

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/26/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Millard		STREET ADDRESS, CITY, STATE, ZIP CODE 12856 Deauville Drive Omaha, NE 68137	
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 0692 Level of Harm - Actual harm Residents Affected - Some	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) and 12-006.09(J)(iii). Based on observation, interview and record review the facility failed to identify a significant weight loss, implement interventions to prevent further weight loss and failed to obtain weights for 4 (Resident 1,26, 40 and 62) of 7 residents. The facility census was 74. The findings are:Record review of the policy titled Weights and Heights dated 9/30/2025 revealed the following: - Purpose: - To ensure that the residents maintain acceptable paraments of nutritional status regarding weight - To report changes in resident's condition (significant weight change) to physician and family and/or resident - To accurately measure weight and height - To monitor weight loss or gain in a resident - Policy: - Initial resident weights and heights are completed within 24 hours of admission and readmission to the location. All residents are weighed at a minimum weekly for the first four weeks following admission and then monthly thereafter. Weights should be obtained during a consistent week of the month and at the same time of the day. - Residents at nutritional risk will be weighed weekly -Procedure: -#7. If weight varies by more than 3 percent, re-weigh the resident and document. A. Record review of Resident 26's undated Comprehensive Care Plan (CCP) revealed Resident 26 admitted on [DATE]. Further review of Resident 26's CCP revealed Resident 26 had the diagnosis of (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0692 Level of Harm - Actual harm Residents Affected - Some	hemiplegia affecting right dominant side, traumatic subdural hematoma with loss of consciousness, unspecified protein calorie malnutrition, depression, and hypertension. Further review of CCP for Resident 26 revealed a nutritional issue was initiated on 12/5/2025 for the following: -resident has a nutritional problem or potential nutritional problem with goal of consume 50% or greater of meals without choking. Interventions listed were to provide a calm quiet setting for meals and to report any chewing or swallowing problems. Review of Resident 26's Minimum Data Set (MDS, a standardized assessment completed for residents of nursing homes) dated 4/28/26 revealed staff assessed Resident 26 with both short-term and long-term memory problems and cognition was severely impaired. The MDS further revealed Resident 26 utilizes a wheelchair for mobility and has range of motion limitations to both upper and lower extremities on the one side. The MDS further identified Resident 26 is able to feed self after set up. Record review of Mini-Nutritional Assessment (MNA) of 11/11/25 indicated Resident 26's BMI was 21-23 with Resident 26's nutritional status normal and no weight loss Record review of Mini-Nutritional assessment dated [DATE] indicated Resident 26's BMI was 19-21 with Resident 26's nutritional status normal and no weight loss. Record review of Resident 26's November 2025 Medication Administration Record (MAR) revealed Resident 26 had orders for an 8-ounce (or 240 millimeters) house supplement twice a day with a start date of 11/4/2025. Further review of the MAR revealed the facility staff had documented twice a day that Resident 26 received 237 milliliters of the supplement. Record review of Resident 26's December 2025 MAR revealed an order for House Supplement give 8 ounces twice a day. Further review of Resident 26's December MAR revealed facility staff documented Resident 26 had received the 237 ml house supplement twice a day for the month. Record review of Resident 26's weights in the residents Electronic Medical Record (EMR) revealed the following: -Weight on 11/05/25 was 159.0 pounds (lbs). -Weight on 11/28/25 was 150.2 lbs., a loss of 8.8 lbs or 5.53% significant weight loss in less than 30 days. Record review of Resident 26's MD/Nursing Communication dated 12-02-2025 revealed the Registered Dietician (RD) had noted a 5% weight loss in less than 30 days and recommended Resident 26's nutritional supplement be increased to 8 ounces twice a day. Record review of Resident 26's weights revealed on 12-19-2025 Resident 26's weight was 143.2 lbs, an additional weight loss of 7 lbs or 4.66% compared to the weight on 11-28-2025 or a loss of 15.8 lbs or 9.93% within 90 days. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident 26's EMR that included progress notes, practitioners orders , CCP and RD nutritional notes revealed there was no indications Resident 26's continued weight loss was evaluated and additional interventions implemented to prevent further loss. Record review of the RD progress note dated 01-05-2026 revealed Resident 26 had not significant weight loss in the last 30 days and the RD would monitor significant weight changes. Further review of Resident 26's weight dated 02-27-26 revealed that Resident 26's weight was 137.0 lbs, a loss of 13.2 lbs or 8.7% weight loss since the 11/28/25 weight. In addition, in reviewing the weight section of the EMR, revealed no weekly or reweights were obtained . Record review of Resident 26's EMR that included progress notes, practitioners orders, Resident 26's CCP and nutritional notes revealed there was no indications Resident 26's weight loss had been evaluated and additional interventions implemented. Record review of Resident 26's EMR for weights revealed Resident 26's weight on 4-03-2026 was identified as 134.6 lbs. A additional weight loss of 2.4 pounds compared to the weight dated 2-27-2026. Record review of Resident 26's EMR for weights revealed Resident 26's weight on 5-06-2026 was identified as 123.7. An additional weight loss of 10.9 lbs or 8.09 % loss compared to the weight obtained on 4-03-2026 or a loss of 35.3 lbs or 22.20% compared to the weight dated 11-05-2025. Review of Resident 26's EMR revealed there was no re-weights obtained, and there was no evaluation of the significant weight loss or implementation of interventions to prevent additional weight loss. Record review of Resident 26's RD progress note dated 05-10-2026 revealed the RD had noted a significant weight loss and requested a reweigh. Record review of Resident 26's weights revealed a weight obtained on 05-15-2026 of 124.8 lbs for a weight loss of 25.4 lbs or 16.9% since the 11-28-2025 weight. An interview conducted with the RD on 05-26-2026 at 10:46 AM confirmed the RD had not identified that Resident 26 had already been receiving the house supplement 8 ounces twice a day when making the recommendation on 12-02-2025. The RD reported Resident 26 was receiving fortified foods since January of 2026. Record review of Resident 26's physician orders did not reveal the presence of an order for fortified diet. Record review of resident 26's meal ticket from dining room, which revealed fortified diet was not included on the document. Record review of facility diet roster revealed Resident 26 was not listed as having a fortified diet. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Interview with Food Service Assistant (FSA) D on 5/26/2026 at 11:10 AM confirmed that Resident 26 had not received fortified foods. Record review of Resident 26's EMR, including progress notes, practitioner's orders, nutritional assessments and MARs revealed there were no new interventions implemented to prevent further weight loss. In addition, in reviewing the weight section of the EMR, revealed no weekly or reweights were obtained. Review of Food and Fluid intake for Resident 26 revealed the following: - For the period of 3/31/2026 through 4/15/2026, 4 dates (4/2/2026, 4/4/2026, 4/6/2026 and 4/7/2026) had no indication of any meal intake. Of the dates with some documentation present, 2 days listed only breakfast intake (4/1/2026 and 4/10/2026). 6 days (3/31/2026, 4/8/2026, 4/11/2026, 4/12/2026, 4/13/2026, 4/13/2026) listed breakfast and lunch but no dinner. 9 days (3/31/2026, 4/1/2026, 4/2/2026, 4/4/2026, 4/7/2026, 4/8/2026, 4/10/2026, 4/13/2026, and 4/14/2026) did not have any documentation of a snack offered. - For the period of 4/15/2026 to 4/30/2026, 2 days (4/16/2026 and 4/19/2026) had no documentation of any meal intake. Of the dates with some documentation present, 5 days listed only breakfast intake (4/24/2026, 4/25/2026, 4/27/2026, 4/28/2026 and 4/30/2026). 8 days (4/16/2026, 4/19/2026, 4/22/2026, 4/24/2026, 4/26/2026, 4/27/2026, 4/28/2026, and 4/30/2026) did not have any documentation of a snack offered. - For the period 4/30/2026 to 5/15/2026, 2 dates (5/3/2026 and 5/15/2026) had no indication of any meal intake. Of the days with some documentation present, 3 days (4/30/2026, 5/9/2026 and 5/10/2026) listed only breakfast intake. 6 (5/1/2026, 5/2/2026, 5/4/2026, 5/6/2026, 5/7/2026 and 5/13/2026) days did not have documentation of dinner intake. 6 days (4/30/2026, 5/4/2026, 5/6/2026, 5/7/2026, 5/13/2026 and 5/15/2026) did not have any documentation to verify whether a snack was offered. Review of facility menu for the week of May 3 to May 9, 2026, revealed that Hamburgers are listed as Always Available to residents who do not like the featured meal. On 05/18/2026 at 8:19 AM, observed Resident 26 feeding self at breakfast eating approximately 50% of meal. Observation on 5/19/26 at 1:15 PM revealed Resident 26 laying flat in bed with lunch tray at bedside. Resident 26 was not able to access the tray the meal tray. During observation, Resident 26's family member expressed concern regarding Resident 26's eating to CNA in room. CNA replied that if it is something Resident 26 likes, they eat very well. CNA further stated that they love cheeseburgers. However, no alternate meal was provided to Resident 26. Observation of Resident 26 on 5/20/26 at 7:45 AM revealed Resident was in bed with an uneaten banana and wrapped cookie on their bedside table. These snacks were outside of Resident 26's reach and they could not consume these items independently. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Interview on 5/21/26 at 8:47 AM with Director of Nursing (DON) confirmed weekly weights for Resident 26 were not obtained as was facility policy for residents with nutritional risk. The DON also reported it is the facility process that when weight loss is identified, nursing would notify the RD, however, for this resident, nursing did not notice the weight loss nor follow up with the RD to allow for follow up as needed. A follow up interview with DON on 5/21/26 was conducted at 9:05 AM. During the interview the DON reviewed the printed meal ticket, Diet Roster and Care plan of 5/18/26 for Resident 26. After these documents were reviewed, the DON confirmed that fortified diet was not included on any of the documents. DON asked to review care plan in the EMR during interview. DON opened nutrition care plan and stated that they could see fortified diet was listed on care plan as of 12/2/2025. After reviewing the CP revision information in the EMR, the DON confirmed that the fortified diet was added on 5/21/2026, not on 12/2/2025. B. Review of Resident 40's CCP revealed an admission date of 3/27/2026. Further review of Resident 26's CCP revealed resident had diagnoses of melena, hemorrhage of anus and rectum, ulcerative proctitis without complication, bilateral paralytic syndrome following cerebral infarction, vascular dementia and pressure ulcer of sacral region, stage 3. Resident 40's care plan further revealed nutritional problem or potential problem and indicated that Resident 40 received a minced and moist diet with thin liquids. This CCP's listed interventions of providing nutritional support as needed, to weigh as ordered, to offer a bedtime snack and to observe for signs and symptoms of chewing or swallowing difficulties and choking. Review of Resident 40's CCP also revealed an entry addressing a pressure ulcer on the sacrum. An intervention for this wound was to monitor nutritional status. Review of Resident 40's MDS dated [DATE] revealed that Resident 40 has severe cognitive impairment and was dependent for all activities of daily living. Resident 40 also was noted to have limitations to their range of motion. Review of Mini Nutritional Assessment (MNA) dated 3/30/26 indicated that Resident 40 has normal nutritional status. No follow up MNAs were found in the EMR. Record review of Resident 40's weights in the Electronic Medical Record (EMR) revealed the following: -Weight on 3/29/2026 was 263.5 pounds (lbs) - Weight on 4/23/2026 and was 234.5 lbs, a loss of 29 pounds or 11.5% loss in less than one month. This weight loss was not planned for on the CCP. - EMR did not have any weights entered for the month of May. Review of progress note in EMR reveals that on 4/26/26, a weight change trigger was noted with direction from the RD to re-weigh; however, no additional weights were located in EMR between (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	4/26/2026 and 5/20/2026. Review of Resident 40's TAR for May 2026, reveals that a reweigh was ordered for 5/14/2026. However, this reweigh had not been obtained by 5/18/2026 at 3:38 PM. Resident 40 was observed during breakfast and lunch on 5/18/26. They were able to drink beverages with a straw when cup held up for them. Resident 40 required total assistance to move food from plate to mouth. No choking or other issues noted during the meal. On 5/20/26 at 7:35AM, observed of Resident 40 in bed with eyes closed. There were 2 wrapped cookies laying on bedside table. Prior observations had revealed that, Resident 40 required total assistance for eating and were not able to reach or consume these snacks without assistance. On 5/26/26 at 9:15AM, observation Resident 40 in bed with eyes open. Noted that there were 3 unopened packages of cookies on the bedside table. Also noted that there is no water pitcher or cup available for Resident 40 to drink from. Review of Food and Fluid intake for Resident 40 revealed the following: -For the period of 4/30/2026 through 5/15/2026 2 days (5/3/2026 and 5/15/2026) contained no documentation of any meal intake. 4 dates (4/30/2026, 5/10/2026, 5/13/2026 and 5/14/2026) contained only breakfast intake. 6 days (5/1/2026, 5/2/2026, 5/4/2026, 5/6/2026, 5/7/2026, 5/9/2026) contained only breakfast and lunch intake. 7 dates (4/30/2026, 5/4/2026, 5/5/2026, 5/7/2026, 5/10/2026, 5/13/2026 and 5/15/2026) contained no documentation regarding snack intake. Interview on 5/20/26 at 9:10 AM with RD confirmed the requested reweigh was not completed for Resident 40 due to Resident 40's significant weight loss. RD stated getting re-weighs is hard. During follow up interview of RD on 5/20/2026 at 11:15 AM, RD produced documentation containing a weight for resident which was obtained on 4/13/26. The weight of 258.7, was obtained from hospital documentation, not obtained by the facility. If the newly obtained hospital weight of 258.7 and the final weight available in the EMR (234.5 pounds) are compared, the weight loss is 9.35%. Per MDS guidelines, a weight loss of 5 pounds or greater constitutes a significant weight loss. Interview on 5/21/26 at 8:47 AM with DON confirmed that weekly weights for Resident 40 were not obtained per facility policy and that the reweigh requested by the RD was not completed. C. Record review of Resident 62's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	13 to 15 indicates a person is cognitively intact. -required supervision with eating and transfers. -required limited assistance with hygiene, toileting, bathing and dressing. -weighed 163 pounds (lbs). -had not had a 10% weight loss in the last 6 months. Record review of Resident 62's CCP dated 03-18-2026 revealed Resident 62 had a nutritional problem or potential nutritional problem related to diagnosis of dementia and chronic kidney disease stage 4. The goal was Resident 62 would consume greater than 50% of meals through the next review date. Interventions listed on the CCP: -diet level 7, regular texture and thin liquids -prefers to eat meals in the dining room but may order room trays -weigh as ordered -offer a snack at bedtime. Record review of Resident 62's weights in the EMR revealed Resident 62 weighed 182 lbs on 09-18-2025 and weighed 168 lbs on 12-01-2025 equaling a 14 lb weight loss or 7.6% weight loss in 74 days. Record review of Resident 62's MNA dated 12-19-2025 revealed Resident 62 had not had a weight loss during the last 3 months. Record review of Resident 62's Progress Notes (PN) dated 01-05-2026 revealed Resident 62 had an 8.9 % significant weight loss in 90 days and had recommended a Boost Plus nutritional supplement 237 milliliters (ml) daily related to a significant weight loss. Record review of Resident 62's Medical Doctor (MD)/Nursing Communication dated 01-08-2026 revealed Resident 62's practitioner ordered the recommended Boost Plus nutritional supplement 237 ml daily. Record review of Resident 62's MAR for January 2026 revealed the absence of Boost Plus nutritional supplement order. Record review of Resident 62's MAR for February 2026 revealed the presence of an order for the house supplement 237 ml daily for weight loss dated 02-14-2026, 37 days after Resident 62's practitioner signed the order. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Record review of Resident 62's EMR under weights revealed Resident 62 weighed 168 lbs on 12-01-2025 and weighed 162 lbs on 01-19-2026 for an additional 6 lb weight loss. An observation conducted on 05-19-2026 at 8:00 AM revealed Resident 62 was not in the dining room for breakfast. An observation conducted on 05-19-2026 at 9:00 AM revealed Resident 62 was in bed in room with lights off, eyes closed and no room tray. An observation conducted on 05-19-2026 at 11:00 AM revealed Resident 62 in bed with eyes closed. An observation conducted on 05-19-2026 at 12:00 PM revealed Resident 62 was not in the dining room lunch. An observation conducted on 05-19-2026 at 12:15 PM revealed Resident 62 was in bed in room with eyes closed. An interview conducted on 05-19-2026 at 1:00 PM with Resident 62 revealed Resident 62 hadn't felt good this morning and had not wanted to eat breakfast or lunch. An interview conducted on 05-20-2026 at 11:30 AM with the RD confirmed the MNA dated 12-19-2026 for Resident 62 was incorrect and confirmed the recommended nutritional supplement was not initiated until 02-14-2026 and should have been initiated on 01-08-2026. D. Record review of Resident 1's admission Record (AR) revealed the facility admitted the resident on 01/12/2024. Further review of the AR identified Resident 1 had diagnoses of protein-calorie malnutrition (a condition where the body does not receive enough food, calories, or protein), hyperlipidemia (elevated fat in the blood), and dysphagia (difficulty swallowing). Record review of Resident 1's MDS revealed the Resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 10. According to the MDS manual, a score of 10 indicated the resident had moderately impaired cognition. Further review of the MDS identified resident 1 required setup or clean-up assistance with meals. Record review of Resident 1'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 an intervention to weigh as ordered dated 05/03/2026. Record review of Resident 1's Order Summary Report revealed a lack of an order for any weight measurements. Record review of Resident 1's Weight Change note dated 04/26/2026 identified the resident had a (continued on next page)		

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Licensure Reference Number 175 NAC 12-006.01(A)Based on observations, record reviews, and interviews, the facility management failed to utilize its resources to attain or maintain the highest practicable physical and psychosocial well-being of each resident as identified by the deficient practices cited. The facility staff identified a census of 74.Findings are:Record review of the facility administrator job description revealed the position was responsible for the overall leadership and management of the location, including meeting established goals and outcomes, ensuring regulatory and organization compliance, directing and coordinating work, financial and operational stability, and demonstrating leadership. Further review of the job description revealed it was the facility administrator's responsibility for ensuring a QAPI Program was in place. Ensures documentation and reports are completed as required by regulations and/or policy and procedure.Record review of the Director of Nursing (DON) job description revealed the DON was responsible for administering the nursing program in a long-term care facility to maintain standards of resident care. Further review of the DON job description revealed it was DON's responsibility to facilitate the optimization of the geriatric care process to improve the quality and efficiency of service. The DON was responsible for the overall quality of care provided by the organization's nursing personnel and to monitor operations of nursing staff and ensured compliance with regulations on organizational and governmental standards and practices.Record review of the Dietitian job description revealed it was the responsibility of the dietitian to plan, develop, and provide diet interventions, medical nutrition therapy, nutrition care and preventive counseling to individuals and groups in all areas of primary and specialty patient/resident care. -F550: The facility failed to timely notify the selected funeral home of needed services for Resident 88.-F605: The facility failed to perform an abnormal involuntary movement score (AIMS) evaluation for Resident 3.-F641: The facility failed to accurately code the mood score on the MDS for Resident 11.-F677: The facility failed to ensure that Resident 95 received dining assistance in a timely manner. Observations on 5/21/26 at 8:55 AM revealed the heated room tray cart containing resident breakfast trays was placed in the kitchen area of unit five. The Nurse Aide began to deliver room trays at 9:40 AM. Resident 95 did not receive their tray until 10:00 AM and did not receive assistance to eat until 10:15 AM, one hour and 20 minutes after the trays were delivered. Observations on 5/26/26 at 9:00 AM revealed the heated cart containing breakfast trays was delivered to the dining area of Unit 5. NA O began to deliver trays to the resident's rooms at 9:05AM. Breakfast was delivered last to Resident 95 at 9:35am. Licensed Practical Nurse (LPN) N entered Resident 95's room at 9:55AM to assist Resident 95 with eating. The time between the tray arriving at the unit and the resident being fed breakfast was 55 minutes.Interview on 5/18/26 at 2:15 PM with the Speech Therapist (ST) P confirmed Resident 95 required assistance with eating.Interview on 5/26/26 at 9:55 AM with Licensed Practical Nurse (LPN)-N confirmed Resident 95 had been waiting for almost an hour for their breakfast and that was not ideal.Interview on 5/26/26 at 11:02 AM with the DON confirmed waiting for 55 minutes or longer to have assistance eating was not the facility expectation for an assisted diner.-F684: The facility failed to monitor bowel movements and implement a bowel protocol for Resident 2; and the facility failed to monitor blood glucose per physician's orders for Resident 87.Record review of Resident 2's bowel movement log revealed Resident 2 did not have a bowel movement, except for a small on 5/7/26. Interview on 5/20/26 at 1:30 PM with the DON confirmed Resident2 did not have a bowel movement, except for a small on 5/7/26 and further confirmed bowel protocol medications were not given and should have been.Record review of Resident 87's blood sugar summary dated 05/01/26 through 05/07/26 (continued on next page)		

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F 0835 Level of Harm - Actual harm Residents Affected - Some	revealed there was no blood sugar reading for the evening of 05/02/26, 05/03/26, and 05/04/26. Interview on 5/20/26 at 12:58 PM with the DON confirmed a lack of documentation of the blood sugar readings for the evening of 05/02/2025, 05/03/2025, and 05/04/2025. The DON further confirmed there was no place on the MR to document the reading.-F686: The facility failed to identify causal factors and implement interventions to promote wound healing and prevent further pressure ulcer development for Resident 26.-F688: the facility failed to implement an ambulation program as recommended by therapy and per resident wishes for Resident 42 and failed to implement a restorative range of motion program for the treatment of contractures and prevention of further limitations for Resident 26. An interview conducted on 05-26-2026 at 1:55 PM with the Restorative Aid (RA) E confirmed a restorative program had not been provided for Resident 42 because RA E was not informed of the recommendation for restorative services. Interview of RA-E on 5/26/2026 at 2:31 PM revealed that RA-E did not receive any notification regarding the present of a restorative program for Resident 26. RA-E added that Resident 26 was referred for therapy, but services were discontinued due to insurance problems and RA-E did not receive any referral for restorative services. -F692: The facility failed to identify a significant weight loss and implement interventions to prevent further weight loss for Resident 26, 40 and 62 and failed to monitor meal intakes after identification of significant weight loss for Resident 1. Interview on 5/21/26 at 8:47 AM with DON confirmed that weekly weights for Resident 26 were not obtained as was facility policy for residents with nutritional risk. DON also stated that it is the facility process that when weight loss is identified, nursing would notify the RD. However, for this resident, nursing did not notice the weight loss nor follow up with the RD to allow for follow up as needed. Interview on 5/21/26 at 8:47 AM with DON confirmed that weekly weights for Resident 40 were not obtained per facility policy and that the reweigh requested by the RD was not completed. An interview conducted on 05-20-2026 at 11:30 AM with the RD confirmed the MNA dated 12-19-2026 for Resident 62 was incorrect and confirmed the recommended nutritional supplement was not initiated until 02-14-2026 and should have been initiated on 01-08-2026. During an interview on 05/20/2026 at 11:08 AM, the RD confirmed any resident who was identified as a significant weight loss should have weekly weight. The RD further confirmed the results of the dietitian report are provided both verbally and in writing to the facility. The RD confirmed there was an absence of weekly weights from 04/23/2026 until 05/20/2026.-F695: The facility failed to ensure Continuous Positive Airway Pressure (CPAP: a machine that delivers a steady stream of pressurized air through a mask to keep the throat open when asleep) orders were obtained and followed for Resident 4. An interview conducted with the Director of Nursing (DON) on 05-20-2026 at 1:30 PM confirmed orders for CPAP machine settings were not obtained until 05-19-2026 and should have been obtained when ordered.-F712: The facility failed to ensure residents were seen by a physician for the initial comprehensive visit for Resident 6, Resident 8, Resident 42, and Resident 95.-F756: The facility failed to perform follow up on the consultant pharmacist's monthly recommendations Resident 3 and Resident 62. An interview conducted with the DON on 05-21-2026 at 9:50 AM confirmed the pharmacy recommendations detailed above were not followed up on and should have been. During an interview on 05/26/2026 at 9:39 AM, the Director of Nursing (DON) confirmed the pharmacy recommendations were not followed up on and should have been. -F761: The facility failed to ensure that medication cards were secured in the medication cart during medication administration.-F838: the facility failed to review and update the facility assessment with input from the Medical Director and Director of Nursing. During an interview on 05/26/2026 at 12:22 PM, the Administrator (ADM) revealed the facility assessment was completed one-to-one with corporate level staff.-F843: the facility staff failed to have a transfer agreement between the facility and hospital.-F865: The facility failed to ensure the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0835 Level of Harm - Actual harm Residents Affected - Some	Quality Assurance Performance Improvement Program (QAPI - a facility process that identifies problems in the facility and works to correct the concerns) identified and addressed concerns related to deficient practice identified on the annual survey 2026 (F605, F641, F677, F684, F686, F688, F692, F695, F712, F756, F761, F835, F838, F843, F880, and F865).A telephone interview on 5/26/2026 at 3:30PM with the Quality Assurance and Performance Improvement Coordinator (C) confirmed they were not aware of the issues identified by the survey team prior to the survey. The QAPI C reported the Facility Administrator informed the QAPI Coordinator after the survey is completed. The QAPI C confirmed they do not usually have a written plan related to issues. The QAPI C confirmed that identified issues are presented to them during the monthly QAPI meeting after which the coordinator delegates responsibilities to the QAPI committee member. The issues are followed up at the next QAPI meeting.-F880: The facility failed to handle linen in a manner to prevent cross contamination, failed to perform hand hygiene with glove changes during the provision of medication administration for Resident 15, failed to clean CPAP mask and tubing for Resident 4, and failed to label and store nebulizer equipment in a manner to prevent cross contamination for Residents 4, 15 and 45.		

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F 0865 Level of Harm - Actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Licensure Reference Number 175 NAC 12-006.07(C) Based on record review and interview, the facility failed to ensure the Quality Assurance Performance Improvement Program (QAPI - a facility process that identifies problems in the facility and works to correct the concerns) identified and addressed concerns related to deficient practice identified on the annual survey 2026 (F550, F605, F641, F677, F684, F686, F688, F692, F695, F712, F756, F761, F835, F838, F843, F880, and F865) This had the potential to affect 74 residents who resided in the facility. The facility claimed a census of 74 A record review of the 2026 Quality Assurance and Performance Improvement Plan, dated March 24, 2026, revealed the following information:QAPI Plan Purpose:The Quality Assurance Performance Improvement (QAPI) Plan is designed to outline a comprehensive and data driven QAPI program that focuses on improving the outcomes and experiences of those we serve.The QAPI Plan provides a description of the strategic approach to prevention, identification, reporting, investigation, analysis, and development of performance improvement activities. This document also delineates the responsibility, accountability, reporting structure, and strategic priorities for performance improvement activities of groups and organizations responsible for affecting the QAPI plan.Location QAPI CommitteeThe location administrator is the leader of the QAPI committee, with assistance from the QAPI Coordinator, and is responsible for its effective operation. The location QAPI Committee ensures an effective QAPI program is in place, and the program is adequately resourced with time, personnel, training (including contract staff), equipment, and financial resources.QAPI StructureThe location QAPI Committee meets at least quarterly to address identified quality concerns. Each service line is responsible for tracking individual performance and report data to the location QAPI Committee. When deficiencies are identified, a causal analysis and action plan development will occur, if deemed necessary. Action plans are to be presented to the location QAPI Committee for monitoring and to ensure sustained improvement. A record review of an undated paper sheet titled QAA Committee revealed the QAPI Committee meets every 4 weeks.The recent survey with an end date of 05/26/2026 identified the following citations:F605 The facility failed to perform an abnormal involuntary movement score (AIMS, an evaluation used to look for involuntary muscle movements usually in the face, lips, tongue, hands, and feet) evaluation for the use of antipsychotic medications for 1 (Resident 3) of 5 sampled residents. F641 The facility staff failed to accurately code the mood score on the 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) for 1 (Resident 1) of 5 sampled residents. F677 The facility failed to ensure assistance with meals was provided to Resident 95 in a timely manner.F684 The facility failed to monitor bowel movements and implement a bowel protocol for 1 resident (Resident 2) of 1 resident sampled and failed to monitor blood glucose per physicians order for 1 resident (Resident 87) of 1 resident sampled. F686 The facility failed to identify causal factors and implement interventions to promote wound healing and prevent further pressure ulcer development for Resident 26.F688 The facility failed to implement an ambulation program as recommended by therapy and per resident wishes for Resident 42 and failed to implement a restorative range of motion program for the treatment of contractures and prevention of further limitations for Resident 26. F692 The facility failed to identify significant weight loss and implement interventions to prevent further weight loss for Resident 26, Resident 40, and Resident 62; Failed to monitor weights and failed to accurately complete the Mini Nutritional Assessment (MNA - a validated screening and assessment tool used to identify older adults (65 and older) who are malnourished or at risk of malnutrition) for Resident 62; and the facility failed to monitor meal intakes (continued on next page)		

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F 0865 Level of Harm - Actual harm Residents Affected - Some	after identification of significant weight loss for resident 1.F695 The facility failed to ensure Continuous Positive Airway Pressure (CPAP: a machine that delivers a steady stream of pressurized air through a mask to keep the throat open when asleep) orders were obtained and followed for 1 (Resident 4) of 1 resident sampled. F712 The facility failed to ensure residents were seen by a physician as required for Residents 6, 8, 42, and 95.F756 The facility failed to follow up on pharmacist recommendations for Residents 3 and 62.F761 The facility failed to ensure medications were secured in the medication cart during the medication administration. F 835 The facility failed to have effective administration as evidenced by deficiencies during the annual survey.F838 The facility failed to review and update the facility assessment with input from the Medical Director and Director of Nursing. This has the potential to affect all residents in the facility. F843 The facility staff failed to have a transfer agreement between the facility and hospital. This had the potential to affect all residents in the facility. F880 The facility failed to utilize enhanced barrier precautions while providing wound care for Resident 4; failed to perform hand hygiene between glove changes during catheter care for Resident 9 and the provision of medication administration for Resident 15; failed to store CPAP mask in a bag when not in use, failed to clean CPAP supplies, and failed to change CPAP tubing for Resident 4; and failed to label nebulizer equipment and store masks in a manner that prevents cross contamination for Residents 4, 15, and 45; and failed to handle linen in a manner to prevent cross contamination.F865 The facility QAPI program failed to identify deficient practice prior to the survey. A telephone interview on 5/26/2026 at 3:30 PM with the Quality Assurance and Performance Improvement (QAPI - a data-driven framework used in healthcare to continuously improve safety, care, and quality of life) Coordinator (C) confirmed they were not aware of the issues identified by the survey team prior to the survey. The QAPI C reported the Facility Administrator informed the QAPI Coordinator after the survey is completed. The QAPI C confirmed they do not usually have a written plan related to issues. The QAPI C confirmed that identified issues are presented to them during the monthly QAPI meeting after which the coordinator delegates responsibilities to the QAPI committee member. The issues are followed up at the next QAPI meeting.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to review and update the facility assessment with input from the Medical Director and Director of Nursing. This has the potential to affect all residents in the facility. The facility staff identified a census of 74. Findings are: Record review of the facility assessment dated [DATE] revealed: - To ensure the required thoroughness, the facility must ensure active involvement of the following participants in the process; nursing home leadership, including but not limited to, a member of the governing body, the medical director, administrator and director of nursing. Also, must include direct care staff, including but not limited to, RNs, LPNs, CNAs, or other representatives of direct care staff. The facility must solicit and consider input received from residents, resident representatives, and family members. Further review of the facility assessment revealed the only name or title recorded involved in completing the facility assessment was the facility administrator. During an interview on 05/26/2026 at 12:22 PM, the Administrator (ADM) revealed the facility assessment was completed one-to-one with corporate level staff.		

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on record review and interview; the facility staff failed to have a transfer agreement between the facility and hospital. This had the potential to effect all residents in the facility. The facility staff identified a census of 74. Findings are: Record review of the facility agreements revealed there was no evidence of a transfer agreement between the facility and the hospital. Interview on 05/26/2026 at 2:12 PM with the Administrator (ADM) revealed the facility did not have a hospital transfer agreement.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were seen by a physician for the initial comprehensive visit for 4 (Resident 6, Resident 8, Resident 42, and Resident 95) of 4 sampled residents. Facility staff identified a census of 74. Findings are: Record review of facility policy entitled Physician's Visits-Rehab/Skilled dated reviewed/revised 03/04/2024 revealed the attending physician would see the resident every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Further review of the policy identified after the initial visit, in skilled nursing facilities in which the state allows their use, a qualified nurse practitioner, physician assistant or clinical nurse specialist may make every other required visit. A. A record review of Resident 95's admission Record revealed resident was admitted to the facility on [DATE] with a diagnosis of an unstable burst fracture (an injury which could develop more damage) of T7-T8 vertebra (the 7th and 8th bone in the upper middle back). A record review of Resident 95's admission Record revealed Resident 95's primary payer source was Medicare A. A record review of Resident 95's progress notes revealed Resident 95 did not receive an initial visit from the residents physician. An interview on 5/26/26 at 11:02 AM with the Director of Nursing confirmed Resident 95's admission visit was conducted by an Advanced Practice Registered Nurse (APRN & a Registered Nurse who has completed graduate-level education and has the authority to assess, diagnose, treat illnesses, order tests, and prescribe medications). The DON did not know that Medicare A patients require the initial provider assessment visit to be conducted by a physician. B. A record review of Resident 8's admission Record revealed resident was admitted to the facility on [DATE] following a left periprosthetic femur fracture (a break in the bone surrounding a hip or knee replacement implant). A record review of Resident 8's admission Record revealed Resident 8's primary payer source was Medicare A. A record review of Resident 8's Provider notes revealed Resident 8 did not receive an initial visit from their physician. A record review of the residents progress notes revealed that all of the Provider visit notes were conducted by an APRN. An interview on 5/26/26 at 11:02 AM with the Director of Nursing confirmed that all provider visits were conducted by an APRN. The Provider note dates were: 3/23/26, 4/5/26, 4/19/26, 4/26/26, 4/25/26, 5/2/26 and 5/18/26. T (continued on next page)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of Resident 6's admission Record (AR) revealed the facility admitted the resident on 12/19/2025. Further review of the AR identified Resident 6 had diagnoses of hypokalemia (low potassium), chronic atrial fibrillation (irregular heartbeat), end stage renal disease, type 2 diabetes mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production), and dependence on renal dialysis (the process of removing blood from an artery, purifying it by dialysis, adding vital substances, and returning it to a vein). Record review of Resident 6's admission and Medicare 5-day 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 12/24/2025 identified the primary medical condition for Resident 6's admission was stage five chronic renal failure. Record review of Resident 6's Order Summary Report identified an order to admit Resident 6 to the skilled nursing facility dated 12/19/2025. Record review of an untitled document pertaining to Resident 6 with a date of service of 12/19/2025 identified the Resident 6 was seen for medication reconciliation, hospital follow up and history and physical. The evaluation was signed and completed by an advanced practice registered nurse. Record review of Resident 6's Electronic Health Record (EHR) including progress notes and scanned documents lacked evidence Resident 6 had been seen by a physician for the initial comprehensive visit. Interview on 05/26/2026 at 11:49 AM with the Director of Nursing (DON) revealed the nurse practitioner typically completes the comprehensive visit. The DON reported they were unaware a physician must complete the initial comprehensive visit. D. Record review of Resident 42's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-11-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with toileting, transfers and lower body dressing. -required extensive assistance with bathing and bed mobility. Record review of Resident 42's Practitioner Visit Notes (PVN) revealed Resident 42 was seen by an Advanced Practice Nurse Practitioner on the following dates: (continued on next page)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-03-12-2026 admission follow up visit -03-19-2026 -03-26-2026 -04-02-2026 -05-04-2026. An interview was conducted on 05-18-2026 at 11:00 AM with Resident 42 revealed Resident 42 had not seen a physician since admission. An interview conducted with the Director of Nursing (DON) on 05-26-2026 at 11:46 AM confirmed Resident 42 had not seen a physician since admission on [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 1-005.06(D,E &F), 12-006.19, 12-006.18(B). Based on observation, interview and record review the facility failed to store Nebulizer equipment, clean CPAP mask and tubing and failed to utilize handwashing and gloving techniques to prevent potential cross contamination for 4 (Resident 4, 10, 15 and 45). The total sample size was 31. The findings are: Review of facility policy titled Infection Prevention and Control Program, dated 3/25/2026, revealed the following: - Purpose: To establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable disease and infections. - Policy: An infection prevention and control program is a set of evidence-based policies, procedures, and practices implemented in healthcare settings to prevent and minimize the spread of infections among residents/patients/clients, employees, and visitors. The program utilizes a combination of strategies such as hand hygiene, appropriate use of personal protective equipment, cleaning and disinfection and transmission-based precautions to reduce infections and improve safety and quality of care. Review of facility policy packet, titled Laundry, dated 8/21/2025, revealed the following: - Purpose: To provide policy and procedures for the collecting and transporting of soiled clothes, linens, and other laundered items. - Policy: Soiled laundry will be collected to prevent the spread of potentially infectious diseases. All soiled clothes, linens, and other laundered items soiled with potentially infectious material, will be treated as if it is infectious. - Handling of Soiled Linen and Clothing: - Clothes and linens should be handled as little as possible to prevent the spread of potentially infectious materials - Clothes and linens should be placed directly into plastic bags before leaving the resident rooms/units. Record review of facility policy titled Nebulizer, dated 04/02/2026, revealed: - Policy: - To assist in loosening lung secretions (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- To administer bronchial medications and humidifying agents into the lungs - Procedure: - Following Medication administration, clean nebulizer after each use - Replace the tubing when the nebulizer cup is replaced weekly or as needed. - Separate the nebulizer parts and rinse thoroughly with water after each use - Place mask or mouthpiece and cup on paper towel and air-dry until the next use. Cover with clean cloth or towel. - Record review of facility policy titled Hand Hygiene, dated 11/13/2025 revealed: - Purpose: - To define terms related to hand hygiene. - To guide compliance for hand hygiene with the Centers for Disease Control and Prevention (CDC) and the World Health Organization's Moments of Hand Hygiene recommendations - To establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to patients and personnel in healthcare settings - To provide guidance regarding lotion use, glove use, and fingernail care - POLICY: - All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. - All employees in patient care areas will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. - Entering Room - Before Clean Task - After Bodily Fluid/Glove Removal - Exiting Room - Zones: Patient zone and Health-care zones. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The preferred method of hand hygiene for most patient care settings is the use of waterless alcohol-based hand sanitizer. - Access to hand hygiene products is provided in all work units (wall mounted, attached to carts or positioned on counters). A Review of Resident 45's Electronic Medical Record (EMR) revealed that a Minimum Data Set (MDS, a standardized assessment completed for residents residing in nursing facilities) revealed that they have a Brief Interview of Mental Status score of 5, which indicates cognitive impairment. Record review of Resident 45's May 2026 Treatment Administration Record (TAR) revealed Resident 45 has received DuoNeb Solution nebulizer treatment three times a day each day of May 2026. Observation of Resident 45 on 5/17/26 at 6:15 PM revealed Resident 45 had a nebulizer set up in their room. The nebulizer mouthpiece and medication cup reservoir (cup) were laying on chair next to resident bed; pieces were fully assembled with drops of fluid visible within the cup and did not have a barrier. There is no visible labeling on the nebulizer tubing to indicate date the tubing or mouthpiece & cup were put into use. Observation of Resident 45's room on 5/18/26 at 8:30 AM revealed the nebulizer tubing was not labeled. The nebulizer mouthpiece and cup are laying on chair next to resident bed and the pieces were fully assembled with drops of fluid visible within the cup. There was no labeling on the nebulizer tubing. There was no barrier being used to place the nebulizer items on. Observation of nebulizer machine and tubing in Resident 45's room at 4:25 PM on 5/19/2026 revealed the tubing remained unlabeled. The nebulizer mouthpiece and cup were laying on a chair next to resident bed with pieces fully assembled and no barrier was in use. Observation of Resident 45's room on 5/20/26 at 7:20 AM confirmed that nebulizer mouthpiece and cup were fully assembled and laying on a chair next to Resident 45's bed and no barrier for the equipment to be placed on was in use. There was no label on tubing to indicate date that the tubing was put into use. B. An observation on 5/19/26 at 8:10 AM of medication administration to Resident 10 by Medication Aide (MA) Q revealed MA Q used hand sanitizer and donned gloves. MA Q removed the medication cards from the cart and popped the tablets one by one into their gloved hand and placed them in the medication cup. MA Q opened the carts drawers and searched for two bottled medications, touching 2 separate cart drawers and 5 bottles before they found the correct bottles. MA Q without changing or completing hand hygiene opened the bottles, removed the tablets, and placed them in the medication cup before returning the bottles to the drawer. MA Q removed the cart keys from their pocket to open the locked narcotic drawer. MA Q with the same soiled gloves removed an oxycodone tablet from the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents card and placed it in the cup. MA Q removed the narcotic sign out book and signed the medication removal, returned the book to the drawer and closed the drawer. MA Q opened and searched the bottom drawer for Resident 10's lidocaine patches, touching the other resident lidocaine boxes with their still gloved hands. MA Q removed 2 patches, removed a pair of scissors from the top drawer, opened the lidocaine patch packets, and signed and dated the patches using a pen pulled from their pocket with their still gloved hands. MA Q filled a cup with water and gathered the medications to be administered to the resident. MA Q entered Resident 10's room, still wearing the original soiled gloves donned at the start of the medication task and administered the medication to the resident. After administering the oral medication by handing the resident the medication cup and then the water cup and watching the resident take the medications, MA Q left the residents room, wearing the same gloves they had donned at the beginning of the task. MA Q removed their gloves and used hand sanitizer. An interview on 5/18/2026 at 8:10AM with MA Q confirmed wearing the gloves, touching the drawers, medication cards, medication narcotic book, pen, scissors, and keys, touching the medications, and the Residents room door created an infection control breach (a failure to act according to infection control practices) with several opportunities for cross contamination. C. An observation on 5/18/2026 at 7:47 AM revealed Resident 15 had dry crusty material on their left eye. MA R entered the residents bathroom and donned a pair of gloves. MA R did not use hand sanitizer or wash their hands before donning the gloves. MA R wet a washcloth with warm water, wrung the excess water, and then used the wash cloth to wipe the resident left eye. MA R moved to a clean portion of the wash cloth and wiped the residents right eye. MA R discarded the wash cloth and changed gloves without using hand sanitizer or washing their hands. MA R administered artificial tears to the residents eyes by holding the residents eyes open, one at a time with their left hand and placing a drop of solution into each eye without touching the eye surface. MA R wiped the residents eyes with a tissue and then replaced the lid on the bottle of artificial tears. MA R poured Resident 15's liquid medication into their mouth by their request and followed it with water. MA R poured the tablet form medications into the residents mouth, followed by water. MA R discarded the medication cups and water cup. An interview on 5/18/2026 at 7:47 AM with MA R confirmed they should have used hand sanitizer before donning gloves and should have changed gloves and used hand sanitizer after she had wiped the residents eyes and before she administered the eye drops. MA R confirmed this was a breach of infection control. D. An observation on 5/18/2026 at 7:47 AM revealed Resident 15's nebulizer mask (a medical accessory that fits over the nose and mouth to deliver aerosolized medication directly into the respiratory system) and undated tubing lying directly on the bedside table. An interview on 5/18/2026 at 7:47 AM with MA R confirmed the nebulizer mask and tubing should have been dated and stored in a plastic bag when not in use. MA R confirmed this was a breach of infection control and could be a source of cross contamination. E. Record review of Resident 4's Minimum Data Set (MDS: a federally mandated assessment used for (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care planning) dated 04-27-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with upper body dressing -required extensive assistance with bathing, lower body dressing, hygiene, and bed mobility -required total assistance with toileting and transfers. -required oxygen and a non-invasive mechanical ventilator. -had a pressure ulcer. Record review of Resident 4's Medication Administration Record revealed an order dated 12-24-2026 for Enhanced Barrier Precautions (EBP): Personal Protective Equipment (PPE) required for high resident contact care activities. Record review of the EBP sign on Resident 4's doorway revealed directions for everyone to clean their hands, including before entering and when leaving the room. Staff must also wear gloves and a gown for the following High Contact Resident Care Activities: dressing, bathing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care such as urinary catheters and feeding tubes and wound care. An observation conducted on 05-20-2026 at 9:20 AM of Registered Nurse (RN) A and the Clinical Education Specialist (CES) performing wound care for Resident 4 revealed an EBP sign on the door and PPE supplies were available in the room and both RN A and the CES performed hand hygiene and donned gloves. RN A and the CES handled Resident 4's bed linens and removed Resident 4's clothing to perform the procedure. RN A performed the wound care procedure and the CES assisted in rolling the resident and donning clothes after the procedure was finished. An interview was conducted on 05-20-2026 at 9:35 AM with the CES confirmed EBP was not used during the wound care procedure and should have been. F. Record review of Resident 4's Electronic Medical Record (EMR) under the section orders, revealed an order dated 11-26-2025 for CPAP put on at bedtime and remove in the morning for Obstructive Sleep Apnea (OSA). Further review of Resident 4's order listing revealed the lack of orders for cleaning of the CPAP mask and tubing, and tubing changes for the CPAP machine. An observation conducted on 05-18-2026 at 2:00 PM revealed Resident 4's CPAP mask was laying on the bedside table without a barrier between the mask and the surface of the table. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation conducted on 05-19-2026 at 7:55AM revealed Resident 4'ss CPAP mask was laying on the bedside table without a barrier. An interview conducted with the Director of Nursing (DON) on 05-20-2026 at 1:30 PM confirmed orders were not obtained for cleaning of the CPAP mask and machine and tubing changes until 05-19-2026 and confirmed the CPAP mask was not stored in a manner to prevent cross contamination.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(S)Based on record review and interview, the facility failed to timely notify the selected funeral home of needed services for 1 (Resident 88) of 1 sampled resident. The facility staff identified a census of 74.Findings are:Record review of facility policy entitled Resident Dignity - Rehab/Skilled revised [DATE] revealed the location would promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.Record review of Resident 88's Tracking Record (required governmental evaluation that shows when a resident has entered a facility or when a death has occurred) dated [DATE] revealed the facility admitted Resident 88 on [DATE]. Further review of the tracking record showed the resident expired on [DATE] in the facility.Record review of Resident 88's Code Status Form dated [DATE] revealed Resident 88 selected a do not resuscitate status.Record review of Resident 88's Progress Notes dated [DATE] revealed facility staff observed Resident 88 on the floor inside the bathroom. Resident 88 was unresponsive and death was confirmed by two nurses. Three staff members assisted Resident 88 off the floor and into bed by mechanical lift. Post-mortem care was performed and facility staff notified Resident 88's physician and family.Record review of funeral home notifications for Resident 88 revealed facility staff called the funeral home to assume Resident 88's care on [DATE] at 6:39 AM.An interview on [DATE] at 2:18 PM with Licensed Practical Nurse (LPN)-I revealed when a resident is declared deceased , the facility Registered Nurse (RN) should notify the resident's family, either the LPN or RN should notify the resident's physician, and either the LPN or RN should review the resident's medical record for a funeral home name and telephone number. LPN-I confirmed the funeral home should be notified as soon as post-mortem cares were completed and after a grieving period for a resident's loved-one if there was any family present or planning to come to the facility. LPN-I further confirmed they are not aware of any reason to delay calling the funeral home after being requested to do so by a resident's family.An interview on [DATE] at 4:20 PM with the Director of Nursing (DON) revealed the DON's expectation is to allow the family time to grieve if desired, notify the provider and obtain an order to release the body, and call the funeral home.A telephone interview on [DATE] at 10:07 AM with Resident 88's family member (FM) revealed the facility nurse called to notify of Resident 88's passing. The FM reported they, along with three additional family members, responded to the facility and all four left together at approximately 11:00 PM. Resident 88's FM reported when all family left the facility, the FM informed Registered Nurse (RN)-J of the funeral home name and telephone number. Resident 88's FM revealed they felt it was neither dignified nor respectful to the decedent to lie in a bed for nearly eight hours without notifying the funeral home of the need for services.		

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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 record review and interview, the facility failed to perform an abnormal involuntary movement score (AIMS, an evaluation used to look for involuntary muscle movements usually in the face, lips, tongue, hands, and feet) evaluation for the use of antipsychotic medications for 1 (Resident 3) of 5 sampled residents. The facility staff identified a census of 74.Findings are:Record review of facility policy entitled Psychotropic Medications - Rehab/skilled dated reviewed/revised 12/09/2025 revealed: - Each resident's drug regimen must be free from unnecessary drugs. Anunnecessary drug is any drug when used: - without adequate indications for its use. - When a resident is admitted on psychotropic medications or returns from hospitalization on new psychotropic medications, the following must be completed: - c. If the medication is an antipsychotic, a registered nurse must complete the Abnormal Involuntary Movement Scale. Record review of Resident 6's admission 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 09/25/2025 revealed the facility evaluated the following about Resident 6: -The facility admitted Resident 6 on 09/19/2025. -Resident 6 had diagnoses of anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it) and depression. -Resident 6 received an antipsychotic medication on a scheduled basis only. Record review of Consultant Pharmacist's Medication Regimen Review with dates of 09/22/2025, 10/30/2025, 11/30/2025, 12/31/2025, and 01/31/2026 revealed the consultant pharmacist had written admitted to the facility with an order for quetiapine. Quetiapine can cause involuntary movements. Recommend completing an AIMS now and at least every 6 months going forward. Record review of Resident 6's Electronic Health Record including progress notes, scanned documents, and evaluations revealed a lack of evidence facility staff completed an AIMS assessment prior to 02/11/2026. During an interview on 05/21/2026 at 8:07 AM, the Director of Nursing (DON) confirmed Resident 6 admitted on [DATE] and Resident 6 had orders for antipsychotic medication at the time of admission. The DON further confirmed an AIMS assessment was not completed on admission and should have been completed.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review and interview, the facility staff failed to accurately code the mood score on the 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) for 1 (Resident 1) of 5 sampled residents. The facility staff identified a census of 74.Findings are:Record review of facility policy entitled MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)- Rehab/Skilled & Therapy and Rehab dated reviewed/revised 10/27/2025 revealed lack of information regarding accuracy of MDS assessment. Further review of the facility policy directed staff to refer to the MDS Manual for topics not covered in the policy.Record Review of the Center for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.20.2 dated October 2025 revealed that the signature of all persons who completed any part of the MDS attested to the accuracy of the area they signed.Record review of Resident 1's admission Record (AR) revealed the facility admitted the resident on 01/12/2024. Further review of the AR revealed Resident 1 had a diagnosis of major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies).Record review of Resident 1's quarterly MDS dated [DATE] revealed a Patient Health Questionnaire (PHQ-2 to 9, a validated interview that screens symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder) total severity score of 16. According to the MDS manual, a total severity score of 15-19 indicated moderately severe depression.Record review of Resident 1's undated PHQ-2 to 9 evaluation with a total severity score of zero.An interview on 05/20/2026 at 2:30 PM with the Social Services Coordinator (SSC) confirmed Resident 1's undated PHQ-2 to 9 evaluation was completed on 03/10/2026 and confirmed the total severity score of zero. The SSC confirmed the evaluation was completed and not locked. The SSC reported they believed if the evaluation was not locked, it would not transfer over to the MDS correctly. The SSC confirmed the total severity score on 03/10/2026 MDS as 16. The SSC further confirmed the MDS PHQ-2 to 9 and total severity score on the MDS was coded inaccurately.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(1)Based on observation, record review and interview, the facility failed to ensure that 1 resident (Resident 95) received dining assistance in a timely manner. The facility had a census of 74. A record review of Resident 95's admission Record revealed resident was admitted to the facility on [DATE] with a diagnosis of an unstable burst fracture (an injury which could develop more damage) of T7-T8 vertebra (the 7th and 8th bone in the upper middle back).A record review of Resident 95's Brief Cognitive Assessment Tool - short form (BCAT - a clinical test used by healthcare professionals to evaluate a patient's cognitive functioning and practical judgement) result revealed Resident 95 had a score of 12 which indicated Resident 95 had severe cognitive impairment.A record review of Resident 95's Care Plan (CP - a personalized, actionable document that outlines a patient's health needs, goals and specific interventions to manage their care) revealed resident had the following diagnoses: unstable burst fracture of T7-T8 vertebra, Wedge compression fracture (a fracture where the front of the bone is crushed resulting in a wedge shape) of the third lumbar vertebra (the central bone in the lower back), spinal stenosis (the narrowing of spaces within the spine), obesity, cognitive communication deficit (difficulty with communication caused by problems in thinking processes), acute pain caused by trauma, major depressive disorder (a severe mood disorder causing persistent feelings of sadness, hopelessness and a loss of interest in activities) and a history of falling.An observation on 5/18/2026 at 1:45 PM of Resident 95's room revealed Resident 95 was in the room with the lunch tray on their bedside table. No staff were observed assisting the resident with their meal. An observation on 5/21/26 at 8:55 AM revealed the heated cart containing the residents breakfast trays was placed on the kitchen area of unit 5. Further observation on 5/21/2026 revealed Resident 95 received their breakfast tray at 10:00 AM. and had not received assistance with the meal as of 10:15 AM An observation on 5/26/2026 at 9:00 AM revealed the heated cart containing breakfast trays was being delivered to the dining area of Unit 5. NA O began to deliver trays to the residents rooms at 9:05AM. Further observations revealed Resident 95 received their breakfast tray at 9:35 AM. Licensed Practical Nurse (LPN) N entered Resident 95's room at 9:55 AM to assist Resident 95 with eating. The time between the tray arriving on the unit and the resident being fed breakfast was 55 minutes.An observation on 5/26/2026 at 1:07 PM revealed the heated cart containing lunch trays was delivered to the dining area of Unit 5. Further observations revealed Resident 95 received their meal at 1:55 PM.An interview on 5/18/2026 at 2:15 PM with (ST) P confirmed Resident 95 is supposed to have assistance with eating. An interview on 5/26/2026 at 9:55 AM with LPN N confirmed Resident 95 had been waiting almost an hour for their breakfast and that was not ideal.An interview on 5/26/2026 at 11:02 PM with the Director of Nursing (DON)confirmed that waiting 55 minutes or longer to be fed was not the facility expectation for an assisted diner.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5) and 12-006.09 Based on interview and record review the facility failed to monitor bowel movements and implement a bowel protocol for 1(Resident 2) of 1 resident sampled and failed to monitor blood glucose per physician's order for 1 (Resident 87) of 1 resident sampled. The facility census was 74. The findings are: A.Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-14-2025 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 5. According to the MDS Manual, a score of 0 to 7 indicates severe cognitive impairment. -had a diagnosis of Alzheimer's Disease. -required limited assistance with hygiene, bed mobility and transfers -required extensive assistance with toileting, bathing and dressing. Record review of Resident 2's Bowel Movement (BM) log printed on 05-19-2026 revealed the following bowel movements in the last 30 days: -05-01-2026 no charting -05-02-2026 charted no BM -05-03-2026 charted no BM -05-04-2026 charted no BM -05-05-2026 no charting -05-06-2026 charted no BM -05-07-2026 charted a small BM -05-08-2026 charted no BM -05-09-2026 charted no BM -05-10-2026 charted no BM (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05-11-2026 charted no BM -05-12-2026 charted medium BM Record review of Resident 2's Medication Administration Record (MAR) for May 2026 revealed the following orders for bowels: -Miralax (a laxative) oral powder give one scoop by mouth in the morning for constipation. -Senna (a laxative) oral tablet 8.6 milligrams (mg) two times a day for constipation. -Bowel Protocol on day 2 of no BM give prune juice, day 3 of no BM give Milk of Magnesia 30 milliliters (ml), day 4 of no BM give biscodyl suppository, day 5 of no BM give fleet enema and notify the primary care provider as needed (prn) for constipation. Further review of Resident 2's MAR for May 2026 revealed Resident 2 did not receive the prn bowel protocol medications from 05-01-2026 to 05-13-2026. Record review of Resident 2's Progress Notes (PN) dated 05-13-2026 revealed Resident 2 had an episode of diarrhea and emesis. Record review of Resident 2's Comprehensive Care Plan (CCP) printed on 05-19-2026 revealed the lack of evidence that constipation was a potential problem for Resident 2 and provided no interventions for constipation. An interview conducted with the Director of Nursing (DON) on 05-20-2026 at 1:30 PM confirmed Resident 2 had not had a BM other than a small on 05-07-2026 and confirmed the prn bowel protocol medications were not given and should have been. B. Record review of facility policy entitled Blood Glucose Monitoring, Disinfecting and Cleaning R/S, LTC dated reviewed/revised 09/30/2025 showed facility staff would document the resident's blood glucose results in the Weights and Vitals tab in PCC. Record review of Resident 87's admission Record (AR) revealed the facility admitted the resident on 04/14/2025. Record review of Resident 87's admission MDS identified the resident had a diagnosis of diabetes mellitus. Record review of Resident 87's Medication Record (MR) dated May 2025 revealed the following: -An order for Tresiba insulin scheduled for the morning medication pass dated 04/15/2025. The order had an area to document the morning blood sugar reading. -An order for blood sugar reading twice daily for the morning and evening medication passes. There was no area available to document the blood sugar reading. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Millard		STREET ADDRESS, CITY, STATE, ZIP CODE 12856 Deauville Drive Omaha, NE 68137	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 87's Blood Sugar Summary revealed there was no record of blood sugar readings for the evening on 05/02/2025, 05/03/2025, and 05/04/2025. Record review of Resident 87's Progress Notes dated 05/01/2025 through 05/07/2025 revealed no information regarding the blood sugar levels for 05/02/2025, 05/03/2025, or 05/04/2025. An interview on 05/20/2026 at 12:58 PM with the Director of Nursing (DON) confirmed a lack of documentation of the blood sugar readings for the evening of 05/02/2025, 05/03/2025, and 05/04/2025. The DON further confirmed there was no place on the MR to document the reading.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview; the facility staff failed to implement interventions to promote pressure ulcer healing for 1 (Resident 26) of 4 sampled residents. The facility census was 74. Findings are: A. Record review of Resident 26's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-28-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -had short-term and long-term memory problems. -required limited assistance with bed mobility and transfers. -required extensive assistance with toileting, bathing and upper body dressing -required total assistance with lower body dressing. -had a Traumatic Brain Injury (TBI) and hemiplegia (a medical condition that causes severe or complete paralysis on one vertical half of the body). -had limited Range of Motion (ROM) on one side of the body. -was at risk of developing a pressure ulcer. -had a stage 3 pressure ulcer Record review of Resident 26's Comprehensive Care Plan (CCP) revised on 03-19-2026 revealed Resident 26 had a potential or actual impairment to skin integrity related to localized edema and protein-calorie malnutrition. Resident 26 had a pressure ulcer to the right side of the right foot and the right heel. The goals listed was Resident 26 would not have complications related to pressure ulcers and would be free from skin injury through the review date. Interventions listed were: -monitor location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, or maceration to the health care provider. -Restorative Nursing Referral. -provide pressure relieving/reducing device and/or skin protective device. The CCP did not indicate what pressure relieving device to use, for what area of the body or for how often. Record review of Resident 26's Wound Data Collection Sheet (WDCS) dated 01-13-2026 revealed Resident 26 had a new stage 3 pressure ulcer (According to the MDS Manual a stage 3 pressure ulcer is a wound with full thickness skin loss where the dermis is completely lost), to the right foot measuring 1.13 centimeters (cm) in length by 1.6 cm in width by 0.1 cm depth. Record review of Resident 26's Treatment Administration Record (TAR) for November 2025 revealed the absence of an order for pressure relieving boots. Record review of Resident 26's TAR for December 2025 revealed the absence of an order for pressure relieving boots. Record review of Resident 26's TAR for January 2026 revealed an order dated 01-14-2026 after the stage 3 pressure ulcer was identified for Prevalon boots to bilateral lower extremities, encourage to wear at all times in bed as resident allows. Record review of Resident 26's Progress Note dated 03-04-2026 revealed Resident 26 had developed a new pressure ulcer to the right foot near toe, staged as a Deep Tissue Injury (DTI: a purple or maroon area of discolored skin due to damage of underlying soft tissue) measuring 0.81 cm in length by 1.31cm in width by 0.2 cm in depth. Record review of Resident 26's Electronic Medical Record (EMR) under Tasks was a listing for Prevalon boot to right and left foot as resident allows revealed from 04-27-2026 to 05-26-2026 revealed no documentation of the use of Prevalon boots. Observation of Resident 26 in bed on 5/26/2026 at 8:15 AM revealed that resident is in bed. It was noted that resident was not wearing the Prevalon protective boots at time of observation. These boots were discovered in Resident 26's wheelchair. Interview with DON on 5/26/26 at 1:20 PM confirmed the facility had not initiated pressure relieving boots until after Resident 26 had developed a stage 3 pressure ulcer to the right foot.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(v). Based on record review and interview the facility failed to implement an ambulation program as recommended by therapy and per resident wishes for 1 (Resident 42) of 2 sampled residents. The facility census was 74. The findings are: A.Record review of Resident 42's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-11-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored as a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with toileting, transfers and lower body dressing. -required extensive assistance with bathing and bed mobility. Record review of Resident 42's Physical Therapy Discharge Summary (PTDS) dated 03-20-2026 revealed the Physical Therapist (PT) recommended a restorative ambulation program for Resident 42 to ambulate with a 4 wheeled walker, follow with wheelchair and Contact Guard Assist (CGA: a level of physical assistance where staff maintains constant, light physical contact with the patient usually with a gait belt to provide security and prevent falls) and a restorative Range of Motion (ROM) program for bilateral lower extremities. An interview conducted on 05-26-2026 at 1:15 PM with Resident 42 revealed when (gender) moved from the 500 hallway to the 100 hallway all exercise programs stopped and did not remember being offered a restorative program or refusing to participate in one. An interview conducted on 05-26-2026 at 1:55 PM with the Restorative Aid (RA) E confirmed a restorative program had not been provided for Resident 42 because RA E was not informed of the recommendation for restorative services.An interview conducted on 05-26-2026 at 2:00 PM with Physical Therapy Assistant (PTA) H revealed no knowledge of a restorative program for Resident 42 and would contact the PT that worked with Resident 42 to obtain information.As of 05-26-2026 at 6:00 PM the facility staff did not provide any further information regarding a restorative program for Resident 42.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, interview and record review the facility failed to ensure Continuous Positive Airway Pressure (CPAP: a machine that delivers a steady stream of pressurized air through a mask to keep the throat open when asleep) orders were obtained and followed for 1 (Resident 4) of 1 resident sampled. The facility census was 74. The findings are: A. Record review of Resident 4's Minimum Data Set (MDS: a federally mandated assessment used for care planning) dated 04-27-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with upper body dressing-required extensive assistance with bathing, lower body dressing, hygiene, and bed mobility-required total assistance with toileting and transfers. -required oxygen and a non-invasive mechanical ventilator. Record review of Resident 4's Electronic Medical Record (EMR) under the section orders, revealed an order dated 11-26-2025 for CPAP put on at bedtime and remove in the morning for Obstructive Sleep Apnea (OSA). Further review of the Resident 4's order listing revealed the absence of settings for the CPAP machine. An observation conducted on 05-19-2026 at 7:55AM revealed a Res Med Air Sense 10 auto set CPAP machine on Resident 4's bedside table. An interview conducted with the Director of Nursing (DON) on 05-20-2026 at 1:30 PM confirmed orders for CPAP machine settings were not obtained until 05-19-2026 and should have been obtained when ordered.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and interview, the facility failed to perform follow up on the consultant pharmacist's monthly recommendations for 2 (Resident 3 and Resident 62) of 5 sampled residents. Facility staff identified a census of 74. Findings are: Record review of facility policy entitled Medication: Drug Regimen Review & R/S, LTC dated reviewed/revised 12/01/2025 revealed drug irregularities would be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. A. Record review of Resident 6's admission 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 09/25/2025 revealed the facility evaluated the following about Resident 6: -The facility admitted Resident 6 on 09/19/2025. -Resident 6 had diagnoses of anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it) and depression. -Resident 6 received an antipsychotic medication on a scheduled basis only. Record review of Consultant Pharmacist's Medication Regimen Reviews identified the following: -On 09/22/2025, a recommendation was made to complete an Abnormal Involuntary Movement Scale (AIMS) assessment related to the use of antipsychotic medications, and to request a duration of therapy for an alprazolam (antianxiety medication) order. -On 10/30/2025, a recommendation was made to complete an AIMS assessment, to complete the antipsychotic medication assessment to ensure all documentation was in order, and to request a duration of therapy for alprazolam. -On 11/30/2025, a recommendation was made to complete an AIMS assessment and to complete the antipsychotic medication assessment to ensure all documentation was in order, and to request a duration of therapy for alprazolam. -On 12/31/2025, a recommendation was made to complete an AIMS assessment and to complete the antipsychotic medication assessment to ensure all documentation was in order, and to request a duration of therapy for alprazolam. -On 01/31/2026, a recommendation was made to complete an AIMS assessment and to complete the antipsychotic medication assessment to ensure all documentation was in order, and to request a duration of therapy for alprazolam. -On 02/28/2026, a recommendation was made to obtain a diagnosis for a prednisone (steroid) medication to support the continued use of the medication -On 03/31/2026, a recommendation was written to request a diagnosis for the continued use of (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prednisone. -On 04/29/2026, a recommendation was written to request a diagnosis for the continued use of prednisone. Record review of Resident 6's Electronic Health Record (EHR) including scanned documents and progress notes revealed lack of evidence the pharmacy recommendation follow ups were completed. During an interview on 05/26/2026 at 9:39 AM, the Director of Nursing (DON) confirmed the pharmacy recommendations detailed above were not followed up on and should have been. B.Record review of Resident 62's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required supervision with eating and transfers. -required limited assistance with hygiene, toileting, bathing and dressing. -was taking an antipsychotic medication. Record review of Resident 62's Consultant Pharmacist's Medication Regimen Reviews identified the following: -On 09-22-2025, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 10-30-2025, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 11-30-2025, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 12-31-2025, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 01-31-2026, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 02-28-2026, a recommendation was made to complete an AIMS assessment related to the use of an antipsychotic medication and an order for daily target behavior monitoring. -On 03-31-2026, a recommendation was made to complete an AIMS assessment related to the use of (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an antipsychotic medication and an order for daily target behavior monitoring. An interview conducted with the DON on 05-21-2026 at 9:50 AM confirmed the pharmacy recommendations detailed above were not followed up on and should have been.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Licensure Reference Number 175 NAC 12-006.12(D)(i)Based on observation and interview, the facility failed to ensure that medication were secured for 1 (Resident 10) during medication administration. The facility had a census of 74. An observation on 5/19/2026 at 8:10AM of medication administration by Medication Aide (MA) Q to Resident 10 revealed the following: MA Q had prepared the medications for administration to Resident 10 and locked the medication cart. MA Q had left the medication cards, which still contained medications, on the top of the cart. MA Q walked down the hall away from the cart with the prepared medications and had reached Resident 10's door before they looked back to the cart and saw the medication cards unsecured on the cart. MA Q returned to the medication cart, unlocked the cart, and secured the medication cards before continuing on to Resident 10's room to administer their medication. The medications left on the cart were as follows:Finasteride tablet 5mg, Amlodipine Besylate. 10mg tablet, Sertraline HCL 50mg tablet, Carvedilol. 6.25mg and Sevelamer Carbonate 800mg tablet. An interview on 5/19/2026 at 8:10AM with MA Q confirmed they had left the medications on top of the cart, and they should have secured the medication cards in the cart before they walked away to administer the resident medication.		