STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05(H)Based on interview and record review; the facility failed to ensure residents were protected from residents with adverse behaviors for 2 (Residents 5 and 10) of 11 sampled residents. The facility census was 52.Findings are: A. Review of the facility policy Abuse, Neglect, or Misappropriation of Property with a reviewed date of 7/15/25 revealed the policy was a mechanism for the prompt identification, investigation and reporting of any allegation or complaint of abuse, neglect, or exploitation. If a staff member witnessed or suspected resident to abuse resident, neglect or any type of crime, the staff were to immediately intervene and take steps to protect the resident. Staff were to keep residents and other staff away from any abusive/aggressive residents. The policy indicated allegations of potential abuse were to be immediately reported to a supervisor, the facility Administrator or designee and in accordance with the state and federal laws. If there was reasonable suspicion of a crime or if serious bodily injury occurred then the report was to be made immediately but no later than 2 hours. Staff were to investigate the incident, implement and document necessary precautions/interventions to prevent further occurrence. The responsible parties and the Primary Care Physicians (PCP) of all residents involved were to be notified and the findings were to be documented. A completed report was to be sent to the State Agency within the required timeframe. B. Review of the facility policy Romantic Relationships and Consent Policy with a revised date of 7/13/25 revealed the purpose of the policy was to support the residents' rights to dignity, privacy, intimacy, companionship, and self-determination while ensuring protection from abuse, coercion, exploitation, or non-consensual contact. The policy was to establish standards for evaluating consent capacity related to romantic or intimate relationships within the facility. Residents with a Brief Interview for Mental Status (BIMS- a standardized cognitive assessment used primarily in skilled nursing facilities and long-term care. It measures a patient's attention, orientation, and ability to recall information. Scores range from 0 to 15, with higher scores indicating better cognitive function) score of 13 or above were considered cognitively intact and capable of informed consent. Residents with a score of less than 13 may have impaired decision making capacity related to intimate relationships and were to receive additional evaluation. The facility was to consider/determine the following:-ability to identify the other individual.-ability to communicate yes, no or a refusal.-understand the nature of the relationship.-awareness of potential risks or consequences.-presence or absence of distress, fear, resistance, or coercion.-consistency of preferences over time.-ability to withdraw consent. C. Review of Resident 5's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/12/26 revealed the resident was admitted [DATE] with diagnoses of prostate cancer, anemia, heart failure, diabetes, depression, schizophrenia, and insomnia. The resident was assessed as cognitively intact and was identified as taking an antipsychotic (a class of prescription psychiatric medications primarily used to manage psychosis, including symptoms delusions, hallucinations, and disordered thinking), an antidepressant and an antianxiety medication. Review of Resident 5's undated care plan revealed the resident had entered into a consensual (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	relationship with another resident in the facility and the resident's Power of Attorney (POA) was aware of the relationship. The following interventions were identified:-to leave the room door open when visited by other residents.-staff to provide safe environment for the residents to visit.-allow the residents time to interact if doing so safely, redirect when needed.-may express self sexually with partner in a private setting.-Ombudsman (impartial, independent official designated to investigate, report on, and help settle complaints. Act as a neutral liaison to mediate disputes, ensure fairness, and protect individuals from unfair treatment, administrative abuse, or policy violations) aware. Review of Resident 5's Progress Notes revealed the following:-9/20/25 at 1:09 AM wandered in the corridor and wanted to know, who are these people. Spoke sternly to another resident telling the resident to get out of here, get going, you get out of here. Opened the closed door of another resident's room and watched as the staff provided toileting cares to a female resident. The resident was very loud for over an hour until family came to visit and then calmed down. -10/12/25 at 11:20 PM very loud and called out is anyone there over and over until neighboring residents told Resident 5 to shut up.-10/27/25 at 7:24 PM hollering and cursing. Distressed when staff were assisting other residents and not immediately helping Resident 5.-11/5/25 at 5:42 PM screaming in the corridor.-11/5/25 at 11:52 PM more confused and did not accept redirection unless being provided exclusive 1:1 attention from the staff.-11/15/25 at 12:10 AM stood in the resident's room naked with the urinary catheter (thin, flexible tube inserted into the bladder to drain and collect urine) lying on the floor.-11/22/25 at 8:11 PM tipped over the recliner in the resident's room.-11/29/25 at 5:05 PM exhibited aggressive behaviors and yelled in the corridor.-12/14/25 at 5:12 PM very needy and wanted the staff to sit and visit with the resident for long periods of time about Resident 10 who Resident 5 was looking for to have a companionship with.-12/16/25 at 10:45 PM very distraught and angry, slammed the walker into the floor. Paced the corridor and then threw the walker over. -12/21/25 at 10:47 PM repetitive and obsessive.-12/25/25 at 12:08 PM paced for most of the morning, yelling and screaming.-1/10/26 at 3:45 PM agitated and restless, yelling/screaming continuously.-1/14/26 at 2:40 AM very loud and using vulgar language. Paced the corridor screaming and slammed the walker down repeatedly with more than moderate force.-1/27/26 at 5:54 PM increasingly obsessive towards Resident 10 and yelling at the staff when Resident 10 was out of sight.-1/27/26 at 6:51 PM staff informed Resident 5 that Resident 10 was not interested in a companionship and was not interested in Resident 5. -1/29/26 at 9:30 PM Resident 10 had been in Resident 5's room visiting and left to go to bed. Resident 5 became very upset and went out into the corridor and yelled for Resident 10.-1/30/26 at 1:10 PM returned from lunch and was looking for Resident 10. The resident became very agitated and slammed the walker on the floor calling out for Resident 10 who was visiting with family. Review of a Physician Communication Facsimile (fax) dated 1/30/26 at 1:30 PM revealed the physician was notified of the resident's behaviors concerning Resident 10. A new order was received for Haldol (antipsychotic medication used to manage symptoms of severe psychiatric and neurological conditions) 0.5 milligrams (mg) every 12 hours as needed, for 14 days for severe agitation, and to increase Seroquel (medication used to treat delusions and hallucinations with schizophrenia or bipolar disorders) to 25 mg twice a day. Review of Resident 5's Progress Notes revealed the following:-2/1/26 at 7:20 PM paced in the corridor, yelling and swearing, looking for Resident 10. -2/2/26 at 6:30 PM agitated and paced in the corridor looking for Resident 10. Review of an appointment at [NAME] Behavioral Health for Resident 5 on 2/12/26 at 9:30 AM revealed the staff had reported the resident was frequently anxious with obsessive thoughts and behaviors. In addition, the staff had reported the resident was obsessed with Resident 10 to the point the resident was afraid of Resident 5. Resident 5 would yell at Resident 10 and was angry when unable to find. If Resident 5 could not see Resident 10, would scream and would become very agitated. New orders were received to continue Ativan (medication used to treat anxiety), 0.5 mg as needed, to increased Seroquel to 50 mg twice a day, to continue Lexapro (medications used to treat depression) 20 mg daily, Buspar (medication used to treat depression) 10 mg twice a day and to start (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Licensure Reference Number NAC 12-006.09Based on observations, interviews and record reviews; the facility failed to implement interventions to manage behaviors for 1 (Resident 1) of 11 sampled residents. The facility census was 52. Findings are:A. Review of the facility policy Behavior Management Program, last revised 7/13/25 revealed residents who displayed mental or psychosocial adjustment difficulty would receive appropriate services in an attempt to correct the problem. The guidelines included:-behaviors would be identified through the RAI (Resident Assessment Instruction Manual- a standardized comprehensive guide to evaluate resident's clinical, functional, and cognitive status) process and through staff interaction;-further assessments to identify and manage behaviors may be conducted;-identified behaviors should be evaluated through frequency, duration and intensity for a pattern;-the Interdisciplinary Team would decide which residents needed a behavior management program vs residents that were care planned with appropriate interventions by evaluating the behavior monitoring; and-the plan of care would be reviewed at least quarterly for continued need for behavior management and appropriate interventions. B. Review of Resident 1's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 4/9/26 revealed the resident had long and short-term memory problems, had severe cognitive deficit which included not being ablet to recall the current season, staff names/faces, and that the resident resided in a nursing home; exhibited rejection of care, wandering, and physical and verbal behaviors; required substantial assistance with toileting, dressing and hygiene; had Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety, Depression, and Psychotic Disorder for Diagnoses; and received antipsychotic, antianxiety, and antidepressant medications. C. Review of Resident 1's Care Plan last revised 3/27/26 revealed the following:-the resident required assistance from staff for bed mobility, dressing, oral hygiene, personal hygiene, and toileting;-the resident had impaired cognitive function and confusion;-the resident had behaviors of constant worry, repeatedly voicing concerns, crying, restlessness, pacing, attention seeking, verbal statements of nervousness, looking for their parents, and being scared; and-interventions for behaviors included: monitoring of medication side effects; assisting with arranging community activities; required 1:1 bedside activities; alter the cause of anxiety if able; alter the resident's environment during anxiety by taking on a walk or take to an activity; listen to the resident to resolve why the resident was upset; reassurance; and encourage activities of resident's choice to keep the resident occupied. D. Review of the Facility Investigation Report dated 11/24/25 revealed Resident 1 had an altercation with Resident 2. Resident 2 used their arms to create a boundary for their personal space and Resident 1 invaded Resident 2's personal space. Resident 2 made physical contact with Resident 1 resulting in a superficial break in the skin. The residents were separated and the intervention for Resident 1 was that staff would engage the resident in an activity when Resident 1 began to consistently enter the other resident's personal spaces. There was no evidence of documentation that this intervention was included in Resident 1's Care Plan. E. The following observations were made regarding Resident 1:-5/26/26 at 9:30 AM the resident was in the main sitting room sitting in a recliner attempting to talk to another resident who had their eyes closed. Resident 1 was sitting on the edge of the seat leaning close to talk to the other resident. There were no activities besides the tv (on a cooking show) at this time;-5/26/26 at 9:40 AM the resident was ambulated from the recliner to their Room by Nursing Assistant (NA)-C and Medication Aide (MA)-B. At 9:45 AM the NA and MA ambulated the resident back to sit in the recliner and resume watching tv;-5/26/26 at 10:15 AM the resident was watching a cooking show on the tv. No other activities were observed;-5/26/26 at 11:15 AM the resident was observed ambulating independently out of Resident 2's room when this surveyor entered the Unit. Resident 2 was observed sitting in a recliner in their room. Resident 1 continued to ambulate independently into the next 2 rooms (no residents in them) before Resident 1 sat in a recliner in the main sitting room. Staff were (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisting other residents and there was no resident engagement activity going on at the time;-5/26/26 at 2:15 PM the resident was observed ambulating around the Unit independently. The resident sat down by this surveyor for approximately 4 minutes and talked non-stop and was talking in a jumble of words and phrases. The resident then got up and ambulated towards MA-B who was going through the cupboards near the nurses station. MA-B assisted the resident over to the recliners in the main siting area near the tv and assisted the resident to sit down then MA-B resumed going through the cupboards. MA-B did not offer the resident any independent activities. The resident sat there for approximately 3 minutes before they got up and started rummaging through the cupboards near the tv. There was no resident engagement activity at that time;-5/27/26 at 7:25 AM the resident was dressed in their pajamas and was observed wandering in and out of other resident rooms (no residents in them at the time. The resident was going down the hallway and in and out of each room on one side. Staff were assisting other residents at that time;-5/27/26 at 9:30 AM the resident was resting in a recliner in the sitting room in front of the tv with eyes closed and chin resting on their chest. The staff were sitting at a table and there was no activity at that time. F. The following interviews were conducted with staff:-5/26/26 at 9:25 with MA-B revealed the behavior management interventions were to keep the residents separated. MA-B revealed that the staff in the Unit do not provide activities because no one would participate;-5/26/26 at 10:30 AM interview with NA-C revealed behavior management interventions for Resident 1 were to offer snacks and toileting. Further interview revealed Activities Staff did 1:1 with residents a couple of times per week but the Unit staff did not provide activities;-5/26/26 at 2:30 PM interview with MA's G and F revealed the interventions for behavior management were to separate the residents and provide a calmer setting, offer snacks and toileting;-5/27/26 at 7:30 AM with MA-J and NA-K revealed the intervention for behavior management was to keep the residents separated. Further interview confirmed Activity Staff did 1:1 with residents a few times a week but the Unit staff does not provide activities;-5/27/26 at 7:50 AM with the staff-L revealed that Resident 1 would refuse to leave the Unit to participate in activities most of the time and it depends on the residents mood and how the day has been for the resident whether they attempted to get Resident 1 to go to the activity room;-on 5/27/26 at 11:45 AM interview with the Social Services Director and the Director of Nursing revealed the resident was mobile and wandered so it was hard to do any activities with Resident 1 for a long period of time. G. Interview on 5/27/26 at 11:55 AM with Registered Nurse-N confirmed the intervention on 11/24/25 for staff to engage Resident 1 with an activity when the resident was consistently entering others personal spaces was not included on Resident 1's Care Plan. Further interview confirmed that was no new intervention implemented for the resident to resident incident between Resident 1 and Resident 2 on 11/24/25.