealed they were admitted to the facility on [DATE]. Record review of Resident 25's EMR revealed no evidence of Resident 25 receiving or refusing the COVID-19 immunization, or being medically ineligible to receive it. An interview on 5/21/26 at 9:07 AM with the Director of Nursing revealed the facility documented the immunizations for each resident in the EMR when residents received those immunizations at the facility. The interview revealed the facility did not document the immunizations received outside the facility in the EMR or have COVID-19 immunizations/declinations documented for Residents 14, 21, and 25.

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Indian Hills Manor	1720 North Spruce Ogallala, NE 69153

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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 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) Based on record review, observation, and interview, the facility failed to ensure 1 (Resident 21) of 2 sampled resident's care plan accurately reflected their physical mobility and psychosocial care, and 1 (Resident 25) of 2 sampled resident's care plan accurately reflected their physical mobility and activities of daily living (ADLs). The facility identified a census of 32 residents. Findings are: Record review of a facility policy titled, Care planning, last revised March 2019, revealed the residents' care plans should be updated between care conferences to reflect current care needs as changes occur. A. A record review of Resident 21's admission record dated 5/21/26 revealed an original admission date of 10/17/2025. The admission record revealed the following relevant diagnoses with onset dates: -Meniere's Disease, unspecified ear (a chronic inner ear disorder caused by an abnormal buildup of fluid, that causes sudden severe vertigo, hearing loss, ringing in the eat and a feeling of aural fullness or pressure) dated 10/17/25, -Pain in right shoulder dated 10/17/25, -Pain in left knee dated 10/17/25, -Dizziness and giddiness dated 10/17/25, -Other chronic pain dated 10/17/25, -Anxiety disorder dated 2/16/26, and -Other reduced mobility dated 10/17/25. Record review of Resident 21's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 4/14/26 revealed Section GG that the resident was dependent on staff for toileting hygiene, and required partial/moderate staff assistance for chair/bed-to-chair and toilet transfers, as well as for going from sitting to standing. An observation made at 8:28AM on 5/19/26 revealed staff assisting Resident 21 with toileting hygiene in bed without offering to bring the resident to the toilet. Nurse Aid (NA)-A and NA-F donned gowns and gloves and then knocked on the resident's door, announcing themselves by saying Nursing before entering the residents' room. NA-A began asking the resident how they were feeling. Both staff members then began removing the blanket from Resident 21. NA-F then grabbed a package of wipes, then both staff members proceeded to remove the resident's brief and perform perineal care. Staff then assisted Resident 21 to roll side to side to remove the soiled brief and pads and replace them with clean ones. After securing a clean brief on the Resident, the staff members turned the resident to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their right side and placed a pillow underneath the resident's left hip to relieve pressure. Both staff members then worked to replace the resident's blanket and adjusted the head of the bed to the resident's comfort. An interview at 3:20 PM on 5/18/2026 with Resident 21 confirmed that upon admission to the facility they were able to walk to and from the bathroom with a walker, and they were no longer able to do that. Resident 21 also confirmed they require the use of a Hoyer lift for all transfers. An additional interview at 9:49 AM on 5/20/26 with Resident 21 confirmed that they had only gotten out of bed with the use of a Hoyer lift for baths and a few other times to sit in their recliner since their return from the hospital. Resident 21 confirmed that they would like to get out of bed more often but that it is stressful to get into the Hoyer lift because they have a fear of falling due to history of falling and Meniere's disease that causes dizziness. Resident 21 also confirmed that they had a goal of being able to walk to and from the bathroom as they were able to before. A record review of Resident 21's undated care plan revealed a last review date of 5/19/2026. Resident 21's care plan revealed the following focus points and interventions with date initiated: -Focus: Impaired Physical Mobility. Interventions: Determine level of needed assistance based on Activities of Daily Living (ADL) /Instrumental Activities of Daily Living (IADLs) evaluation dated 10/24/2025. Encourage use of prescribed assistive devices, dated 10/24/2025. -Focus: The resident has an ADL self-care performance deficit related to activity intolerance, fatigue, and impaired balance dated 01/19/2026. Interventions: the resident requires limited assistance x1 staff for toileting dated 01/19/2026, the resident uses a walker with stand-by assistance to maximize independence with transferring dated 01/19/2026. Continued record review of Resident 21's undated care plan revealed no information reflecting their current need for two staff, maximum assistance for toileting hygiene or their need for the Hoyer lift for transfers. Further record review of Resident 21's MDS dated [DATE] revealed the resident was taking antidepressant medication. Record review of Resident 21's Progress Note dated 4/19/26 and labeled 'Psychotropic meds' revealed an order for Buspar 7.5 milligrams (mg) two times a day (B.I.D) related to anxiety. Resident 21 is having increased anxiety, relates fear of falling when we reposition (gender). staff is giving as needed (PRN) meds routinely. Continued record review of Resident 21's care plan revealed no focus listed to psychosocial needs or preferences/interventions related to their fears of falling. The care plan also contained no evidence of information about the resident's antidepressant or antianxiety medication usage, indications, or clinical rationales. An interview at 11:18 AM on 5/20/26 with the Director of Nursing (DON) confirmed that Resident 21's care plan was last reviewed on 5/19/26 and the next review would be on 8/11/26. The DON confirmed that Resident 21's care plan revealed that Resident 21's ADL's and transfers were listed as a 1x assist from staff, and the resident was not care planned for Hoyer lifts and 2 or more staff assists with cares. At 11:44 AM during the same interview, the DON confirmed the resident did not (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have any information listed in the care plan regarding psychosocial needs, behaviors, or necessity of Anti-Anxiety/Anti-Depressant medications and there was only information regarding monitoring for side effects of these medications. B. Record review of Resident 25's face sheet revealed they were admitted to the facility on [DATE] and diagnosed with urine retention, history of falls, lumbar vertebral compression fracture (fracture of a bone in the lower spine), and polymyalgia rheumatica (an inflammatory condition that causes muscle pain and stiffness, especially in the shoulders, neck, and hips). Record review of an untitled facility document dated 1/8/26 revealed an incident summary for Resident 25 following an unwitnessed fall that took place 1/2/26. The document revealed Resident 25 was transferred to the hospital following the fall then transferred to a hospital in Denver for additional care. The record also revealed Resident 25 was found to have a fractured hip and pelvis. Record review of Resident 25's undated care plan revealed the following about their mobility and activities of daily living: -Transfer: The resident uses walker x1-2 assist to maximize independence with transferring, last revised 1/02/2026. -Toilet use: The resident requires moderate assist x1-2 staff for toilet use. Prefers to use a urinal at bedside at night/when in bed, last revised 1/02/2026. -Dressing: The resident requires moderate assistance x1 staff to dress, last revised 1/02/2026. -Bed mobility: The resident requires moderate assistance x1-2 staff for bedmobility (sitting up/lying down), last revised 1/02/2026. -Ambulation: The resident requires moderate assistance by 1-2 staff to walk inroom and bathroom and as necessary, last revised 1/02/2026. Record review of Resident 25's comprehensive MDS dated [DATE], section GG (Functional Abilities and Goals) revealed the following: -Resident 25 used a wheelchair. -Resident 25 was dependent (helper does all the effort) for toileting hygiene. -Resident 25 required partial to moderate assistance for showering and/or bathing. -Resident 25 required substantial/maximal assistance for upper body dressing, were dependent for lower body dressing and putting on or removing footwear. -Resident 25 was dependent for the following rolling left and right in bed, moving from sitting on the edge of the bed to lying down, and from lying down to sitting up. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Section H of the same MDS revealed Resident 25 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) and always incontinent of bowel. An interview on 5/20/26 at 3:35 PM with the DON revealed Resident 25 did not wish to be in the wheelchair outside of their room, which included not going to the dining room or attending activities. Record review of Resident 25's care plan did not reveal information regarding the resident's preference to eat in their room for every meal. An interview on 5/21/26 at 9:10 AM with the DON revealed Resident 25 was not able to ambulate since they returned to the facility on 2/20/26 and was no longer weight bearing. The interview confirmed Resident 25 required a Hoyer mechanical lift for all transfers. The interview confirmed the care plan should have been updated to include the resident's current care information and preferences.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, interview, and record review, the facility failed to ensure oxygen concentrators were turned off when not in use for 2 (Residents 30 and 3) of 5 sampled residents to prevent the potential for accidents. The facility identified a census of 32 residents.Findings are: A record review of the American Lung Association website, https://www.lung.org/lung-health-diseases/lung-procedures-and-tests/oxygen-therapy/using-oxygen-safely, oxygen is a safe gas and is non-flammable, however, it supports combustion. Materials burn more readily in an oxygen-enriched environment. In the Store Oxygen Safely section it stated to turn off the oxygen when not in use, don't set the cannula or mask on a bed or chair if the oxygen is turned on. A:Record review of Resident 30's physician order dated 7/9/2025 revealed the resident was to be administered oxygen at 2 liters per minute to maintain oxygen saturation above 90%. Observation on 5/18/2026 at 10:27 AM, 11:35 AM, 12:41 PM, 1:44 PM and 2:51 PM revealed the oxygen concentrator (a medical device that provides up to 95% pure oxygen for individuals with respiratory conditions and provides continuous flow of oxygen) in Resident 30's room was observed running with oxygen tubing draped over the bed. Resident 30 was observed to be in the common area at these times, therefore oxygen was flowing without being in use by the resident. Observation on 5/19/2026 at 8:22 AM, 9:55 AM, 10:50 AM, 11:48 AM, 12:35 PM and 1:42 PM revealed the oxygen concentrator running in Resident 30's room with oxygen tubing draped over the bed and resident was noted to be in the common area, therefore oxygen was flowing without being in use by the resident. Observation on 5/20/2026 at 8:01 AM, 9:15 AM, 10:42 AM, 11:50 AM, 12:51 PM and 1:44 PM the oxygen concentrator was observed running in Resident 30's room with oxygen tubing draped over the bed while the resident was observed to be in the common area, therefore oxygen was flowing without being in use by the resident. During an interview on 5/20/2026 at 1:42 PM, NA-D confirmed the concentrator was running in Resident 30's room and stated It (the concentrator) runs all the time, and the resident just puts it on whenever they want to wear it in the room. B:Record review of Resident 3's physician order dated 3/20/2026 revealed the resident is to be administered oxygen at 2 liters per minute as needed related to chronic obstructive pulmonary disease (COPD). Observation on 5/18/2026 at 10:27 AM, 11:35 AM, 12:41 PM, 1:44 PM and 2:51 PM revealed the oxygen concentrator in Resident 3's room was observed running with oxygen tubing coiled up and tucked into the handle of the concentrator. Resident 3 was observed to be in the common area at these times, therefore oxygen was flowing without being in use by the resident. Observation on 5/19/2026 at 8:22 AM, 9:55 AM, 10:50 AM, 11:48 AM, 12:35 PM and 1:42 PM the concentrator was observed running in Resident 3's room with the tubing coiled up and tucked into the handle of the concentrator. Resident 3 was noted to be in the common area at these times; therefore, oxygen was flowing without being in use by the resident. Observation on 5/20/2026 at 8:01 AM, 9:15 AM, 10:42 AM, 11:50 AM, 12:51 PM and 1:44 PM Resident 3's oxygen concentrator was observed running in the room with tubing coiled up and tucked into the handle of the concentrator. Resident 3 was noted to be in the common area at these times; therefore, oxygen was flowing without being in use by the resident.

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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)(iii)Based on observation, record review, and interview, the facility failed to ensure 2 of 2 sampled residents (Residents 14 and 22) received hydration to meet their daily needs. The facility identified a census of 32 residents.Findings are: Record review of a facility policy titled, Resident hydration and dehydration prevention policy, last revised March 2019, revealed the facility would provide adequate hydration, and prevent and treat dehydration, which included providing and encouraging intake of bedside, snack, and mealtime fluids on a daily and routine basis as a part of daily care. A. Record review of Resident 14's face sheet revealed they were admitted to the facility on [DATE] and diagnosed with Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), constipation (a problem with passing stool infrequently or because it is hard), moderate intellectual disabilities (limitation in intellectual function, understanding and use of language, and adaptive behavior), chronic kidney disease, and history of urinary tract infections. A record review of Resident 14's physician orders revealed they had a regular diet for dysphagia (difficulty swallowing) with puree food texture and nectar-consistency thickened liquids, beginning on 2/25/2025. Record review of Resident 14's most recent Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) in section GG (Functional Abilities and Goals) dated 2/6/26 revealed Resident 14 used a wheelchair and was dependent (the helper does all of the effort, the resident does none of the effort, or the assistance of 2 or more helpers is required) for eating and all other activities of daily living. Record review of Resident 14's undated care plan revealed the following directions: Resident 14 required extensive assistance from 1 staff to eat, initiated on 2/28/2025. Encourage good nutrition and hydration to promote healthier skin, initiated on 2/26/2025. Encourage fluids during the day to promote prompted voiding responses, initiated on 1/04/2026. Observations revealed Resident 14 did not have a drinking cup or fluids available to drink in their room at the following times: On 5/18/2026 at 2:05 PM, Resident 14 was in their room, with no drinking water or cup within reach. On 5/19/2026 at 3:02 PM, Resident 14 was in bed awake with their hand behind their head, no water or other fluid or cup nearby. Continuous observation until 3:23 PM revealed no staff entered Resident 14's room. On 5/20/2026 at 10:20 AM, Resident 14 was sitting in a wheelchair in their room, no water, other fluid, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or cup present in the room. On 5/20/2026 at 1:40 PM, Resident 14 was sitting in a wheelchair in their room, no water, other fluid, or cup present in the room. On 5/20/2026 at 3:04 PM, Resident 14 was in bed with the room darkened, no cup or fluids available in their room. An interview on 5/20/26 at 3:06 PM with the Director of Nursing (DON) confirmed Resident 14 was served fluids at mealtimes, and that they were able hold a cup but were not able to use a straw. The interview also revealed that Resident 14 was expected to have fluids in their room to meet their daily needs. The interview revealed they were not aware Resident 14 did not have fluids available to drink in their room and confirmed they were not receiving enough fluids. B. Record review of Resident 22's census data revealed the resident was admitted to the facility on [DATE]. A record review of Resident 22's Diagnosis List revealed the following diagnoses: -A diagnosis of Unspecified Dementia (a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior) was added on 11/11/2024. -A diagnosis of Down Syndrome (a genetic condition where a person is born with an extra copy of chromosome 21. This can affect how their brain and body develop) was added on 11/11/2024. -A diagnosis of Esophageal Obstruction (narrowing or blockage of the swallowing tube. It frequently leads to progressive difficulty swallowing) was added on 11/11/2024. -A diagnosis of Gastro-Esophageal Reflux Disease without Esophagitis (GERD, a chronic digestive condition where stomach acid frequently flows back into the esophagus [the tube connecting your mouth and stomach] but it doesn't cause any damage to the esophagus) was added on 11/11/2024. Record review of Resident 22's quarterly MDS completed on 4/21/2026 revealed the Staff Assessment for Mental Status determined that Resident 22's ability to make decisions regarding tasks of daily life was severely impaired, and they never/rarely made decisions. Resident 22 was dependent (helper does all the effort) for eating and bringing food and/or liquid to the mouth. Resident 22 requires the use of a wheelchair for mobility with maximal assistance to get around in the wheelchair. Resident 22 had a mechanically altered diet (require changes in texture of food or liquids). A record review of Resident 22's Physician Orders revealed an order for Regular diet, dysphagia puree texture, regular consistency started on 11/11/2024. Record review of Resident 22's care plan dated 5/11/2026 revealed a focus that the resident has bladder incontinence r/t dementia, impaired mobility, inability to communicate needs, initiated and revised on 1/3/26. An intervention for this focus included encourage fluids during the day to promote prompted voiding responses which was initiated on 1/3/26. A focus of Diet/Eating: I require (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance in eating was initiated on 2/10/25. Record review of the task labeled Nutrition – Breakfast - Amount eaten under Question 2 – Amount of fluids consumed in ccs/ml (cubic centimeters/milliliters) for dates 4/22/2026 through 5/21/2026 revealed 3 days of 0 mls consumed, 5 days of 20-100 mls consumed, 16 days of 120-200 mls consumed, and 2 days of 300 mls consumed. The task also revealed there was 1 day marked Resident Not Available, 1 day marked Resident Refused, and 2 days marked Not Applicable. Record review of the task labeled Nutrition – Lunch - Amount eaten under Question 2 – Amount of fluids consumed in ccs/ml for dates 4/22/2026 through 5/20/2026 revealed 4 days of 0 mls consumed, 17 days of 200-300 mls consumed, and 6 days of 370-480 mls consumed. The task revealed there was 1 day marked Not Applicable. Record review of the task labeled Nutrition – Dinner - Amount eaten under Question 2 – Amount of fluids consumed in ccs/ml for dates 4/22/2026 through 5/20/2026 revealed 13 days of 0 mls consumed, 10 days of 25-80 mls consumed, 2 days of 120-140 mls consumed, and 2 days of 320-380 mls consumed. The task revealed there was 1 day marked Resident Refused and 2 days marked Not Applicable. An observation on 5/19/2026 at 1:15 PM revealed Nurse Aide (NA)-A was assisting Resident 22 with eating at the dining room table. NA-A picked up a glass of water and brought glass of water to Resident 22's mouth and tipped it for Resident 22 to take a drink. An observation on 5/20/2026 at 8:42 AM revealed Resident 22 being assisted with eating and being given drinks of liquid from a cup with full assistance. An observation on 5/20/2026 at 10:44 AM in Resident 22's room revealed a full pitcher of water, with no ice, on their bedside table. The beside table was along the wall next to Resident 22's room door. This table was across the room and not within Resident 22's reach while in their recliner or bed. An observation on 5/20/2026 at 11:45 AM revealed Resident 22 sitting at the dining room table. They picked up a can of unopened Pepsi, tilting it side to side, and touched the top of can. Resident 22 was unsuccessful in opening the can or having a drink. An observation on 5/20/2026 at 12:38 PM revealed Resident 22 at the dining table being assisted with eating and getting drinks of liquid from a cup with full assistance. An observation on 5/21/2026 at 9:11 AM revealed a full pitcher of water, with no ice, on bedside table. The beside table was along the wall next to Resident 22's room door. This table was across the room from Resident 22's recliner and bed. The bedside table and pitcher were in same spot as prior observation on 5/20/2026 at 10:44 AM. An observation on 5/21/2026 at 2:02 PM revealed Resident 22 sitting in the recliner in their room. There was a full pitcher of water, with no ice, on bedside table which was along the wall next to Resident 22's room door. This table was across the room from Resident 22's recliner and bed. The bedside table and pitcher in same place as in prior observations on 5/20/202 at 10:44 AM and 5/21/2026 at 9:11 AM. An interview with NA-C on 5/21/2026 at 2:04 PM confirmed that Resident 22 required assistance with (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drinking fluids at mealtimes. NA-C confirmed that Resident 22 could take drinks if the cup is handed to them. An interview with MA-E on 5/21/2026 at 2:15 PM confirmed that Resident 22 needed assistance with picking up cups from the table. MA-E confirmed that staff must hand Resident 22 the cup and set the cup down. MA-E confirmed that Resident 22 doesn't drink any liquids in their room between meals unless someone is in Resident 22's room and can give Resident 22 assistance with getting a drink.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18 Based on observation, interview, record review, the facility failed to ensure oxygen tubing was maintained in a clean and sanitary manner, changed and dated according to physician orders and facility policy to prevent the potential for infection for 1 (Resident 30) of 5 sampled residents. The facility identified a census of 32 residents.Findings Are: Record review of facility policy titled Oxygen Usage Policy with revision date of January 2022 revealed under Care of Equipment section, item number 5 titled oxygen tubing, the policy read to change tubing and mask/cannula at least every two weeks and change tubing if visibly soiled or if cannula/mask becomes contaminated. Record review of Resident 30's physician order dated 7/9/2025 reveals the resident is to be administered oxygen at 2 liters per minute to maintain oxygen saturation above 90%. The resident also had an order to change their oxygen tubing every two weeks and to ensure the tubing was dated. Observations on 5/18/2026 at 10:27 AM, 11:35 AM, 12:41 PM, 1:44 PM and 2:51 PM revealed Resident 30 was not in their room, and their oxygen tubing nasal cannula was observed draped over the resident's bed. No date was noted on the tubing. Observations on 5/19/2026 at 8:22 AM, 9:55 AM, 10:50 AM, 11:48 AM, 12:35 PM, and 1:42 PM revealed Resident 30 was not in their room, and their oxygen tubing nasal cannula was observed lying across the resident's bed with no date noted on the tubing. Observations on 5/20/2026 at 8:01 AM, 9:15 AM, 10:42 AM, 11:50 AM, 12:51 PM and 1:44 PM revealed Resident 30 was not in their room, and their oxygen tubing nasal cannula was observed lying across the resident's bed with no date noted on the tubing. An interview on 5/20/2026 at 1:42 PM, Nurse Aide (NA)-D confirmed the placement of Resident 30's oxygen tubing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Hills Manor	1720 North Spruce Ogallala, NE 69153

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure 1 of 5 sampled residents' (Resident 14) medication regimens were free from unnecessary antibiotics. The facility identified a census of 32 residents. Record review of Resident 14's face sheet revealed they were admitted to the facility on [DATE] and diagnosed with Alzheimer's disease (a type of dementia that affects memory, thinking, and behavior), constipation (a problem with passing stool infrequently or because it is hard), moderate intellectual disabilities (limitation in intellectual function, understanding and use of language, and adaptive behavior), chronic kidney disease, and history of urinary tract infections.A record review of Resident 14's physician orders revealed an order for Bactrim (sulfamethoxazole-trimethoprim, an antibiotic) 400-80 milligrams by mouth, once a day, ordered for personal history of urinary tract infections, dated 5/02/2026.A record review of Resident 14's Medication Administration Record (MAR) for May 2026 (printed on May 19, 2026) revealed Resident 14 had received the 5/2/26 Bactrim order daily, beginning on 5/3/26. Resident 14 received Bactrim on 5/1/26 and 5/2/26 to fulfill an order that started 10/2/25 (the same dose size, schedule, and indication).A record review of Resident 14's MAR for April 2026 confirmed the resident received Bactrim daily during April for the same order which was dated 10/2/25.A record review of a facility document titled, Pathology services, subtitled ?Urine culture,' dated 10/11/25 revealed a laboratory report for Resident 14's urine sample which was collected on 10/8/25, with final urine culture results on 10/11/25. Resident 14's urine culture resulted in growth of the bacteria Escherichia coli greater than 100,000 colony forming units per milliliter. The report also included which antibiotics the organism was susceptible and resistant to. The organism was resistant to Bactrim, meaning the bacteria in Resident 14's urine was resistant to being killed in the laboratory test by Bactrim, to the mathematical degree reported.An interview on 5/20/26 at 3:27 PM with the Director of Nursing (DON) confirmed Resident 14 was on long-term antibiotic therapy for a history of urinary tract infections. The DON stated the order was received from Resident 14's urologist along with an order for oral Vitamin C, and the facility was unable to provide any documentation of the provider's rationale for continuing the antibiotic, or that the provider was aware in October that the bacteria in Resident 14's urine was resistant to the antibiotic.