STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285108	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of O'Neill	1102 North Harrison Street O' Neill, NE 68763

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview; the facility failed to report the potential neglect of Resident 12 (not receiving laboratory work as ordered and IV (Intravenous-administered through an intravenous (placed in a vein) catheter (fluids or medications)) to the State Agency as required. The sample size was 12 and the facility census was 45. Findings are: Review of the facility policy Vulnerable Adult dated 10/19/22 revealed the facility supported zero tolerance for resident abuse, neglect, mistreatment, and/or misappropriation of resident property. The facility reported maltreatment of vulnerable adults in compliance of requirements included suspected abuse. The process included identification, recognition, and reporting. The facility description of neglect was the facility failure to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Reports were made to Department of Health and Human Services (DHHS)/Adult Protective Services (APS) by the facility Administrator or Director or Nursing (DON). Review of Resident 12's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 4/23/25 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Clinically Complex medical conditions, and Renal (kidney) Insufficiency. Review of Resident 12's Care Plan initiated on 12/26/25 revealed the resident had severe chronic kidney disease (stage 4-severe), and chronic lung disease. A revision on 12/31/25 indicated the resident did not want to be resuscitated. The resident had cognitive impairment and the resident's family chose long term placement in the nursing facility. Review of Resident 12's Progress Notes revealed the following:-On 1/14/26 at 6:03 PM the facility received an order to stop Lasix (diuretic) and Potassium Chloride (supplement used to replace potassium often depleted by the use of diuretics) and the check a BMP (Basic Metabolic Profile-standard laboratory (lab) test to check things including kidney function, fluid balance, and blood glucose levels) in 2 days.-On 1/16/26 at 12:49 PM the resident returned from a urology (medical specialty that treats disorders of the genitourinary (involving the reproduction and urinary systems) appointment. There was no evidence ordered lab for the BMP was completed at the facility or the urology clinic. -On 1/21/26 at 9:04 AM the facility noted that after a follow up appointment the facility identified the BMP had not been obtained on 1/16/26 as ordered by urology. In addition, the resident had not received 1 liter of LR (lactated ringers- IV solution used to replace lost fluids and essential electrolytes) also ordered on 1/14/26 and scheduled to be given on 1/15/26 at a 10:00 AM appointment.-On 1/21/26 at 11:03 PM the BMP laboratory findings were reviewed by the physician with a critical high Creatinine of 6.1 thus the resident was transferred to the emergency room (ER). Review of the facility reports to the State Agency from 6/1/25 through 6/1/26 revealed no evidence of a report containing information about Resident 12's not having received ordered labs or IV fluids in January 2026. During a phone interview on 6/3/26 at 2:24 PM the facility Administrator confirmed that after the missed orders and labs for resident 12 were identified, the facility investigated and determined an agency staff member had not processed physician's orders according to facility protocol thus the facility implemented forms for Agency Staff orientation that included multiple areas (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to ensure facility processes were being followed. This included a check list and multiple forms for review with the most notable being the facility process to triple note new orders with the nurse receiving the order and then with the oncoming nurse for the next shift. A review was then conducted by the facility Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop careplans)/Care plan Registered Nurse (RN), and then a final review by the Director of Nursing (DON) before the order was sent to medical records for scanning to the electronic medical records. Further interview confirmed the facility had received a notification from the hospital when the resident was discharged back to the facility following treatment for the critically high lab findings. The hospital after identifying the error reported the concern to Adult Protective Services (APS). The Administrator also confirmed that a representative from APS was at the facility and conducted an investigation, however, the facility did not report the potential abuse/neglect (significant error of a laboratory omission and IV fluids not given), investigation and findings to the State Agency as required.

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on record review and interview; the facility failed to implement physicians' orders for Residents 3, 4,12, and 50. The sample size was 12 and the facility census was 45. Findings are: A. Review of the facility policy Provision of Quality Care dated 12/3/25 revealed the facility ensured resident's received treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans and the resident's choices. Qualified persons provided care and treatment in accordance with professional standards of practice, the residents' care plan, and the residents' choice. B. Review of Resident 12's History and Physical dated 12/12/25 revealed the resident's condition had worsened over the past 4-5 days. The resident presented to the provider with fever, chills, sore throat, cough, and a weight change. The resident was subsequently admitted to the hospital. Review of Resident 12's Hospital Discharge Information dated 12/24/25 and provided to the nursing facility at the time of admission revealed the resident was discharged from the hospital on [DATE]. Diagnoses included Pulmonary Hypertension (type of high blood pressure that can damage the blood vessels in the lungs and lead to heart failure), Peptic Ulcer, Weakness, and Chronic Kidney Disease (stage 4-severe). Review of the included laboratory findings for BUN and Creatinine (tests used to determine overall kidney function) dated 12/24/24 revealed an elevated BUN of 38 (normal 7-25) and an elevated Creatinine of 1.9 (normal 0.6 to 1.2). Review of Resident 12's New admission Diagnosis information for the nursing facility dated 12/24/26 and signed by the medical provider revealed a primary diagnosis of Weakness and Chronic Kidney Disease. Review of Resident 12's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 4/23/25 revealed the resident was admitted to the facility on [DATE]. Diagnoses included Clinically Complex medical conditions, and Renal (kidney) Insufficiency. Review of Resident 12's Care Plan initiated on 12/26/25 revealed the resident had chronic kidney disease (stage 4-severe), and chronic lung disease. A revision on 12/31/25 indicated the resident did not want to be resuscitated. The resident had cognitive impairment and the resident's family chose long term placement in the nursing facility. Review of Resident 12's Progress Notes revealed the following: -on 12/24/26 the resident arrived at the facility in the facility van from the local hospital. The resident was admitted for pneumonia and chronic lung disease and was receiving oxygen. The resident was to receive skilled therapy for strengthening. At 12:21 PM the admission paperwork was completed with family, and the resident chose to not be resuscitated. The hospital nurse report included a report that the resident had declined and weakened over the last few days. -On 1/3/26 at 1:34 AM the resident awoke at midnight and complained of can't breathe. The resident's oxygen saturation was 59% and with repositioning increased to 74-76% (low as normal is 90-100%). The resident was transferred by ambulance to the local hospital at 1:45 AM. -On 1/4/26 at 1:07 PM the hospital reported the resident would not be returning for 4-7 days and had tested positive for Influenza-A. -On 1/8/26 at 11:45 AM the resident (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	returned from the hospital. -On 1/8/26 at 1:24 AM an evaluation revealed the resident had an indwelling catheter in the urinary bladder. -On 1/9/26 at 10:05 PM the resident's doctor was in the facility and ordered oxygen use of 1 liter during the day and 3 liters at night. The resident had reportedly been refusing to get out of bed, refusing therapy and having hallucinations. -On 1/12/26 at 2:40 PM the facility attempted 3 times to get the resident out of bed, however the resident refused. The resident continued to have a urinary catheter and was receiving oxygen. -On 1/13/26 at 1:40 AM the resident continued to refuse therapy. -On 1/13/26 at 5:48 PM the resident's catheter was noted to be blood tinged. -On 1/14/26 at 2:12 PM the resident left the facility for an appointment. -On 1/14/26 at 6:03 PM the facility received an order to stop Lasix (diuretic) and Potassium Chloride (supplement used to replace potassium often depleted by the use of diuretics) and the check a BMP (Basic Metabolic Profile- standard laboratory test to check things including kidney function, fluid balance, and blood glucose levels) in 2 days.-On 1/16/26 at 12:49 PM the resident returned from a urology (medical specialty that treats disorders of the genitourinary (involving the reproduction and urinary) systems) appointment. The orders received were to conduct a voiding trial (urinary catheter removal and assessment of the ability to void effectively after removal). The facility called the urology clinic and requested clarification. There was no evidence ordered lab for the BMP was completed at the facility or the urology clinic. -On 1/19/26 at 8:29 AM the urology clinic called and reported they would fax clarification orders for the voiding trial.-On 1/19/26 at 11:36 PM the note indicated the urinary catheter had been removed at 3:00 PM. -On 1/20/26 at 8:47 AM the resident had not urinated through the night thus the urinary catheter was re-inserted at 6:15 AM and urology was notified. -On 1/21/26 at 9:04 AM the facility noted that after a follow up appointment the facility identified the BMP had not been obtained on 1/16/26 as ordered by urology. In addition, the resident had not received 1 liter of LR (lactated ringers) IV (Intravenous-administered through an intravenous catheter directly into the blood stream) solution used to replace lost fluids and essential electrolytes) also ordered on 1/14/26 and scheduled to be given on 1/15/26 at a 10:00 AM appointment. -On 1/21/26 at 11:03 PM the BMP laboratory findings were reviewed by the physician with a critical high Creatinine of 6.1 thus the resident was transferred to the emergency room (ER). Review of the hospital Resident 12's History and Physical report dated 1/3/26 Assessment included Acute Kidney injury superimposed on chronic kidney disease stage 4. This report was generated from the ER Visit and subsequent hospitalization. Laboratory values revealed the BUN had increased to 52 and the Creatinine had increased to 2.4. In addition, the potassium level was low at 2.9 and the Hemoglobin (blood oxygen carrying capacity) was low at 9.9 with evidence of acute kidney injury. Review of Resident 12's urology appointment and patient plan dated 1/14/26 revealed orders to discontinue the resident's Lasix, and Potassium, and to complete a BMP in 2 days. In addition, the report stated the resident needed 1 liter of LR in the ER treatment room over 4 hours for acute renal failure on 1/15/26 at 10:00 AM. The resident's current creatinine was 3.7 which was well above the usual baseline. Review of Resident 12's History and Physical dated 1/21/26 revealed the resident presented to the ER from the nursing home due to an elevated Creatinine. The resident had been seen by urology on 1/14/26 and had labs drawn, on January 15 the resident was to present to the treatment room for IV fluids but that was not completed. The facility had held the residents' Lasix and Potassium as ordered. Redraw of the resident's blood revealed worsening Creatinine and thus was instructed to present to the ER for evaluation. The resident presented awake and alert and in no acute distress. During an interview on 6/3/26 at 12:49 PM the consultant Registered Nurse (RN) revealed the facility had not completed the ordered lab and/or facilitated the appointment for IV fluids for Resident 12, on (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	1/15/26 and 1/16/26 and when the labs were completed on 1/21/26 the residents BUN and Creatinine were identified as critically high and the resident required evaluation in the ER. During an interview on 6/3/26 at 1:21 PM regarding Resident 12 RN-K revealed the facility identified through investigation that the order for the IV LR was not put in the computer by an agency nurse. The agency nurse received the order and discontinued the Lasix and Potassium but did not put it in the lab and IV fluid orders in computer. By the time the error was identified the agency nurse was no longer working in the facility. In response the facility re-evaluated the orientation process for agency nurses which included a quick reference for documentation and education that required a triple noting process for new orders. In addition, the Documentation Quick Reference guide for charting included appointment documentation that included documenting where the resident went, who transferred the resident, and new orders and skin conditions. C. Review of Resident 3's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 2/18/26 revealed the resident was admitted [DATE]; was cognitively intact; had diagnoses of Dementia, Anxiety, Depression, Psychotic Disorder, Schizophrenia and Post-Traumatic Stress Disorder; and was independent with dressing, transfers, and hygiene. Review of Resident 3's Care Plan last revised 6/1/26 revealed the resident was independent with dressing, eating, toileting, transfers and personal hygiene; had diagnoses of delusional disorder, anxiety, depression, and schizophrenia; was independent with dressing, toileting, transfers and hygiene; and was able to make needs known. Review of the facility form Pharmacist Recommendation History Report from 6/1/25 through 6/1/26 regarding Resident 3 revealed the following notes: -on 11/6/25 the following laboratory blood tests (labs) were ordered to start on 9/15/25, but there were no results on the chart: Complete Blood Count (CBC-a standard blood test that measures the types and numbers of cells in your blood of [NAME] and Red blood cells, Platelets and Hemoglobin), Comprehensive Metabolic Panel (CMP-a routine blood test that measures kidney and liver function, blood sugar and protein levels), Thyroid Stimulating Hormone (TSH- a blood test to measure thyroid function), and a Vitamin D level (a blood test that measures the amount of Vitamin D in your blood stream); -on 12/3/25 the following lab was ordered on 9/12/26 to be drawn 9/15/26, but no results were on the chart: CBC, CMP, TSH, Vitamin D; and -on 5/5/26 the following lab was ordered September 2025 to be drawn every 6 months, but there were no results on the chart: CBC, CMP, TSH, Vitamin D. Review of the facility form Order Summary Report with active orders dated 6/3/26 revealed Resident 3 had orders for CBC, CMP, TSH, and a Vitamin D level to be drawn every 6 months starting on 9/15/25. Review of Resident 3's Medical Record revealed on 3/3/26 the Resident had a CBC drawn. There was no evidence any of the other labs had been drawn in the resident's Medical Record. Further review revealed no evidence the labs were drawn in September of 2025 or in March of 2026 when they were (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	due. Interview on 6/3/26 at 11:55 AM with the Director of Nursing confirmed the CBC, CMP, TSH, and Vitamin D levels were not drawn in September of 2025 and the CMP, TSH and Vitamin D levels were not drawn in March of 2026 when they were due. D. Review of Resident 4's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of heart failure, Multi-Drug Resistant Organism (MDRO-microorganism which is resistant to multiple antibiotics), anxiety, heart failure, high blood pressure, and depression. Review of a Recommendation History Report for Resident 4 with Monthly Medication Regimen Reviews from 6/25 to 6/26 revealed the Consultant Pharmacist identified on 12/3/25 the resident had an order dated 10/2/25 to have a CMP and a CBC which was to be drawn on 11/1/25. Review of a Pharmacist's Report to Nursing revealed the resident's Primary Care Practitioner (PCP) was notified on 12/18/25 that the CMP and the CBC had not been completed. Further review revealed a new order dated 2/16/26 (4 months since the testing was first ordered) to draw the lab this week. Review of a Nursing Progress Note dated 2/18/26 at 9:37 AM revealed the CBC and the CMP were drawn for Resident 4. During an interview on 6/2/26 at 9:13 AM, the Interim DON confirmed the resident had an order dated 10/1/25 for a CMP and a CBC which was not drawn until 2/18/26. The Pharmacist identified the lab was not drawn with monthly review on 12/3/25. The PCP was notified about the missed lab on 12/18/25 but the missed lab was not addressed and/or drawn until 2/16/26. E. Review of Resident 50's Progress Notes revealed the following: -On 12/3/25 at 10:35 AM a verbal order was received to collect a urinalysis (UA) (a diagnostic lab test that evaluates the urine for an infection) due to altered mental status. -On 12/11/25 at 11:30 AM a UA was obtained and taken to the hospital laboratory (lab). -On 12/16/25 at 11:32 AM a call was placed to the lab to obtain results of the UA. Further review of Resident 50's progress note dated 12/16/2025 revealed addition that was for annual CBC and CMP were drawn and taken to the lab. -On 12/16/25 at 2:36 PM lab results were received from the CBC, CMP, and UA and faxed to the physician. -On 12/16/25 at 6:14 PM a new order was received for an antibiotic, Levaquin 250 mg, for 7 days for a Urinary Tract Infection (UTI). -On 12/17/25 at 8:23 AM the facility was waiting to receive Levaquin 250 mg from the pharmacy. -On 12/18/25 at 1:01 PM the primary care physician was in-house for recertification, no new orders received. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-On 12/18/25 at 2:21 PM the physician replied to CBC and CMP results stating no new orders. -On 12/18/25 at 6:32 PM the nurse was notified that the resident was feeling faint and shaking. Blood pressure initially was 212/178, recheck was 148/104. Emergency department was called and updated on the residents' condition. Order was received to transfer the resident by ambulance to the ER. -12/19/25 at 10:55 AM Report received that resident would be returning from the hospital after being treated with IV antibiotic, Levaquin, for pneumonia and UTI. -12/19/25 at 11:45 AM Resident returned to the facility. Review of resident's Treatment Administration Record (TAR) dated 12/25 revealed that a UA was to be obtained on 12/4/25, review of documentation revealed that this was not completed. Review of UA lab results from 12/11/25, (8 days after physician's order was received), revealed a physician's order was received on 12/16/25 for Levaquin 250 mg for 7 days. Review of resident's Medication Administration Record (MAR) dated 12/25 revealed that the resident received one dose of Levaquin 250 mg on 12/18/25, the order was received on 12/16/25. Review of the physician's progress note from 12/18/25 at 3:38 PM revealed that the resident was evaluated by the physician with no new orders received. Review of History and Physical updated 12/18/25 revealed that the resident does have a history of UTI's. Review of the resident's Hospital Discharge Information dated 12/19/25 provided to the nursing facility revealed the resident's diagnosis for treatment was a UTI and Parainfluenza virus pneumonia (respiratory virus). An interview with the DON on 6/3/26 at 11:30 AM confirmed that the UA ordered on 12/3/25 should have been completed within 48 hours of receiving the order, the UA was not collected until 12/11/25, 8 days after the order was received.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(iv)(1)Based on observations, record review, and interview; the facility failed to provide appropriate care and services for the management of Resident 4's indwelling urinary catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) to prevent the potential for infections. The sample size was 3 and the facility census was 45.Findings are:A. Review of the facility policy titled Catheter Care with a revision date of 11/13/24 indicated a goal to prevent urinary tract infections and to maintain proper functioning of the urinary drainage system. B. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/13/26 revealed the resident was admitted [DATE] with diagnoses of heart failure, Multi-Drug Resistant Organism (MDRO-microorganism which is resistant to multiple antibiotics), anxiety, heart failure, high blood pressure, and depression.Review of Resident 4's current Care Plan with a revision date of 4/24/26 revealed the resident had an indwelling urinary catheter and identified the following interventions:-change the catheter as directed by the resident's physician.-monitor for signs of a urinary tract infection (UTI) such as decreased urine output, odorous urine smell, leakage around the catheter, dark urine, and any complaints of discomfort related to the catheter.-provide catheter cares twice a day. Review of an Order Summary Report with active orders as of 6/3/26 revealed the following orders related to the resident's indwelling catheter:-ensure catheter cares are completed each shift.-change catheter every 30 days for infection control or with dislodgement.-monitor catheter output each shift. Observations of Resident 4 included the following:-6/1/26 at 9:59 AM, the resident was observed seated in a wheelchair in the resident's room. A privacy bag which contained a urinary catheter drainage bag was hanging from a brace underneath the seat of the wheelchair.-6/1/26 at 11:59 AM, the resident was independent with wheelchair mobility from the residents' room to the dining room. The resident's urinary catheter drainage bag was covered with a privacy bag which remained underneath of the resident's wheelchair seat. The urine to the catheter drainage tube was cloudy with a milky like discharge and was in direct contact with the floor in the corridors and then the dining room. -6/2/26 at 10:07 AM, the resident was seated in a wheelchair in the resident's room. Bath Aide (BA)-F positioned a walker in front of the resident, removed the privacy bag with the urinary catheter drainage bag from the wheelchair and tied the bag to a lower brace of the walker. Resident 4 stood and then ambulated from the resident's room to the bath house. BA-F lowered the resident's slacks and removed a lightly soiled incontinence brief from the resident and assisted the resident onto a shower chair. BA-F removed the drainage bag from the privacy bag and indicated there was no hanging hook at the top of the bag to use with positioning the catheter bag. Resident 4 commented it probably came off when someone wheeled over top of it. BA-F then placed the catheter drainage bag directly on the floor of the shower room. As BA-F picked up the soiled brief and slacks, BA-F stepped directly on top of the drainage bag. BA-F left the catheter drainage bag on the floor throughout the resident's shower. -6/3/26 at 11:52 AM, the resident was independent with wheelchair mobility from the resident's room to the dining room. The catheter drainage tube was in direct contact with the floor from the resident's room, in the corridors and the dining room.-6/4/26 at 7:57 AM, the resident was independent with wheelchair mobility from the resident's room to the dining room. The urinary catheter drainage tube was in direct contact with the floor in the corridor and in the dining room. During an interview on 6/2/26 at 11:02 AM, BA-F confirmed the resident had an indwelling urinary catheter and confirmed the urinary catheter drainage bag and the drainage tube should not have come in direct contact with the floor of the resident's room, the shower room, the corridors, or the dining room.