STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285106	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lakeview	1405 West Hwy 34 Grand Island, NE 68801

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on record review and interview the facility failed to ensure that the resident choice for Cardiopulmonary Resuscitation (CPR) (a lifesaving attempt combination of rescue breathing and chest compressions when someone's heart has stopped) matched the physician signed advanced directive for 2 of 24 residents reviewed (Residents 47 and 71). This had the potential for the facility to not follow the resident preference for CPR in the event of cardiac arrest. The facility census was 74. The facility Administrator was notified on [DATE] at 5:15PM of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by surveyor onsite verification. Findings are: A.Record review of the facility policy titled Advance Directive Policy and Procedure dated 1/2024 revealed that it is the policy of the facility to establish, implement, and maintain written policies and procedures for advanced directive. The resident has the right, and the facility will assist, the resident to formulate an advance directive at their option. The facility will educate and inform the resident of their rights and formulate an advance directive. Resident choices will be incorporated into treatment, care, and services. All advance directive document copies will be obtained and located in the resident chart. Resident wishes will be communicated to the staff and the resident's physician. During quarterly resident assessment process and with any significant changes of condition, the facility staff will identify, clarify, and review the existing care instructions and whether the resident wishes to change or continue instructions from the advance directive. The section titled Cardiopulmonary Resuscitation (CPR) revealed that the facility will provide basic life support, including CPR, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to the physician order and resident choice indicated in the resident's advanced directives. Nurses and other care staff are educated to initiate CPR unless the resident has a valid Do Not Resuscitate Order in place. Record review of the admission Record dated [DATE] for Resident 47 revealed that Resident 47 admitted into the facility on [DATE]. Diagnoses included Cardiac Arrhythmia (an abnormal heart rhythm where the heart beats too fast, too slow, or has an irregular pattern causing risk of cardiac arrest or stroke) and Intracranial Hemorrhage (a critical, life-threatening medical emergency involving bleeding inside the skull, which can rapidly destroy brain cells by causing pressure and oxygen deprivation). Record review of the progress note for Resident 47 dated [DATE] at 2:02 AM revealed that at approximately 1:35 AM the nurse aide informed the nurse that Resident 47 was less responsive. The nurse assessed Resident 47. Resident 47 was lethargic and unable to be aroused. Breathing was shallow with periods of apnea (temporary stoppage of breathing) lasting approximately 15 seconds. Use of accessory muscles (extra muscles recruited to aid in breathing in addition to the typical muscles used for breathing when the normal muscles are not working sufficiently for breathing) was noted with breathing. The on-call provider ordered that Resident 47 be sent to the emergency room. Resident 47 was transported to the hospital emergency room by emergency services. Record review of the progress note for Resident 47 dated [DATE] at 11:10 AM revealed that the hospital provided the update that Resident 47 was still admitted with a diagnosis of hypoxia (low levels of oxygen in the (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	body tissues that can be life-threatening).Record review of the progress note for Resident 47 dated [DATE] at 1:00 PM revealed that Resident 47 returned to the facility. Record review of the Advance Directive Code (Resuscitate) Status form dated [DATE] for Resident 47 revealed the choice of Full Code- I understand that if my heart stops beating or is inadequate, or that if I stop breathing or my breathing is inadequate, all resuscitation procedures will be initiated. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR. The form was signed by the medical provider on [DATE]. Record review of the Care Plan Report dated [DATE] for Resident 47 revealed that the resident has the following Advanced Directive: Full Code (CPR).Record review of the Advance Directive section of the admission Record dated [DATE] for Resident 47 revealed Do Not Resuscitate (DNR) (A type of advance directive in which health care providers should not perform cardiopulmonary resuscitation (restarting the heart) if his or her heart or breathing stops), Do Not Intubate (DNI) (a medical directive instructing healthcare providers not to insert a breathing tube). (This contradicts the current choice of Resident 47 to have CPR).Record review of the electronic medical record for Resident 47 revealed that the resident care profile page dated [DATE] showed a code status of DNR, DNI for Resident 47. (This contradicts the current choice of Resident 47 to have CPR).Interview on [DATE] at 1:57 PM with Licensed Practical Nurse-G (LPN-G) confirmed that for a resident in cardiac arrest, LPN-G would determine the resident code status from the resident care profile page in the electronic health record. LPN-G would have someone call 911 and call the doctor for a resident that was a full code. LPN-G revealed that the facility has an Automated External Defibrillator (AED) (a portable, life-saving medical device used to treat sudden cardiac arrest by analyzing the heart's rhythm) on each hall. LPN-G revealed that the crash cart (a wheeled container carrying medicine and equipment for use in resuscitation efforts) is by the fax machine. Interview on [DATE] at 2:16 PM with Registered Nurse-C (RN-C) confirmed that RN-C would check the resident code status on the resident care profile page for a resident in cardiac or respiratory arrest. Interview on [DATE] at 2:30 PM with the facility Social Services Director (SSD) revealed that on admission the SSD reviews the Advance Directive Code Status form with the resident and family and records their choice for CPR or DNR on the form. The SSD revealed that the SSD faxes the form to the doctor for signature and puts the form in the mailbox for the Director of Nursing (DON). The SSD revealed that the DON ensures that the form is received back signed from the doctor and then ensures that the resident choice for CPR or DNR is entered into the electronic medical record for the resident. Interview on [DATE] at 2:52 PM with Licensed Practical Nurse-H (LPN-H) revealed that LPN-H has worked in the facility over the past 3 months. LPN-H confirmed that the facility did not provide any orientation related to resident code status. LPN-H confirmed that LPN-H would determine the resident code status from the resident care profile page in the electronic health record. Interview on [DATE] at 3:07 PM with the facility Director of Nursing (DON) revealed that the facility considers the newly admitted resident as a full code until the Advance Directive Code Status form is received back from the physician with the signature. The DON revealed that when the Advance Directive Code Status form is returned to the facility the resident care plan is updated, the resident care profile is updated, and the order for the resident code status is put into the resident medical record. The DON revealed that the Advance Directive Code Status form is then scanned into the resident electronic medical record. The DON revealed that the resident code status is reviewed at care plan meetings and if the resident wants to change their choice, a new form is completed and sent to the physician for signature. The DON confirmed that the resident care profile for Resident 47 showed Resident 47 was a DNR. The DON confirmed that the Advance Directive Code Status form signed by the physician noted Resident 47 as a full code. The DON confirmed that the resident code status of DNR on the resident care profile was not correct and did not match the resident choice for CPR to be performed in the event of cardiac arrest. B.Record review of the admission Record dated [DATE] for Resident 71 revealed that Resident 71 admitted into the facility on [DATE]. Diagnoses included End Stage Renal Disease (the final, permanent stage of chronic kidney disease (CKD) where kidney function drops to (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	less than 15% of normal, necessitating dialysis or a transplant for survival. At this stage, kidneys fail to filter waste, toxins, and fluids from the blood effectively, leading to critical health complications throughout the body); Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs that prevents airflow to the lungs causing breathing problems); and Chronic Diastolic Heart Failure (stiffness of the left heart muscle causing low blood flow).Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated [DATE] for Resident 71 revealed that Resident 71 receives dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to).Record review of the American Heart Associaton study titled Risk Assessment for Sudden Cardiac Death in Dialysis Patients dated [DATE] revealed that sudden cardiac death is the single most common form of death in dialysis patients.Record review of the progress note for Resident 71 dated [DATE] at 2:06 PM revealed that Resident 71 was hospitalized for fistula (a surgically created connection between an artery and a vein, usually in the arm, which provides durable, high-flow access for dialysis) revision. Record review of the progress note for Resident 71 dated [DATE] at 2:20 PM revealed that Resident 71 returned to the facility from the hospital and signed a full code status. Fax was sent to the doctor and waiting for response. Record review of the Advance Directive Code (Resuscitate) Status form dated [DATE] for Resident 47 revealed the choice of Full Code- I understand that if my heart stops beating or is inadequate, or that if I stop breathing or my breathing is inadequate, all resuscitation procedures will be initiated. This process can include chest compressions, intubation, and defibrillation and is referred to as CPR. The form was signed by the medical provider.Record review of the Care Plan Report dated [DATE] for Resident 71 revealed that Resident 71 has the Advanced Directive DNR/DNI. (This contradicts the current choice of Resident 71 to have CPR).Record review of the Advance Directive section of the admission Record dated [DATE] for Resident 71 revealed DNR/DNI (Do Not Resuscitate, Do Not Intubate). (This contradicts the current choice of Resident 71 to have CPR).Record review of the electronic medical record for Resident 71 revealed that the resident care profile page showed a code status of DNR/DNI for Resident 71. (This contradicts the current choice of Resident 71 to have CPR).Interview on [DATE] at 1:57 PM with Licensed Practical Nurse-G (LPN-G) confirmed that for a resident in cardiac arrest, LPN-G would determine the resident code status from the resident care profile page in the electronic health record. LPN-G would have someone call 911 and call the doctor for a resident that was a full code. LPN-G revealed that the facility has an Automated External Defibrillator (AED) (a portable, life-saving medical device used to treat sudden cardiac arrest by analyzing the heart's rhythm) on each hall. LPN-G revealed that the crash cart (a wheeled container carrying medicine and equipment for use in resuscitation efforts) is by the fax machine. Interview on [DATE] at 2:16 PM with Registered Nurse-C (RN-C) confirmed that RN-C would check the resident code status on the resident care profile page for a resident in cardiac or respiratory arrest. RN-C revealed that RN-C could also check the paper report sheet for the code status of Resident 71. RN confirmed that the paper report sheet documented the code status of Resident 71 as DNR. Interview on [DATE] at 2:30 PM with the facility Social Services Director (SSD) revealed that on admission the SSD reviews the Advance Directive Code Status form with the resident and family and records their choice for CPR or DNR on the form. The SSD revealed that the SSD faxes the form to the doctor for signature and puts the form in the mailbox for the Director of Nursing (DON). The SSD revealed that the DON ensures that the form is received back signed from the doctor and then ensures that the resident choice for CPR or DNR is entered into the electronic medical record for the resident. Interview on [DATE] at 2:52 PM with Licensed Practical Nurse-H (LPN-H) revealed that LPN-H has worked in the facility over the past 3 months. LPN-H confirmed that the facility did not provide any orientation related to resident code status. LPN-H confirmed that LPN-H would determine the resident code status from the resident care profile page in the electronic health record.Interview on [DATE] at 3:07 PM with the facility Director of Nursing (DON) revealed that the facility considers the newly admitted resident as a full code until (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the Advance Directive Code Status form is received back from the physician with the signature. The DON revealed that when the Advance Directive Code Status form is returned to the facility the resident care plan is updated, the resident care profile is updated, and the order for the resident code status is put into the resident medical record. The DON revealed that the Advance Directive Code Status form is then scanned into the resident electronic medical record. The DON revealed that the resident code status is reviewed at care plan meetings and if the resident wants to change their choice, a new form is completed and sent to the physician for signature. The DON confirmed that the resident care profile for Resident 71 showed Resident 71 was a DNR. The DON confirmed that the Advance Directive Code Status form signed by the physician noted Resident 71 as a full code. The DON confirmed that the resident code status of DNR on the resident care profile was not correct and did not match the resident choice for CPR to be performed in the event of cardiac arrest. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.The facility Abatement Plan statement dated [DATE] was provided to this surveyor on [DATE] at 5:19 PM. The Abatement Plan revealed that the facility took immediate corrective action and the code status for Resident 47 and Resident 71 was reviewed and corrected. Preventive measures implemented to prevent recurrence of similar issues included an enhanced review process, staff training, new process, and periodic audits. The enhanced review process revealed that the DON or responsible party will review current resident signed code status with the physician orders. The staff training revealed that the DON or responsible party will educate all licensed nursing staff and nurse managers on code statuses. Training will include accuracy of the resident care profile related to the signed code status . If residents choose to change code status, Social Services will be notified to redo the form and notify the DON/ADON (Assistant Director of Nursing) to update the order in the electronic medical record. Nurses in the facility were educated immediately. All remaining facility nurses will be educated upon arrival of next scheduled shift. The new process revealed that Social Services will ensure code status will be completed on new admissions and reviewed for all readmissions and at quarterly care plans for accuracy. Social Services will be notified of any requested change in code status orders to ensure the form is updated with the provider's signature, care plan, and resident care profile. Hospital orders and discharge paperwork related to code status does not apply to the facility. Social Services will obtain all code status updates for new admissions, readmissions, or code status changes when requested by the resident or resident representative. The periodic audits revealed that the DON or designee will audit code statuses against the orders, care plan, and the saved signed document once a week for 4 weeks, then monthly thereafter for 3 months to ensure sustained compliance. Results will be taken to the Quality Assurance Process Improvement monthly for review.At the time of exit, the severity of the deficiency was lowered to the D level.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1)Based on record review and interview the facility failed to ensure that nurse aides and medication aides completed at least 12 hours of continuing education annually as required for 5 of 5 sampled staff. The facility census was 74.Findings are:A.Record review of the facility policy titled Required Training, Certification and Continuing Education of Nurse Aides dated 1/2024 revealed that it is the policy of the facility to comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing education of its nurse aides. The facility will provide at least 12 hours of in-service training annually based on the employment date and not on the calendar year. Documentation of in-services will be forwarded to the Human Resources Director and maintained in the employee's personnel file. In-service training will be provided by qualified personnel and will be based on the needs of the residents in the facility. Minimum training will include: Effective communication; Dementia management and care of the cognitively impaired; Abuse, neglect, and exploitation prevention; Elements and goals of the facility's Quality Assurance Process Improvement program; Resident rights and responsibilities; Written standards, policies, and procedures for the facility's infection prevention and control program, Requirements under the facility's compliance and ethics program; Safety and emergency procedures; and Behavioral health. Record review of the untitled and undated list of facility employees revealed that Medication Aide-I (MA-I) had a hire date of 9/11/08.Record review of the facility provided training documents for the last full year based on hire date (9/11/24-9/11/25) for MA-I revealed that the documents contained no amount of time allotted for the education. (No amount of hours of education completed could be calculated).Interview on 1/29/26 at 2:10 PM with the facility Director of Nursing (DON) confirmed that facility nurse aides and medication aides are required to complete a minimum of 12 hours of continuing education annually based on the staff member's hire date. The DON confirmed that the facility had no documentation that MA-I completed 12 hours of education as required. B.Record review of the untitled and undated list of facility employees revealed that Medication Aide-J (MA-J) had a hire date of 11/21/21.Record review of the facility provided training documents for the last full year based on hire date (11/21/24-11/21/25) for MA-J revealed that the documents contained no amount of time allotted for the education. (No amount of hours of education completed could be calculated).Interview on 1/29/26 at 2:10 PM with the DON confirmed that facility nurse aides and medication aides are required to complete a minimum of 12 hours of continuing education annually based on the staff member's hire date. The DON confirmed that the facility had no documentation that MA-J completed 12 hours of education as required. C.Record review of the untitled and undated list of facility employees revealed that Medication Aide-K (MA-K) had a hire date of 4/29/23.The facility had no documented training for MA-K for the last full year based on hire date (4/29/24-4/29/25). (MA-K did not complete 12 hours of education as required).Interview on 1/29/26 at 2:10 PM with the DON confirmed that facility nurse aides and medication aides are required to complete a minimum of 12 hours of continuing education annually based on the staff member's hire date. The DON confirmed that the facility had no documentation of any continuing education for MA-K for the last full year. The DON confirmed that MA-K had not completed 12 hours of education as required. D.Record review of the untitled and undated list of facility employees revealed that Medication Aide-L (MA-L) had a hire date of 11/12/23.Record review of the facility provided training documents for the last full year based on hire date (11/12/24-11/12/25) for MA-L revealed that the documents contained no amount of time allotted for the education. (No amount of hours of education completed could be calculated).Interview on 1/29/26 at 2:10 PM with the DON confirmed that facility nurse aides and medication aides are required to complete a minimum of 12 hours of continuing education annually based on the staff member's hire date. The DON confirmed that the facility had no documentation that MA-L completed (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	12 hours of education as required. E.Record review of the untitled and undated list of facility employees revealed that Medication Aide-M (MA-M) had a hire date of 1/15/24.Record review of the facility provided training documents for the last full year based on hire date (1/15/24-1/15/25) for MA-M revealed that the documents contained no amount of time allotted for the education. (No amount of hours of education completed could be calculated).Interview on 1/29/26 at 2:10 PM with the DON confirmed that facility nurse aides and medication aides are required to complete a minimum of 12 hours of continuing education annually based on the staff member's hire date. The DON confirmed that the facility had no documentation that MA-M completed 12 hours of education as required.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)Licensure Reference Number 175 NAC 12-006.19(B) Based on record review, observation, and interview the facility failed to maintain a sanitary, orderly, and comfortable interior and exterior for 16 of 74 residents (Resident 1, 5, 7, 9, 10, 13, 19, 21, 24, 32, 36, 48, 58, 71, 75, and 85.) Facility census was 74. Findings are: Record review of the facility's undated admission Agreement included a copy of Federal-Resident Rights, upon which the resident and/or resident representative signs and dates in agreement that the facility will provide the following:Safe Environment: The resident has the right to a safe, clean, comfortable, and homelike environment, including ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A.An observation with the Facility Administrator (FA), Maintenance Supervisor (MS), and the Housekeeping Supervisor (HS) on 01/29/26 at 10:30 AM in the room of Resident 1 and Resident 48 confirmed the bathroom toilet paper holder was broken and the bathroom threshold was soiled with a dark buildup. B.An observation with FA, MS, and HS on 01/29/26 at 10:30 AM in the bathroom of Resident 32, Resident 13 and Resident 24 confirmed the toilet contained dark soiling around the base, the threshold of the bathroom to room revealed dark soiling buildup, and the ventilation revealed a grey fuzzy buildup. C.An observation with FA, MS, and HS on 01/29/26 at 10:40 AM in the dining room for 100 hall contained an outside door to the courtyard revealing cobwebs, yard waste, trash, and bird poop. HS revealed they do not clean outdoors until the warmer weather, leaving the buildup until such time. D.An observation with FA, MS, and HS on 01/29/26 at 10:45 AM in the room of Resident 9 and Resident 58 confirmed cobwebs outside of the room (in the hallway) covering the call light, and a soiling buildup on the threshold at the rooms entrance. E.An observation with FA, MS, and HS on 01/29/26 at 10:50 AM in the room of Resident 19 and Resident 10 confirmed a loose baseboard heater vent cover, bathroom threshold buildup of dark soiling, flooring pulled loose between the toilet and wall and worn toilet seat creating an uncleanable surface. F.An observation with FA, MS, and HS on 01/29/26 at 10:50 AM in the main dining room between 200 and 300 hall at the service counter facing the main kitchen revealed a sink covered with a tray and taped up with blue masking tape. MS confirmed the sink was not in operation. MS further revealed the tape was to prevent others from using the sink. FA confirmed that the way the sink was constructed to avoid being used was not appealing. G.An observation with FA, MS, and HS on 01/29/26 at 10:55 AM in the 300 hallway confirmed the overhead light was not lit. MS pushed the light fixture, opened the cover and revealed the ballast (an electrical device that regulates voltage for lamps) needed to be replaced.An undocumented (date and timed) interview with Registered Nurse (RN)-B revealed the 300-hall overhead light has been out for a month or more and makes it difficult to see necessary items while working. H.An observation with FA, MS, and HS on 01/29/26 at 11:00 AM in the room of Resident 36 and Resident 75 confirmed the base heater cover was loose, partially hanging off the unit and was soiled; further confirmed the molding/strip outside of the bathroom was peeling off the walls. I.An observation with FA, MS, and HS on 01/29/26 at 11:00 AM in the room of Resident 21 and Resident 71 confirmed missing tile on the bedroom flooring and a buildup of black scratches all around the edges of the room between 1.5 to 3 feet in height. J.An observation with FA, MS, and HS on 01/29/26 at 11:00 AM in the room of Resident 5 confirmed the toilet is not sealed to the floor, sitting on spacers/risers, visible under the toilet between missing tiles and the base of the toilet, and a buildup of black scratches all around the edges of the room between 1.5 to 3 feet in height. K.An observation with FA, MS, and HS on 01/29/26 at 11:05 AM in the room of Resident 7 revealed missing paint from the door exposing other layers of colored paint. L.An observation with FA, MS, and HS on 01/29/26 at (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:05 AM in the 400-hall revealed an area where a wheelchair scale and an outside door remains revealed a base heater falling off of the wall and peeling wallpaper. Additionally, between the Business Office and entrance to rooms [ROOM NUMBERS] reveal a 10 inch diameter round loose chrome floor covering. M.An observation with FA, MS, and HS on 01/29/26 at 11:10 AM in the bathhouse on 500 hall, and confirmed by FA, that the floor was stained; that cleaning was needed of the grout, the metal heater unit and tiles (due to build up) through out the shower stalls. N.An observation with FA, MS, and HS on 01/29/26 at 11:05 AM in the unoccupied room of 508 and confirmed by FA , that the bathroom ventilation was not operational and ceiling tiles with water stains need replaced. O.An observation with FA, MS, and HS on 01/29/26 at 11:15 AM in the front of the building, FA confirmed the pest box needs a replacement due to weathering, soiling and a build up of debris.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-007.04(D) Based on observation and interviews the facility failed to ensure the ventilation system was in working order in 12 resident bathrooms (rooms 501,502,503, 504, 505, 506, 508, 510, 511, 512, 513, 514) of 24 sampled resident rooms. Findings are:A. An observation with the Facility Administrator (FA), Maintenance Supervisor (MS), and the Housekeeping Supervisor (HS) on 1/29/26 at 11:15 AM a walk through of 500-hall room [ROOM NUMBER] bathroom ventilation system was not pulling when a 1-ply tissue was pressed upon the ventilation system, confirming the vent was non-operational. FA and MS confirmed the ventilation was not working, and that there is no window in the bathroom. During an interview on 1/29/26 at 11:20 AM the MS reveals that no one checks the ventilation system and this is not part of the maintenance program. During an interview on 1/29/26 at 11:20 AM the MS was unaware that ventilation system was not working and that no one alerted (gender) the ventilation system was not working. During an interview on 1/29/26 at 11:20 AM the FA revealed being unaware the ventilation system was not working. An interview with the FA on 1/29/26 at 11:28 AM did not deny the ventilation in rooms 501,502,503, 504, 505, 506, 508, 510, 511, 512, 513, and 514 were not operational. During an interview on 1/29/26 at 3:00 PM the Regional Director of Operation (RDO) revealed the facility did not have a policy on ventilation monitoring.

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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 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, observation, and interview the facility failed to ensure resident dignity by not storing incontinent products out of public sight and for not ensuring residents' body parts were covered for 2 residents (Resident 2 and Resident 5) of 2 sampled residents. The facility census was 74.Findings are:Record review of a facility policy titled Facility Responsibilities dated 01/2024 revealed the residents have a right to a dignified existence, the facility must treat each resident with respect, dignity, and care for each resident in a manner and environment that promotes or enhances their quality of life.A.A record review of an admission Record revealed the facility admitted Resident 2 on 1/02/2026 with a diagnosis of a stroke, (which is the blockage of blood circulation to one or more areas of the brain) affecting the left side of the resident's body.The 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 1/08/2026 revealed Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15, which indicated the resident was cognitively intact. The MDS revealed documentation that the resident was dependent on staff assistance for toilet use and personal hygiene, was always incontinent of bowel and did not have a toileting program.An observation completed on 1/26/2026 at 2:06 PM revealed on top of the dresser, sitting at the foot of Resident 2's bed was a blue and white opened package of incontinence products. The door to the resident's room was open and this was visible while walking down the hallway.An observation completed on 1/27/2026 at 9:35 AM revealed on top of the dresser, sitting at the foot of Resident 2's bed was a blue and white opened package of incontinent products. The door to the resident's room was open and this was visible while walking down the hallway.An observation completed on 1/27/2026 at 3:16 PM revealed on top of the dresser, sitting at the foot of Resident 2's bed was a blue and white opened package of incontinent products. The door to the resident's room was open and this was visible while walking down the hallway.An observation completed on 1/28/2026 at 11:10 AM revealed on top of the dresser, sitting at the foot of Resident 2's bed was a blue and white opened package of incontinence products. The door to the resident's room was open and this was visible while walking down the hallway.An observation completed on 1/28/2026 at 1:40 PM revealed on top of the dresser, sitting at the foot of Resident 2's bed was a blue and white opened package of incontinent products. The door to the resident's room was open and this was visible while walking down the hallway.In an interview conducted on 01/28/2026 at 2:20 PM with Registered Nurse C (RN-C), RN-C confirmed that resident incontinence products should be stored out of sight of the public.B.A record review of an admission Record revealed the facility admitted Resident 5 on 5/10/2019 with a diagnosis of type 2 diabetes, 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 mild cognitive impairment a condition causing noticeable memory or thinking problems that exceed normal aging. The Quarterly MDS dated [DATE] revealed Resident 5 had a BIMS score of 15, indicating the resident was cognitively intact and was dependent on staff assistance for toilet use and personal hygiene and was occasionally incontinent of bowel with no bowel toileting program.An observation completed on 1/26/2026 at 11:30 AM it was observed that Resident 5 was sitting in their wheelchair in front of their open room door. Visible between the back of the wheelchair and the seat of the wheelchair was the resident buttock and incontinence product. Also visible at the foot of the resident's bed sitting on top of the foot of the bed was a white and blue plastic package of incontinence products. In an observation completed on 1/27/2026 at 9:00 AM it was observed that Resident 5 was sitting in their wheelchair in front of their open room door. Visible (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between the back of the wheelchair and the seat of the wheelchair was the resident buttock and incontinence product. The resident was observed to be wearing a hospital gown with a T-shirt underneath it. The hospital gown was observed to have dried fluid spills to the front of it going down the mid chest area. At the foot of the resident's bed ,on top of the residents edema wear, was a white and blue plastic package of incontinence products. In an observation completed on 1/27/2026 at 3:17 PM it was observed that Resident 5 was sitting in their wheelchair in front of their open room door. Visible between the back of the wheelchair and the seat of the wheelchair was the resident buttock and incontinence product. The resident was observed to be wearing a hospital gown with a T-shirt underneath it. At the foot of the resident's bed, on top of the residents edema wear, was a white and blue plastic package of incontinence products. In an interview completed on 1/27/2026 at 3:18 PM with Resident 5, Resident 5 stated that they wear the hospital gown over their T-Shirt for their comfort. The resident stated that they would like their hospital gown to be changed at least daily but sometimes the facility does not have any so they will wear the same one till one comes available to change into. The resident confirmed there was a spill stain to the front of their gown and stated they had spilled their milk at breakfast.In an observation completed on 1/28/2026 at 4:30 PM it was observed that Resident 5 was sitting in their wheelchair in front of their open room door. Visible between the back of the wheelchair and the seat of the wheelchair was the resident buttock and incontinence product. The resident was observed to be wearing a hospital gown with a T-shirt underneath it. The hospital gown was observed to have additional orange dried fluid spills to the front the gown. At the foot of the resident's bed, on top of the resident's edema wear, was a white and blue plastic package of incontinent products. In an observation completed on 1/29/2026 at 9:40 AM it was observed that Resident 5 was sitting in their wheelchair in front of their open room door. Visible between the back of the wheelchair and the seat of the wheelchair was the resident buttock and incontinence product. The resident was observed to be wearing a hospital gown with a T-shirt underneath it. The hospital gown was observed to have clear and orange dried fluid spills and brown dried food particles to the front the gown.In an interview completed on 1/29/2026 at 9:55 AM with Medication Aide A (MA-A), MA-A stated that resident's clothing should be changed daily or when it is visibly soiled. The MA confirmed that Resident 5 preferred to wear a hospital gown when in their room for comfort and this should be changed at the same frequency as it was part of the residents' clothing. The MA stated they were not aware of any shortage of gowns for the residents hindering the frequency of changing the residents' gown. The MA confirmed that residents' incontinent products should be stored in a drawer or closet out of sight of the public. The MA confirmed that the resident's shirt should be pulled down in the back covering their incontinent product and body part and was not.In an interview completed on 1/29/2026 at 1:16 PM with the facility Assistant Director of Nursing (ADON), the ADON confirmed that resident incontinence products were to be stored out of sight, residents clothing should be changed daily and when soiled, and resident incontinence products and or body parts should not be visible by the public.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.17(E)(ii)Based on record review and interview, the facility failed to notify the local state ombudsman of resident transfers in and out of the facility for 1 resident (Resident 75), and failed to provide the resident or their responsible party written information regarding bed hold at the time of transfer for 1 resident (Resident 75). The facility census was 74.Findings are:Review of an admission Record revealed the facility admitted Resident 74 on 01/13/2022 with diagnosis of cerebral palsy, which is a group of permanent movement, muscle tone, or posture disorder caused by abnormal brain development or damage, and functional quadriplegia, which is a medical condition defined by complete immobility due to severe physical frailty or advanced cognitive impairment without underlying brain or spinal cord injury. Review of Resident 47's Census record revealed the resident was transferred out of the hospital on paid hospital leave on 08/09/2025, 11/05/2025, and 11/15/2025. A.Record review of a facility supplied document titled Nursing Facility Transfer or Discharge and dated 04/04/2024 revealed the facility would send a copy of the notice of transfer or discharge to the state ombudsman.In an interview completed on 01/27/2026 at 4:32 PM with the facility Business Office Manager (BOM), the BOM confirmed that they were the individual responsible for compiling information of residents that transferred into and out of the facility. The BOM stated that they were behind on sending/communicating this information to the state ombudsman as outlined in regulations. The BOM confirmed that the facility was not in compliance with the regulations of notification of the state ombudsman of resident transfers into and from the facility.B.Review of a facility policy titled Bed Hold Prior to Transfer and dated 01/2024 revealed prior to transferring a resident to the hospital the facility will provide written information to the resident and or the resident representative regarding bed hold.Review of Resident 47's Progress Notes revealed documentation that the resident was transferred from the facility to the hospital on [DATE]. The documentation revealed no evidence that the resident or their responsible party were notified regarding bed hold at the time of the transfer.Review of Resident 47's Progress Notes revealed documentation that the resident was transferred from the facility to the hospital on [DATE]. The documentation revealed no evidence that the resident or their responsible party were notified regarding bed hold at the time of the transfer.Review of Resident 47's Progress Notes revealed documentation that the resident was transferred from the facility to the hospital on [DATE]. The documentation revealed no evidence that the resident or their responsible party were notified regarding bed hold at the time of the transfer.Review of a facility supplied document titled with the facility name and dated 08/09/2025 revealed documentation that Resident 47 was transferred to the hospital. The document stated that each resident or legal representative would be informed by the facility staff of the facility's bed hold policy upon admission and when the resident leaves the facility for hospitalization and to contact the facility for more information and to review the attached bed hold policy document. The document was signed by the BOM only.Review of a facility supplied document titled Nursing Facility Transfer or Discharge Notice and Resident 47 name and not dated revealed that Resident 7 was transferred on 11/15/2025 to the hospital. The reason for the transfer or discharge was documented as necessary for the residents' welfare and needs could not be met in the facility.In an interview completed on 01/27/2026 at 4:32 PM with the facility BOM, the BOM stated that they complete the resident bed hold paperwork when they are in the office and notified of the transfer. The BOM stated they call the resident' responsible party and mail the bed hold notification to them. The BOM stated this is not completed at the time the resident is transferred consistently. If the BOM is not present at the time of the transfer, the nursing staff would be responsible for completion of the bed hold paperwork and the notification and this should be documented in the resident's health record. The BOM confirmed that Resident 47 was transferred out of the hospital on [DATE], 11/05/2025, and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/15/2025 and there was no documentation in the resident's medical health record that they or their responsible party were notified of the facilities bed hold policy at the time of the transfer.In an interview completed on 01/27/2026 at 4:45 PM with the facility Director of Nursing (DON), the DON confirmed that there was no documentation that Resident 47 or their responsible party were notified at the time of the resident being transferred from the facility of the facility's bed hold policy.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Licensure Reference Number 175 NAC 12-006.09(H)(i)(2)Based on observation, interview, and record review the facility failed to provide treatment and services to maintain or restore a resident's level of functional ability for 1 (Resident 2) of 1 sampled resident. The facility census was 74.Findings are:Record review of a facility policy titled Activities of Daily Living (ADL's) and dated 1/2024 revealed the facility will ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome.A record review of an admission Record revealed the facility admitted Resident 2 on 1/02/2026 with a diagnosis of a stroke, which is the blockage of blood circulation to one or more areas of the brain, affecting the left side of the resident's body.The 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 1/08/2026 revealed Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14, indicating the resident was cognitively intact. The MDS revealed documentation that the resident was dependent on staff assistance for transfers and toileting assistance and required substantial or maximum assistance for bed mobility.In an interview completed on 01/26/2026 at 2:04 PM with Resident 2, Resident 2 stated they were admitted to the facility for rehabilitation services after hospitalization. The resident stated that they plan to receive therapy and then return to their home. The resident confirmed that they have only had therapy services a couple of times since admitting to the facility at the beginning of the month and feels like they are losing strength since admission to the facility and not getting better. The resident voiced that at one of their therapy sessions, they had verbal outburst with the therapist and were told therapy would not work further with the resident until they (the resident) could improve their behavior. The resident stated again their desire to get better and return to their home and felt like they were just left in their bed to rot.Record review of a facility supplied document titled Continuum of Care Transfer Report and dated 01/02/2026 revealed under Instructions after discharge that Physical therapy was to evaluate and treat the resident with their rehabilitation potential being good, occupational therapy to evaluate and treat with their rehabilitation potential of being good, speech therapy to evaluate and treat with their rehabilitation potential of good. Also a physical therapy note dated 12/31/2025 revealed the resident needed stand by assistance with bed mobility from lying flat to a sitting position, minimal assistance for bed mobility from a sitting position to a lying position, transfer assistance from a sitting to a standing position of contact guard or stand by assistance, and that the resident walked 120 feet one time and 60 feet one time with the therapist.In an interview completed on 01/27/2026 at 9:45 AM with Nurse Aide D (NA-D), the nurse aide stated that Resident 2 was not receiving therapy or restorative services that they were aware of. NA-D stated that the resident was dependent on staff assistance with all activities of daily living and had difficulty standing with 2 staff assistance to pivot and transfer out of their bed. The CNA stated that the resident only gets out of bed to bathe and does not walk.In an interview completed on 01/28/2026 at 1:17 PM with the facility Director of Rehab (DOR), the DOR stated that the resident was evaluated by physical, occupational, and speech therapy after admission to the facility. The DOR stated that the resident was rude and demeaning to the physical therapist at evaluation and told the therapist to get out of their room. The therapist returned a time later and the resident again became verbal with the therapist. The therapist made the determination, due to the residents behavior and refusal to cooperate with the evaluation, physical therapy would not see the resident on therapy services. The DOR stated that occupational therapy was able to complete an evaluation with the resident and worked with the resident a few times. The DOR stated that the resident would wish to do things that the therapist could not comply with (leave room and was on isolation precautions so could not leave (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the room) and would get upset and have verbal behavior towards the therapist when their request was not met. The DOR stated that due to this, the resident was discharged from occupational therapy services. The DOR stated that the resident continued to work with speech therapy at this time. The DOR stated that when a resident is discharged from therapy services it is the regular practice to set up the resident with a restorative or exercises program to maintain level of functioning for the resident. The DOR stated that when Resident 2 was discharged from physical and occupational therapy services a restorative or exercise program was not completed for Resident 2 and should have been to maintain level of function and prevent decline.In an interview completed on 01/28/2026 at 2:11 PM with the facility Director of Nursing (DON), the DON confirmed that the resident was not receiving physical or occupational therapy services to maintain or improve their level of functioning. The DON stated that physical and occupational therapy services were discontinued due to the residents' behaviors towards therapists. The DON confirmed that it was the normal practice of the facility to implement a restorative or exercise program for residents discharged from therapy services and this was not done for Resident 2. The DON confirmed that no program or intervention was in place to prevent decline or maintain level of function for Resident 2.

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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. Licensure Reference Number 175 NAC 12-006.09Based on record review and interview the facility failed to thoroughly assess a resident after a possible/probable accident/incident and failed to notify a resident's provider after a possible/probable incident/accident that could result in deterioration of health and need to alter treatment for 1 (Resident 83) of 1 sampled resident, and the facility failed to follow practitioner orders of providing medications as prescribed for 1 (Resident 89) of 1 sampled resident. The facility census was 74. Findings are:A. Record review of a facility policy titled Notification of Changes and dated 01/2024 revealed it is the policy of the facility that changes in a residents' condition or treatment are immediately reported to the physician. Requirements for notification were defined as a significant change including deterioration in health and a need to alter treatment due to adverse consequences. Record review of an admission Record revealed the facility admitted Resident 83 on 06/21/2023 with diagnosis of dementia a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior). Record review of Resident 83's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/09/2025 revealed the resident required supervision or touching assistance with the activity of daily living of eating. The MDS did not reveal the resident had a condition or chronic disease that may result in a life expectancy of less than 6 months. Record review of Resident 83's Progress Notes revealed documentation that on 12/27/2025 at 12:22 PM the resident had a choking episode during breakfast meal and appeared to be putting too much food in their mouth during the meal. The documentation stated that a trial of soft foods would be trialed. The note revealed no documentation of an assessment of the residents' condition after the choking episode. No notification of the resident's provider of the choking episode or the need/change of the resident's diet. Record review of Resident 83's Progress Notes revealed documentation on 12/27/2025 at 3:10 PM that the resident's responsible party was notified that the resident was having increased difficulty with swallowing and breathing. Documentation stated that the resident was declining supplemental oxygen use and wanting to go and be evaluated at the emergency room. The responsible party agreed to the residents' wishes. The note revealed no documentation of an assessment of the resident's condition being performed. Record review of Resident 83's Progress Notes revealed documentation on 12/27/2025 at 5:03 PM that the resident was found to not have a blood pressure or pulse. Record review of Resident 83's Vital Signs documentation revealed no documentation of the residents' vital signs on the date of 12/27/2025. In an interview completed on 01/27/2026 at 1:59 PM with Licensed Practical Nurse N (LPN-N), LPN-N confirmed that a resident having a choking incident during a meal would signify a change in condition and the resident would need a full assessment including vital signs and lung sounds documented in (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's progress notes and the resident's provider should be notified. In an interview completed on 01/27/2026 at 2:05 PM with Registered Nurse O (RN-O) confirmed that a resident having a choking incident during a meal would signify a change in condition and the resident would need a full assessment including vital signs and lung sounds documented in the resident's progress notes and the resident's provider should be notified. In an interview completed on 01/27/2026 at 2:20 PM with the facility Director of Nursing (DON), the DON confirmed that there was no documentation in Resident 83's medical health record that they were fully assessed after the choking episode on 12/27/2025 and that the resident's provider was not notified of the incident, and the resident was later found deceased . The DON confirmed that an assessment of the resident's condition, including vital signs and a minimum of lung sounds, should have been completed after the choking episode and the resident's provider should have been notified and were not. B. Record review of an admission Record for Resident 89 revealed an admission date of 1/21/2026 with a diagnosis of congestive heart failure (condition where the heart cannot pump enough blood), fluid overload (excessive accumulation of fluids in the body, causing swelling), chronic obstructive pulmonary disease (copd; inflammatory lung disease), and type 2 diabetes (a condition where the body doesn't produce enough insulin or doesn't use insulin properly). Record review of Resident 89's Order Summary Report revealed the following orders: -insulin lispro injectable 100/milliliter (ml) inject 'subcutaneous (sq) per sliding scale before meals and at bedtime with parameters set at: if blood glucose less than 150= 4 units; 150-199=6 units; 200-249=8 units; 250- 299=10 units; 300-349=12 units; 350-400=14 units; greater than 400=call clinic (max 42 units/day) for type 2 diabetes mellitus with other circulatory complications; order date: 1/21/2026 -Tresiba flex injectable 100 unit, inject 7 units subcutaneously daily for type 2 diabetes mellitus with other circulatory complications; order date: 1/21/2026 Record review of Resident 89's Progress Notes revealed documentation that on 1/22/2026 at 4:02 PM Tresiba flex injectable medication was not administered. Record review of Resident 89's Progress Notes revealed documentation that on 1/24/2026 at 8:45 AM insulin lispro injectable medication was not administered. Record review of Resident 89's Medication Administration Report (MAR; a document used to track the scheduled and administered medications) for January 2026 reveals insulin lispro injectable was not provided to Resident 89 on 1/22/2026 before all three meals and at bedtime, on 1/23/2026 before all three meals and at bedtime, and on 1/24/2026 before breakfast at 7:00 AM. Additional record reviews revealed Tresiba flex injectable was not administered to Resident 89 on 1/22/2026. In an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 1/28/2026 at 10:45 AM, DON confirmed Resident 89 did not have medications insulin lispro or Tresiba flex injectable. The DON further revealed reasons for not having the medication available was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because of a prior authorization needed as well as needing parameters. The DON confirmed the physician was not aware that Resident 89 had not received insulin lispro or Tresiba and that the physician should have been notified.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Licensure Reference Number 175 NAC 12-006.08(B)(i)Based on record review and interview the facility failed to ensure that the physician performed the resident initial 30 day visit as required for 1 of 3 residents reviewed (Resident 47). The facility census was 74.Findings are: Record review of the facility policy titled Physician Services dated 1/2026 revealed that the medical care of each resident is under the supervision of a licensed physician. The physician will visit the resident at appropriate intervals. Physician visits are provided in accordance with current regulations and facility policy. The resident must be seen at least once every 30 days for the first 90 days after admission. Record review of federal regulation statute 483.30(c) Table 1 revealed that the Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist may not perform the initial Comprehensive Visit (required 30 day visit) in place of the physician. Record review of the admission Record dated 1/26/26 for Resident 47 revealed that Resident 47 admitted into the facility on 8/15/25. The admission Record revealed that care providers for Resident 47 included the physician, a physician assistant, and a nurse practitioner.Record review of the Attending Provider notes dated 10/9/25 for Resident 47 revealed that Resident 47 was seen on 10/9/25 for the 30 day follow-up. The attending provider was the physician assistant. Interview on 1/29/26 at 2:10 PM with the DON confirmed that the initial 30 day visit after admission is to be completed by the physician. The DON confirmed that the initial visit for Resident 47 was completed by the Physician Assistant and not by the physician as required.

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	285106	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Lakeview	1405 West Hwy 34 Grand Island, NE 68801

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18(B)Based on observation, interview, and record review, the facility failed to ensure staff donned (put on) and doffed (took off) the required PPE (personal protective equipment) during cares for a resident that requires staff to wear PPE for EBP (enhanced barrier precautions), to prevent the potential spread of microorganisms. This affected 1 resident (Resident 4) of 1 sampled resident. The facility failed to clean glucometers per manufacturer recommendations after use affecting 1 resident Resident 76 of 2 sampled residents, and failed to change disposable medical care equipment as ordered for 1 resident Resident 2 of 1 sampled residents. The facility census was 74. Findings are: A. Record review of a document titled Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings dated 2007 from the Centers from Disease Control revealed IV.E.1. the facility is to establish policies and procedures for containing, transporting, and handling patient-care equipment and instruments/devices that may be contaminated with blood or body fluids. Record review of a document titled Evencare ProView blood glucose monitoring system users guide page 6. dated 2018 revealed when using this system always follow the recognized procedures for handling objects that are potentially contaminated with human material. In an observation completed on 1/28/2026 at 11:45 AM Registered Nurse B (RN-B) used a glucometer to obtain resident 76 blood sugar using a drop of blood. The nurse then returned to the medication cart placed the disposable items in the trash can and the test strip from the glucometer with blood visibly on it into the sharps container on the side of the medication cart. The Nurse then placed the glucometer into the top drawer of the medication cart in a divided off space in the drawer. In an interview completed on 1/28/2026 at 11:50 AM with RN-B, RN-B stated that glucometers are not shared between residents and each resident utilized an individual machine and their machine is stored in the medication cart in the residents designated slot separate from the other residents' items. The RN stated that the glucometer is only cleaned when visibly soiled. In an interview completed on 1/28/2026 at 12:15 PM with Registered Nurse C (RN-C) RN-C stated that the glucometer is to be cleaned after each use. The RN confirmed that each resident had used their own glucometer and glucometers were not shared between residents. In an interview completed on 1/28/2026 at 2:10 PM with the facility Director of Nursing (DON), the DON stated they were not aware of a cleaning policy or procedure for the glucometers when they were not shared with other residents. Reviewed with the DON RN-B and RN-C stated cleaning and non-cleaning practices. DON confirmed that nurses were not doing the same thing and should be. In an interview completed on 1/28/2026 at 2:10 PM with the facility Clinical Nurse Consultant (CNC), the CNC confirmed that the facility did not have a policy for glucometer cleaning when the glucometers were not shared between residents. B. Record review of a facility policy titled Care and Treatment of Feeding Tubes dated 01/2024 revealed to use infection control precautions and related techniques to minimize the risk of contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's physician orders revealed an order stating for night shift to provide a new cup for flushing and piston syringe every night shift and to write date and initials on each item. Review of Resident 2's electronic medication administration record for the Month of January 2026 revealed documentation that this order had been completed each night of the month. In an observation completed on 1/28/2026 at 12:35 PM of medication administration via gastric tube, which is a tube that is surgically placed in a resident's digestive system and used for nutrition, hydration, and medication administration. RN-B prepared medications for Resident 2 using liquid forms of medication pored into clear graduated medication cups. The Nurse administered each medication separately into the resident's gastric tube using gravity and a piston syringe. The nurse then flushed the syringe and the gastric tube with clear water and placed the piston syringe back on a towel placed on an over bed table. It was observed that in black marker written on the piston syringe was the date 1/25/26 and initials. In an interview completed on 1/28/2026 at 12:40 PM with RN-B, RN-B confirmed that the piston syringe is to be changed every night on night shift and per the date written on the syringe it had not been changed as ordered. In an interview completed on 1/28/2026 at 1:15 PM with the facility Director of Nursing (DON), the DON confirmed that the piston syringe is to be changed every night by night shift. The DON confirmed that with the date written on the syringe it had not been changed since 1/25/2026 and was ordered to be changed nightly. C. Record review of Resident 4's admission Record dated 1/27/2026 revealed Resident 4's admission date on 10/06/2025. Also listed on the record are diagnosis, revealing: -pressure ulcer of right buttock, stage 2 (partial-thickness skin loss, appearing as a shallow, open pink/red ulcer or an intact/ruptured blister, affecting the epidermis and dermis layers) -morbid obesity -pressure ulcer of unspecified site, stage 3 (a serious, full-thickness wound extending through the skin to reveal subcutaneous fat, appearing as a deep crater) -cellulitis of left lower limb (bacterial skin infection affecting the skin's deeper layers and underlying tissue, often causing rapid-spreading redness, swelling, warmth, and pain) -lymphedema (chronic condition characterized by swelling, caused by a buildup of protein- fluid due to a damaged or obstructed lymphatic system) Record review of Resident 4's Order Summary Report dated 1/27/2026 reveal a practitioner's order to irrigate a foley catheter (a flexible, indwelling tube inserted through the urethra into the bladder to drain urine) every 30 days and as needed. A record review of the facility's Infection Prevention and Control Program dated 1/2017 with a revision date of 1/2024 reveal it is a policy of this facility to establish and maintain an infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Registered Nurses (RN) and Licensed Practical Nurses (LPN) supervise direct care staff in daily activities to assure appropriate precautions and techniques are observed, assess the resident's isolation needs, initiate appropriate precautions in accordance with our established policies and current CDC Infection Control Isolation Guidelines. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO; bacteria or other microorganisms that have developed resistance to at least one or more classes of antimicrobial agents, rendering standard treatments ineffective) that employs targeted gown and glove use during high contact resident care activities' are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. An observation on 1/26/2026 at 9:40 AM a door sign is posted on the door of Resident 4's room stating: Stop, contact precautions; everyone must: -clean their hands, including before entering and when leaving the room. Providers and staff must also: -wear gloves and a gown for the following high-contact resident care activities. -dressing -bathing/showering -transferring -changing linens -providing hygiene -changing briefs or assisting with toileting -device care or use: central lines, urinary catheter, feeding tube, tracheostomy -wound care: any skin opening requiring a dressing Do not wear the same gown and gloves for the care of more than one person. An observation on 01/27/2026 at 2:50 PM Resident 4 is assisted with daily cares and transferred from the bed to the wheelchair. Prior to transfer assisting Resident 4, Nurse Aide (NA)-Q and Medication Aide (MA)-R were not observed washing hands, rather donning gloves, no other PPE were used. Staff member MA-R prepared by cutting several briefs to place on areas of the body that are (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeping, as directed by Resident 4. MA-R grabbed a white canister and placed it on the resident's left side. The canister was opened and the resident lifted their leg with use of a gait belt and MA-R began putting cream on the underside of the left leg which had the appearance of raised red round open areas with shiny moist in appearance about 3-5 centimeter (cm) clusters in diameter from creases of the thigh area to the buttock area. MA-R took off one glove and replaced it with another since the glove was covered in white cream. The resident was then assisted to put on an edema sleeve over the left leg from the ankle to the mid-thigh area. The resident was then assisted to turn to the right side of the body, MA-R then put additional cream on the left hip area, which was also covered in raised red round open areas with shiny moist in appearance about 3-5 centimeter (cm) clusters in diameter; then placing a cut brief over the clusters. MA-R was then observed sliding a sling under the resident's body and assisted the resident in turning on the left side. NA-Q then pulled the sling and brief out from under the resident to cover the resident's backside. The resident was then placed on their back; and the sling was pulled up from between the legs of the resident. Licensed Practical Nurse (LPN)-N, was observed coming into the room donning gloves only with a Hoyer lift (a mechanical, portable, or fixed device designed to safely transfer individuals with limited mobility between beds, wheelchairs, or toilets, reducing caregiver strain). NA-Q maneuvered an electric wheelchair and placed into the room while the lift was situated over Resident 4 and secured to the lift. The resident was lifted from the bed and placed into the wheelchair. LPN-N took the lift out of the room and placed it in the hallway. The lift was not sanitized after use. Both MA-R and NA-Q were observed to use hand sanitizer after leaving Resident 4's room. An interview on 1/27/2026 at 3:45 PM with MA-R and NA-Q revealed not knowing that a gown is necessary. An interview on 1/27/2026 at 3:45 PM with LPN-N revealed not thinking it was necessary unless doing catheter cares. An interview with the Assistant Director of Nursing (ADON) on 1/27/2026 at 3:55 PM revealed staff need to wear a gown and gloves when completing transfers and cares for Resident 4.