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	05/06/2025

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 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. 45739 Licensure Reference Number 175 NAC 12-006.05(S) Based on observation, record review, and interview; the facility failed to ensure a privacy bag was utilized for a catheter bag to promote dignity for Resident 5. The sample size was 1 and the facility census was 45. Findings are: A record review of the facility policy Promoting/Maintaining Resident Dignity dated September 2024 revealed all staff members were involved in providing care to residents to promote and maintain resident dignity and respect resident rights, the resident's lifestyle and personal choices would be considered when providing care and services, and staff would maintain resident privacy. A record review of the facility policy Catheter Care dated September 2024 revealed privacy bags would be available, catheter drainage bags would be covered at all times while in use, and privacy bags would be changed out when soiled, with a catheter change, or as needed. A record review of Resident 5's Minimum Data Set (MDS, a federally mandated assessment tool used in Care Planning) dated 4/3/25 revealed the resident had serious mental illness, had an indwelling catheter, and had diagnoses of Neurogenic Bladder (a condition where a problem in the brain, spinal cord, or peripheral nerves disrupts the signals that control bladder function and can lead to difficulty emptying the bladder or holding urine), Renal Disease, Anxiety, Depression, and Schizophrenia. A record review of Resident 5's Care Plan last revised 4/29/25 revealed the resident had an indwelling catheter with a diagnosis of neuromuscular dysfunction of the bladder, staff were to keep the catheter bag and the tubing below the level of the bladder and away from the entrance room door. The following was observed regarding Resident 5: -On 4/30/25 at 9:40 AM the resident's catheter bag was hanging on the resident's walker. No privacy bag was utilized, and the catheter bag was visible from the hallway. -On 4/30/25 at 1:45 PM the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/1/25 at 7:45 AM the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway, -On 5/1/25 at 11:10 AM the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway. -On 5/1/25 at 1:45 the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway. -On 5/5/25 at 8:05 AM the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway. -On 5/6/25 at 8:10 AM the resident was lying in bed with the catheter drainage bag hanging on the resident's walker, no privacy bag was used, and the drainage bag was visible from the hallway. Interview on 5/5/25 at 2:20 PM with the Director of Nursing confirmed Resident 5 did not have a privacy/dignity bag over their catheter bag. Further interview confirmed dignity bags were to be used for all residents with catheters.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.04(F)(i)(5) Based on record reviews and interviews, the facility failed to; notify Resident 23's practitioner of the unavailability of an anticoagulant medication and to notify Resident 33's practitioner of the resident's non-compliance with fluid restriction and edema wear and failure to administer the resident's steroid eye drops after a surgical procedure. The sample size was 2 and the facility census was 45. Findings are: A record review of the Unavailable Medications Policy dated September 2024 revealed the facility was to notify the physician of the inability to obtain medications when the facility was made aware the medications were not available. If a resident missed a scheduled dose of the medication, the staff were to follow the procedures for a medication error, including notifying the physician. A. A record review of Resident 23's 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 3/12/25 revealed the resident was admitted [DATE] with diagnoses of cancer, atrial fibrillation, dementia, and malnutrition. The following was assessed for Resident 23: -cognition was severely impaired. -verbal behaviors directed at others and rejection of care. -required staff assistance with toileting, dressing, transfers, personal hygiene, and bed mobility. -received an anticoagulant (medication used to help prevent blood clots) daily. A record review of Resident 23's Medication Administration Record (MAR) dated 3/2025 revealed an order dated 3/6/25 for Xarelto (anticoagulant) 15 milligrams (mg) 1 tablet daily. Further review of the MAR revealed from 3/18/25 to 3/24/25 (7 days) the medication was not administered. During an interview on 5/6/25 at 9:29 AM the Director of Nursing (DON) confirmed Resident 23 did not receive the Xarelto 15 mg daily from 3/18/25 to 3/24/25. In addition, the DON confirmed that the resident's practitioner was never notified the resident's anticoagulant medication was not provided for 7 days. 51391 B. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 33's April 2025 MAR revealed a physician's order for: -1800 milliliter (ml) fluid restriction for 24 hours start date 6/27/24, -there was no fluid intake documented for 3 out of 90 shifts, and -the resident's intake exceeded 1800 ml 20 days out of 30. Interview on 5/5/25 at 10:55 AM with the DON confirmed that the resident was on an 1800 ml fluid restriction and staff were not notifying the physician if resident exceeded the 1800 ml intake. A record review of Resident 33's December 2024 MAR revealed the resident had an order for: -prednisoLONE Acetate eye drops (decrease inflammation) 1 drop to right eye four times a day for post cataract surgery for 1 month. The order had a start date of 12/10/24 at 5:00 PM and a discontinue date of 1/7/25 at 10:00 AM. A record review of Resident 33's MAR for December 2024 revealed that the resident did not receive the eye drops on 12/30/24 at 9:00 PM and missed 3 doses on 12/31/24. A record review of Resident 33's MAR for January 2025 revealed the resident received 6 of the 25 doses of the eye drops. Interview on 5/5/25 at 10:55 AM with the DON confirmed that the physician was not notified of eye drops not administered between 12/30/24 at 9 PM through 1/7/25. A record review of Resident 33's December 2024 MAR revealed the resident had an order for: -thigh high compression garments on during the day off at night with a start date 6/27/24. A record review of Resident 33's MAR for December 2024 and January 2025 revealed the resident did not have the compression garments from 12/21/24 to 1/26/25. A record review of Resident 33's nursing documentation from 12/21/24 to 1/26/25 revealed that the compression garments were not being put on because the facility was waiting for a larger size of compression garments. The physician was notified on 1/13/25 of resident's increased non-pitting edema to all extremities and neck, shortness of breath and not having the compression garments due to larger size being ordered. No follow up documentation was received from the physician. An interview on 5/5/25 at 10:55 AM confirmed that the resident should not have gone from 12/21/24 to 1/26/25 without some type of compression garment, the physician should have been notified before 1/13/25 and there was no follow up with the physician after 1/13/25.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.05(G) Based on record review and interview; the facility failed to ensure Gradual Dose Reduction (GDR, stepwise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued) had a documented clinical rationale as to why they were not attempted for Resident 5; and failed to ensure as needed antipsychotic medications (a type of psychoactive medication which alters chemicals in the bran to effect changes in behavior, mood, and emotion) were limited to 14 days for Resident 34. The sample size was 5 and the facility census was 45. Findings are: A record review of the facility policy Use of Psychotropic Drugs, last reviewed February 2020 revealed the following: -residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, -a psychotropic drug was any drug that affected brain activities associated with mental processes and behavior, -psychotropic drugs included but were not limited to antipsychotics, antidepressants, anti-anxiety and hypnotics, -the indications for use would be documented in the medical record, -residents who used psychotropic drugs would receive GDR's unless clinically contraindicated in effort to discontinue the medication, -as needed (PRN) orders for psychotropic drugs would be used only when the medication was necessary to treat a diagnosed specific condition that was documented in the clinical record and for a limited duration of 14 days, -if the prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, he or she would document their clinical rationale in the resident's medical record and indicate a duration, and -PRN orders for antipsychotic drugs were limited to 14 days and cannot be renewed unless the prescribing practitioner evaluated for appropriateness of that medication. A. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 5's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 4/3/25 revealed the resident had a serious mental illness; was cognitively intact; had diagnoses of anxiety, bipolar disorder, and schizophrenia; and received routine anti-psychotic, anti-anxiety, and anti-depressant medications. A record review of Resident 5's Care Plan last revised 4/29/25 revealed the resident received anti-psychotic, anti-depressant, and anti-anxiety medications for diagnoses of schizophrenia, bipolar disorder and anxiety disorder. A record review of Resident 5's Medication Administration Record (MAR) for April 2025 revealed the resident received the following anti-psychotic medications: -Haloperidol (an antipsychotic medication) 5 milligrams (mg) 25 out of 30 doses, -Quetiapine (an antipsychotic medication) 200mg 25 out of 30 doses, -Quetiapine 400mg 27 out of 30 doses, -Clonazepam (a benzodiazepine medication) 0.5mg 52 out of 60 doses, and -Lorazepam (an antianxiety medication) 0.5mg 52 out of 60 doses. Further review of the MAR revealed the missed doses were due to hospitalization s. A record review of the facility facsimile (fax) sent to the prescribing provider for Resident 5 signed 1/21/25 revealed the GDR's for Quetiapine and Haloperidol were marked as contraindicated. There was no documented clinical rationale as to why the dose reduction was not attempted. A record review of the facility fax sent to the prescribing provider signed 2/3/25 revealed the GDR's for Clonazepam and Ativan were marked as contraindicated. There was no documented clinical rationale as to why the dose reduction was not attempted. Interview on 5/6/25 at 8:45 AM with the Director of Nursing (DON) confirmed there was no documented clinical rationale for the contraindicated GDR's for Quetiapine, Haloperidol, Clonazepam, and Ativan. 51391 B. A record review of Resident 34's MDS dated [DATE] revealed the resident had non-traumatic-brain dysfunction, Alzheimer's disease, dementia, anxiety and depression; cognition is severely impaired; and received an antipsychotic medication. A record review of Resident 34's Care Plan last revised 4/7/25 revealed the resident received antipsychotic medications for anxiety and unspecified dementia. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 34's MAR for April 2025 revealed the resident received the following antipsychotic medication: ABH - (Ativan 1 mg, Benadryl 25mg, Haldol 1mg) every 4 hours as needed (PRN) for agitation and restlessness, apply 1 milliliter (ml) to wrist or back of neck with a start date of 12/27/24. A record review of Consultant Pharmacist's Medication Regimen Review (MRR, includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences) revealed the following: -MRR date: 2/10/25, Follow up and add stop date to MAR, ABH gel 1mg every 4 hours as needed, start date 12/27/24, a new order must be written every 14 days for PRN antipsychotic, -MRR date: 3/11/25, Follow up and add stop date to MAR, ABH gel 1mg every 4 hours as needed, start date 12/27/24, a new order must be written every 14 days for PRN antipsychotic, -MRR date 4/8/25, Follow up and add stop date to MAR, and ABH gel 1mg every 4 hours as needed, start date 12/27/24, a new order must be written every 14 days for PRN antipsychotic. A record review of Resident 34's MARs revealed the following: ABH - (Ativan 1 mg, Benadryl 25mg, Haldol 1mg) every 4 hours as needed (PRN) for agitation and restlessness apply 1 mg to wrist or back of neck with a start date of 12/27/24. -January 2025: Administered on the 2nd, 5th, 6th and 8th, -March 2025: Administered on the 4th, 8th and 28th, and -April 2025: Administered on the 3rd, 6th, 15th and 29th. Interview on 5/1/25 at 11:00 AM with the DON confirmed that the facility did not renew the order for the PRN antipsychotic medication ABH every 14 days as required and continued to administer the medication.

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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 0684 Level of Harm - Minimal harm or potential for 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** 45739 Licensure Reference Number 175 NAC 12-006.09 Based on observations, record review, and interviews; the facility failed to ensure laboratory work was obtained in a timely manner for Resident 10; to monitor Resident 33's fluid restriction; to follow Resident 33's physician orders related to eye drops and the resident's edema wear; to assess Resident 40's wound; and to follow Residents 23 and 196's physician orders regarding medications. The sample size was 5 and the facility census was 45. Findings are: A. A record review of the facility policy Provision of Physician Ordered Services dated September 2024 revealed the following: -the facility would maintain a schedule of diagnostic tests (such as laboratory) in accordance with the physician's orders, -qualified nursing personnel would submit timely requests for physician ordered services to the appropriate entity, -qualified nursing personnel would receive and review the diagnostic test reports and communicate the result with the ordering practitioner within 24 hours of receipt, and -documentation of diagnostic tests, results, and date/time of physician notification would be maintained in the resident's medical record. A record review of Resident 10's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 4/24/25 revealed the resident had a serious mental illness, was cognitively intact, had moderate depression, exhibited verbal behaviors, was independent with activities of daily living, and diagnoses included anemia, schizophrenia, dementia, anxiety, and depression. A record review of Resident 10's Care Plan last revised 4/24/25 revealed the resident was independent with activities of daily living; had diagnoses of schizophrenia, anxiety, and depression; and staff were to obtain lab work per orders and notify the physician of the results. A record review of the facility form Order Summary dated 2/27/25 for Resident 10 revealed orders were received for blood tests: a Hemoglobin A1C (measures the average blood sugar level over a 3 month time period), Complete Blood Count (CBC- analyzes the size and quality of blood cells), Basic Metabolic Panel (BMP-measures fluid balance, electrolytes and kidney function), Thyroid-Stimulating Hormone (TSH-measures the thyroid hormone function), Lipid Panel (measures cholesterol in the blood), a Vitamin B12 level, and a urinalysis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 10's lab results dated 3/5/25 revealed the urinalysis was obtained (9 days after it was ordered). A record review of Resident 10's lab results dated 3/18/25 revealed the blood work (Hemoglobin A1C, CBC, BMP, TSH, Lipid Panel, and Vitamin B12 were obtained (22 days after they were ordered). An iron panel was added onto the labs by the provider and the provider noted they would like to talk to the resident in the clinic about the blood test results with an appointment made for 3/25/25. A record review of Resident 10's Progress Notes an entry dated 3/25/25 revealed the resident returned from the appointment with new medication orders and needed an ifob stool sample (a type of stool test that checks for hidden or occult blood in the stool). A record review of the facility form Order Summary dated 4/15/25 for Resident 10 revealed an order was put in for the occult stool sample (21 days after the progress note entry). A record review of Resident 10's lab results dated 4/24/25 revealed the stool sample was collected (30 days after the progress note entry and 9 days after the order was put in). A record review of Resident 10's Progress Notes revealed no documentation that orders were received for lab work on 2/27/25, there were no entries that blood work was obtained on 3/18/25, there were no entries that blood work was refused, no documentation that the facility received the order for the stool test on 4/15/25 and no documentation that the facility obtained the stool sample on 4/24/25. Interview on 5/5/25 at 2:10 PM with the Director of Nursing (DON) confirmed staff should have documented in the resident's medical record any refusals to obtain the lab work, when the lab work was obtained, and when the results were received and sent to the provider. Further interview confirmed the labs were not obtained in a timely manner. 29638 B. A record review of the Unavailable Medications Policy dated September 2024 revealed the facility was to utilize uniform guidelines for unavailable medications. The following guidelines were identified; -the facility was to maintain a contract with a pharmacy provider to supply the facility with routine, as needed and emergency medications. -a supply of commonly used medications was to be maintained in-house for the timely initiation of medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-staff were to take immediate action when it was known a medication was not available: 1) determine the reason for unavailability, length of time the medication was unavailable and what efforts had been attempted by the facility or the pharmacy provider to obtain the medication; 2) notify the physician of inability to obtain medication upon notification or awareness that medications were not available. Obtain alternate treatment order and/or specific orders for monitoring the resident while medication was on hold; and 3) if the facility allows, determine if the resident has a home supply and obtain an order to use the home medication supply. -if a resident missed a scheduled dose of the medication, the staff were to follow the procedures for a medication error, including notifying the physician/family, completion of a medication error report and monitoring the resident for adverse reactions to omission of the medication. A record review of Resident 23's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of cancer, atrial fibrillation, dementia, and malnutrition. The following was assessed for Resident 23: -cognition was severely impaired. -verbal behaviors directed at others and rejection of care. -required staff assistance with toileting, dressing, transfers, personal hygiene, and bed mobility. -received an anticoagulant (medication used to help prevent blood clots) daily. A record review of Resident 23's Medication Administration Record (MAR) dated 3/2025 revealed an order dated 3/6/25 for Xarelto (anticoagulant) 15 milligrams (mg) 1 tablet daily. Further review of the MAR revealed from 3/18/25 to 3/24/25 (7 days) the medication was not administered. A record review of Resident 23's Nursing Progress Notes revealed the following regarding administration of the Xarelto 15 mg daily: -3/18/25 at 9:40 AM the staff were unable to find the medication. -3/19/25 at 8:54 AM the staff were unable to find the medication. -3/21/25 at 10:27 AM the staff were unable to find the medication. -3/22/25 at 7:40 AM the staff were awaiting pharmacy. -3/23/25 at 7:52 AM staff were awaiting drug from the pharmacy. -3/24/25 at 10:31 AM staff were waiting for the pharmacy to deliver the medication. C. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 196's Face Sheet revealed the resident was admitted [DATE] with diagnoses of low back pain, diverticulosis, irritable bowel syndrome, adult failure to thrive, pressure ulcer to the sacral region and malnutrition. A record review of Resident 196's admission orders dated 3/20/25 revealed the following: -Potassium and Sodium Phosphate (electrolyte replacement) powder one packet daily. -Aspirin 81 mg twice a day. -Amlodipine (medication used to treat high blood pressure) 10 mg daily. A record review of Resident 196's MAR dated 3/2025 revealed the following: -from 3/21-3/24 the Amlodipine 10 mg daily was not available/administered. -from 3/21 to 3/23 the Potassium and Sodium Phosphate packets were not available/administered. -from 3/21 to 3/24 the Aspirin 81 mg was not available/administered. During an interview on 5/6/25 at 9:29 AM the DON confirmed the following regarding Residents 23 and 196: -Resident 23 did not receive the Xarelto 15 mg daily from 3/18/25 to 3/24/25. -Resident 196 did not receive Amlodipine 10 mg daily and Aspirin 81 mg twice a day from 3/21/25 to 3/24/25 and did not receive the Potassium and Phosphate packets daily from 3/21/25 to 3/23/25. -no evidence the facility had determined why the resident's medications were not available from the pharmacy. -no evidence of any actions taken to obtain alternate orders for the resident's missing medications. -no monitoring of the residents while these medications were on hold. 51391 D. A record review of the facility's Fluid Restriction Policy with a date of March 2025 revealed the following: -facility was to ensure that fluid restrictions will be followed in accordance with physician's orders, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours between the nutrition and nursing department. The fluid intake will be recorded in the medication record, and -the resident had the right to refuse the fluid restriction, if refused, documentation should support the reason for the refusal, the education of the risks and benefits, and any supporting documentation of the resident's continued refusal, assessment for any changes in condition related to the refusal, and the notification of the physician about the resident's refusal. A record review of the facility's Skin Assessment Policy dated December 2024 revealed the following: -a full body, or head to toe, skin assessment would be conducted by a licensed or registered nurse weekly, -Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions, -Documentation of skin assessment: a. Include date and time of the assessment, your name, and position title, b. Document observations, c. Document type of wound, and d. Describe wounds (measurements, color, type of of tissue in wound bed, drainage, odor, pain). A record review of Resident 33's April 25 MAR revealed a physician order for: -1800 milliliter (ml) fluid restriction for 24 hours start date 6/27/24, -no fluid intake documented 3 out of 90 shifts, and -the resident's intake exceeded 1800 ml 20 days out of 30. A record review of Resident 33's nurse documentation revealed that the physician had not been notified when the resident exceeded the 1800 ml per day and no documentation was found showing why the resident was on a fluid restriction. Interview on 5/5/25 at 10:55 AM with the DON confirmed that resident was on an 1800ml fluid restriction, staff were not monitoring the fluid intake amount and notifying the physician if resident exceeded the 1800 ml intake. DON unable to provide documentation that stated why the resident was on a fluid restriction. A record review of Resident 33's December 2024 MAR revealed the resident had an order for: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-prednisoLONE Acetate eye drops (decrease inflammation) 1 drop to right eye four times a day for post cataract surgery for 1 month. The order had a start date of 12/10/24 at 5:00 PM and a discontinue date of 1/7/25 at 10:00 AM. A record review of Resident 33's MAR for December 2024 revealed that the resident did not receive the eye drops on 12/30/24 at 9:00 PM and missed 3 doses on 12/31/24. A record review of Resident 33's MAR for January 25 revealed the resident received 6 of the 25 doses of the eye drops. A record review of Resident 33's nurse documentation from 12/30/24 to 1/7/25 revealed the eye drop medication was waiting to be received from the pharmacy. No documentation was found to reveal that the pharmacy was notified of needing the medication or the physician being notified of the eye drops not being administered. Interview on 5/5/25 at 10:55 AM with the DON confirmed that the pharmacy was notified on 1/4/25 of needing the eye drops, eye drops were not received, and the pharmacy was not notified of the eye drops not being received. DON also confirmed that the physician was not notified of eye drops not administered from 12/30/24 at 9 PM to 1/7/25. A record review of Resident 33's December 2024 MAR revealed the resident had an order for: -Thigh high compression garments on during the day off at night with a start date 6/27/24. A record review of Resident 33's MAR for December 2024 and January 2025 revealed the resident did not have the compression garments from 12/21/24 to 1/26/25. A record review of Resident 33's nursing documentation from 12/21/24 to 1/26/25 revealed that the compression garments were not being put on because the facility was waiting for a larger size of compression garments. The physician was notified on 1/13/25 of the resident's increased non-pitting edema to all extremities and neck, shortness of breath and not having the compression garments due to larger size being ordered. No follow up documentation was received from the physician. An interview on 5/5/25 at 10:55 AM with the DON confirmed that Resident 33 should not have gone from 12/21/24 to 1/26/25 without some type of compression garment, the physician should have been notified before 1/13/25 and there was no follow up with the physician after 1/13/25. An interview on 5/5/25 at 2:30 PM with the Business Office Manager (BOM-M) confirmed that the compression garments were ordered on 12/19/24, and on 1/13/25 a larger size of compression stockings were ordered and received on 1/27/25. E. A record review of Resident 40's MDS dated [DATE] revealed that resident was admitted on [DATE] with: -diagnoses of non-traumatic brain dysfunction and dementia, -cognition was severely impaired, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dependent on staff for toileting hygiene, bathing, dressing, bed-mobility, transfers, -always incontinent of bowel and bladder, and -3 unstageable non-removable dressing: Known but not stageable due to non-removable dressing/device. a record review of Resident 40's care plan revealed that resident was admitted with an unstageable pressure injury to the left shoulder, left outer trochanter and left outer thigh. Left shoulder and left outer thigh were healed. Observation of cares on 5/1/25 at 10:50 AM revealed that Resident 40 had a wound dressing intact to left hip with a date of 5/1/25. Observation of Resident 40 on 5/5/25 at 10:30 AM revealed a wound dressing to left hip with a date of 5/5/25. Observation on 5/6/25 at 8:10 AM of skin treatment to Resident 40's left hip by the DON revealed that there was an open area to the left hip. A record review of Resident 40's nursing documentation revealed that no weekly documentation for left hip was being completed. Interview with the DON on 5/6/25 at 11:15 AM confirmed that the facility has not completed weekly documentation or measurements to monitor the wound on the left hip.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 29638 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on record reviews and interviews, the facility staff failed to obtain pressure ulcer treatment for 1 (Resident 196) of 1 sampled resident. The facility staff identified a census of 45. Findings are: A record review of the hospital Discharge Summary dated 3/20/25 revealed Resident 196 had been admitted to the hospital after being found in poor condition in the resident's home. The resident had not been eating, only primarily drinking. The resident had a large sacral pressure ulcer. The resident wanted to return home, but the resident realized the sore to the resident's sacrum was serious and could lead to long term problems. Required dressing change 1-2 times a day. A record review of a Nursing Progress Note for Resident 196 dated 3/20/25 at 1:19 PM revealed the resident was admitted from the hospital with diagnoses of chronic pain, adult failure to thrive, pressure ulcer to the sacral region, malnutrition, and alcohol use. A record review of an Admission Skin Assessment for Resident 196 dated 3/20/25 at 1:12 PM revealed the resident had a stage II pressure ulcer (partial thickness skin loss that presents as an abrasion, blister, or shallow crater) which measured 3.5 centimeters (cm) by 2.8 cm with a depth of 1.5 cm. A record review of Resident 196's electronic medical record from 3/21/25 to 3/24/25 revealed no evidence a treatment had been ordered and/or completed on the resident's stage 2 pressure ulcer to the resident's coccyx. A record review of a Nursing Progress Note for Resident 196 dated 3/24/25 at 8:58 PM revealed the resident had notified the Social Service Director and Nursing that the resident was leaving. The resident indicated the wound to the resident's coccyx was not being treated and/or assessed and so the resident was leaving. The resident was educated about the risks of leaving the facility Against Medical Advice (AMA). The resident left the facility with a neighbor at 11:39 AM with the resident's belongings. Interview on 5/6/25 at 9:29 AM with the Director of Nursing (DON) confirmed the resident had been admitted from the hospital on 3/20/25 with a stage 2 pressure ulcer to the resident's coccyx. There were no admission orders related to the care and treatment of the wound and staff failed to contact the resident's physician regarding a treatment order. The resident had alerted the facility on 3/24/25 that the resident was going home as the resident had not received treatment to the pressure ulcer while admitted to the facility. In addition, the facility did not have a policy currently related to the care and management of pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09(I) Based on observations, record review and interviews; the facility failed to assure a safe environment as the staff failed to 1) utilize safe transfer techniques with use of the mechanical lift to prevent potential accidents for Resident 31; 2) revise current interventions or develop new interventions to prevent ongoing falls for Resident 5; and 3) implement assessed fall interventions for Residents 29, 34 and 40. The sample size was 8 and the facility census was 45. Findings are: A record review of the facility policy Safe Resident Handling/Transfers dated 7/24/23 revealed it was the policy of this facility to ensure the residents were handled and transferred safely to prevent or minimize risks of injury and provide and promote a safe, secure and comfortable experience for the residents while keeping the employee safe in accordance with current standards and guidelines. All residents required safe handling when transferred to prevent or minimize the risk of injury to themselves and the employee that assisted them. The Interdisciplinary Team or designee was to evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. Mechanical lifting equipment or other approved transfer aids were to be used based on the resident's needs to prevent manual lifting except in medical emergencies. Mechanical lifts included equipment such as full body lifts (mechanical device that allows residents to be transferred between a bed and a chair using hydraulic power and requires no weight bearing assistance), sit-to-stand lifts (a mobile lift that allows patient transfers from a seated position to a standing position. This lift is designed to support only the upper body of the resident and requires the resident to have some weight-bearing capability) or ceiling track mounted lifts. The following procedure was to be followed: -2 staff members were to be utilized when transferring residents with a mechanical lift. -staff were to be educated on the use of safe handling/transfer practices to include use of the mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. -staff members were expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. -resident's lifting and handling was to be performed according to the resident's individual plan of care. -staff were to perform mechanical lift/transfers according to the manufacturer's instructions for use of the device. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility'sFall Prevention Program Policy dated 9/2024 revealed each resident was to be assessed for fall risk and was to receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive care plan. Fall interventions were to be monitored for effectiveness and the care plan was to be revised as needed. If any resident has a fall the facility will: -assess the resident. -complete a post-fall assessment. -complete an Incident Report. -notify the physician and the family. -review the resident's care plan and update as indicated. -document all assessments and actions. A. A record review of Resident 31's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 3/13/25 revealed the resident was admitted [DATE] with diagnoses of previous stroke, high blood pressure, hemiplegia (paralysis on 1 side of the body), seizure disorder, and depression. The following was assessed for Resident 31: -cognitively intact. -dependent on staff for assistance with toileting hygiene, showering/bathing, dressing, transfers, and bed mobility. -occasionally incontinent of urine. A record review of Resident 31's Care Plan dated 3/21/24 revealed the resident was at risk for falls related to left side hemiplegia, neuropathy, and convulsions. An intervention dated 4/3/24 was identified by the therapy department for two nursing staff to be used for all transfers for the resident utilizing the sit-to-stand mechanical lift. One staff member was to control the lift, and the other staff was to manage the resident's left hand/shoulder. The staff were to use both of their hands (one on the resident's left hand and one on the resident's arm) to ensure proper positioning and to prevent injury risk. During an interview on 4/30/25 at 10:13 AM, Resident 31 identified a history of a previous stroke with left side paralysis/contractures. The resident reported that when the resident was transferred with the mechanical lift, there were always supposed to be 2 staff to assist with the transfer. However, now the staff frequently only used 1 staff person to transfer the resident with the lift and this made the resident feel uncomfortable. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/1/25 at 11:01 AM, Resident 31 was transferred from the commode to the recliner with the mechanical lift. Nurse Aide (NA)-D used the controls to lift the resident from the commode to a standing position and NA-F stood directly behind the resident. The resident used the right hand to hang onto the lift handle, but the resident's left hand/arm hung at the resident's side. When the resident was transferred from the commode, staff failed to place the resident's left hand on the handle of the lift and to hold the left hand in place and to support the resident's left arm/shoulder. The resident was unable to maintain weight bearing status once stood and started to bend at the knees with the resident's left side hanging flaccid. NA-F performed hygiene cares for the resident and then staff quickly moved the resident over to the recliner and lowered the resident to the seat. During an interview on 5/1/25 at 11:45 AM, NA-E and NA-F confirmed 2 staff were not always available to assist Resident 31 with transfers in the mechanical lift. NA-E and NA-F verified education was provided by the therapist for 2 staff to be used for all transfers when using the lift for Resident 31. B. A record review of Resident 29's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of dementia, psychotic disturbance, Alzheimer's disease, history of traumatic brain injury, osteoarthritis, and anxiety. The following was assessed for Resident 29: -severe cognitive impairment. -dependent on staff for assist with eating/drinking, personal hygiene, toileting hygiene, showering/bathing, dressing, transfers, and bed mobility. -functional limitation of range of motion with impairment to both sides of both upper and lower extremities. A record review of Resident 29's Care Plan dated 2/4/25 revealed Resident 29 was at risk for falls related to poor balance and need to use the full mechanical lift for all transfers. The care plan indicated the resident had a fall on 2/7/25 with a new intervention for a mesh Stop Sign across the entrance door of the resident's room and had a fall out of bed on 4/2/25 at 4:15 AM with an intervention for a body pillow to be used to assist with positioning in the resident's bed. Observations of Resident 29 in the resident's room revealed the following: -On 4/20/25 at 10:00 AM the resident was in the wheelchair. The mesh Stop Sign was not across the door of the resident's room. -On 5/1/25 at 7:40 AM the resident was in the room in the wheelchair and the mesh Stop Sign was not across the door of the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 5/1/25 at 10:35 AM and at 2:02 PM the resident was lying in the bed. The body pillow was in a chair next to the resident's bed and was not utilized as a fall intervention. In addition, the mesh Stop Sign had not been placed across the resident's room door. -On 5/5/25 from 8:02 AM to 9:30 AM the resident was lying in bed. The body pillow was in a chair next to the resident's bed and was not utilized in the bed. In addition, the mesh Stop Sign had not been placed across the resident's room door. -On 5/5/25 at 10:35 AM the resident was transferred from the wheelchair and into the resident's bed. The body pillow remained in the chair next to the resident's bed. -On 5/6/25 at 7:39 AM the resident was positioned in the bed. The body pillow had not been placed in the resident's bed and the mesh Stop Sign was not in place across the resident's room door. During an interview on 5/5/25 at 8:57 AM the Director of Nursing (DON) confirmed the following regarding Resident 29's falls: -On 2/7/25 at 3:10 AM, the resident was found lying on the floor next to the resident's bed. Due to the resident's contractures and total dependence on staff for mobility, the staff felt another resident, who had also been found in the room, had removed the resident from bed and laid the resident on the floor. A new intervention was put into place to place a mesh Stop Sign across the doorway of the resident's room to keep any wandering residents out of Resident 29's room. -On 4/2/25 at 4:00 PM the resident was found on the floor beside the resident's bed. A new intervention was put into place for a body pillow to be placed in the bed to assist the resident with positioning and prevent further falls from the bed. -Both interventions remained in place and should have been implemented throughout the survey. 51391 C. A record review of Resident 34's MDS dated [DATE] revealed the resident had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, dementia, anxiety and depression. The following was assessed regarding the resident: -cognitive skills for decision making were severely impaired, -inattention and disorganized thinking fluctuate, -dependent on staff for eating, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene, transfers, bed mobility and wheelchair mobility, -always incontinent of bowel and bladder, -receiving hospice care, -had bed alarm daily and other alarm daily, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-functional limitation of range of motion with impairment to 1 lower extremity. A record review of Resident 34's care plan dated 9/22/23 revealed the resident was at risk for falls related to diagnosis of Alzheimer's disease, used the full mechanical lift for all transfers, and had a history of falls. The care plan indicated the resident had: -A tabs alarm initiated 10/22/24, -secure tabs alarm to the waistband of the pants initiated 11/11/24, -chair alarm initiated 11/21/24, and -do not leave the resident unattended alone in their room when they are in their wheelchair, and assist to the recliner or bed before leaving the room initiated 11/21/2024. On 5/5/25 at 11:00 AM, documentation for the fall from 12/18/24 was reviewed with the DON. Documentation revealed that the resident was sitting on the floor in front of their wheelchair on their bottom. The resident was trying to put a blanket on the bed and slid out. The resident had no alarms in place. Observations of Resident 34 in their room revealed the following: -on 4/30/25 at 10:00 AM Resident 34 was sitting in their room in wheelchair with their eyes closed, no staff were in the room. -On 5/1/25 at 2:25 PM Resident 34 was sitting in their room in wheelchair, eyes opened, reaching for items, sitting forward in the wheelchair. No staff were in the room. During an interview on 5/5/25 at 11:00 AM, DON confirmed the following: -Resident 34 did get left alone in their room in the wheelchair at times, -The resident did not have alarms in place as care planned when their fall occurred on 12/18/24. D. A record review of Resident 40's MDS dated [DATE] revealed the resident had diagnoses of non-traumatic brain dysfunction and dementia. The following was assessed regarding the resident: -cognitive skills for decision making were severely impaired, -had poor attention continuously and disorganized thinking fluctuate, -dependent on staff for oral hygiene, toileting hygiene, bathing, dressing and personal hygiene, transfers, bed mobility and wheelchair mobility, -always incontinent of bowel and bladder, and -had 1 fall with no injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 40's care plan dated 3/10/25 revealed the resident was at risk for falls related to diagnosis of dementia, need to use full mechanical lift for all transfers and was dependent on staff for mobility in wheelchair. The care plan indicated the resident had a fall on 3/6/25 with an intervention to lay down after meals. Observations of Resident 40 revealed the following: -On 4/30/25 at 9:45 AM the resident was sitting in the wheelchair in the lobby area watching TV. -On 4/30/25 at 11:00 AM the resident was sitting in the wheelchair in the lobby area watching TV, closed eyes off and on. -On 4/30/25 at 12:10 PM staff pushed the resident into the dining room for noon meal. -On 4/30/25 at 2:00 PM the resident was sitting in the wheelchair in the lobby area, eyes were closed. -On 5/1/25 at 10:20 AM the resident was sitting in wheelchair in the resident's room with eyes closed. -On 5/1/25 at 10:50 AM the resident had been laid down in bed. -On 5/1/25 at 1:45 PM the resident was sitting in wheelchair in the lobby area, eyes were open and the resident was rocking back and forth in wheelchair. -On 5/1/25 at 2:25 PM the resident was being laid down in bed. An interview with the DON on 5/6/25 at 11:15 AM confirmed that the resident was to be laid down after meals and the expectation was for this to be within 30 minutes of completing meal. DON confirmed that the resident did not always get laid down after meals. 45739 E. A record review of Resident 5's MDS dated [DATE] revealed the resident had a serious mental illness, was cognitively intact, was independent with activities of daily living, had an indwelling catheter, had diagnoses of renal disease, neurogenic bladder (a condition where a problem in the brain, spinal cord, or peripheral nerves disrupts the signals that control bladder function and can lead to difficulty emptying the bladder or holding urine), diabetes, anxiety, bipolar disorder, and schizophrenia, had 2 or more falls without injuries and 1 with a major injury, and had a feeding tube. A record review of Resident 5's Care Plan, last revised 4/29/25 revealed the resident was at risk for falls, required a standby assist with walker but often self-transferred and had the following fall interventions in place: -bed and chair alarms implemented 4/30/24, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-encourage non-skid footwear implemented 4/30/24, -transfers and ambulates with a standby assist with walker implemented on 4/30/24, and -new gripper socks implemented 1/1/25. A record review of Resident 5's Fall Risk Evaluation dated 4/3/25 revealed the resident was a high risk for falls. A record review of the facility Incident Reports for Falls for Resident 5 revealed the following: -A fall on 2/23/25 at 4:00 PM where the resident was found on the floor in the resident room next to the bed with an intervention of bed and chair alarms applied, -A fall on 3/11/25 at 4:15 AM where the resident was found sitting on the floor at the end of the bed with no socks on with an intervention to be a standby assist with a walker for transfers and ambulation, and -A fall on 4/24/25 at 12:52 AM where the resident was found lying on their back beside the bed with an intervention to ensure gripper socks were worn. Interview with the DON on 5/6/25 at 8:45 AM confirmed the falls on 2/23/25, 3/11/25, and 4/24/25 did not have new interventions implemented to prevent further falls.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.12(A) Based on record reviews and interviews, the facility failed to address gradual dose reductions (GDR, stepwise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued) in a timely manner for Residents 31 and 14; and to document a clinical rationale as to why GDRs were not attempted for Residents 5, 14, and 31. The sample size was 5 and the facility census was 45. Findings are: A. A record review of Resident 5's Minimum Data Set (MDS, a federally mandated assessment tool used in Care Planning) dated 4/3/25 revealed the resident had a serious mental illness; was cognitively intact; had diagnoses of anxiety, bipolar disorder, and schizophrenia; and received routine anti-psychotic, anti-anxiety, and anti-depressant medications. A record review of Resident 5's Care Plan last revised 4/29/25 revealed the resident received anti-psychotic, anti-depressant, and anti-anxiety medications for diagnoses of schizophrenia, bipolar disorder, and anxiety disorder. A record review of Resident 5's Medication Administration Record (MAR) for April 2025 revealed the resident received Venlafaxine (anti-depressant medication) 125 milligrams (mg) 78 out of 90 doses. Further review of the MAR revealed the missed doses were due to hospitalization s. A record review of the facility facsimile (fax) sent to the prescribing provider signed 2/3/25 for Resident 5 revealed the GDR for Venlafaxine was marked as contraindicated. There was no documented clinical rationale as to why the dose reduction was not attempted. Interview on 5/6/25 at 8:45 AM with the Director of Nursing (DON) confirmed there was no documented clinical rationale for the contraindicated GDR for Venlafaxine. 29638 B. A record review of Resident 31's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of stroke, high blood pressure, seizure disorder and depression. The assessment indicated the resident was cognitively intact, reported feeling down, depressed, and hopeless at times and the resident received an antidepressant medication daily. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a Note to the Attending Physician/Prescriber from the Consultant Pharmacist dated 9/9/24 for Resident 31 revealed a recommendation to review the resident's orders for Prozac (medication used to treat depression) 20 mg daily and Trazadone (medication used to treat insomnia/depression) 50 mg every evening for potential GDRs. The physician/prescriber returned the note on 9/23/24 and no GDR was identified. Further review revealed there was no evidence that a clinical rationale had ever been provided by the prescriber as to why the GDR was clinically contraindicated. A record review of the Consultant Pharmacists Monthly Medication Regimen (MMR, includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences) reviews for Resident 31 revealed the following recommendations: -12/10/24 at 1:25 PM: GDR of the Prozac and Trazadone. -1/14/25 at 2:19 PM: follow up for a GDR of the Prozac and Trazodone. A record review of the Consultant Pharmacists MMR dated 2/11/25 at 8:57 AM for Resident 31 revealed a follow up recommendation for a GDR for the resident's Prozac. A record review of Resident 31's physician orders revealed on 2/24/25 the resident's Trazadone was decreased from 50 mg to 25 mg daily. Further review of the resident's physician orders revealed no evidence the resident's Prozac was reviewed for a potential GDR. An interview with the DON on 5/6/25 at 9:40 AM confirmed the following related to Resident 31's psychotropic medications: -Current orders for Prozac 20 mg for depression and Trazadone 50 mg 1/2 tablet at bedtime for insomnia. -On 9/9/24 the Consultant Pharmacist made a recommendation for a GDR of the resident's Prozac and Trazadone. -On 9/23/24 the physician refused the GDR but there was no documented clinical rationale as to why the GDR was contraindicated. -On 12/10/24 the Consultant Pharmacist again recommended a GRD for the resident's Trazadone and Prozac. -On 1/14/25 the Consultant Pharmacist sent a follow up letter regarding a recommended GDR of the resident's antidepressant medications. -On 2/24/25 the resident's Trazadone was decreased from 50 mg to 25 mg daily for insomnia, but the resident's Prozac was not addressed. C. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 14's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of debility, heart failure, high blood pressure, previous stroke, depression, and anemia. The resident was cognitively intact and took an antianxiety and an antidepressant medication daily. A record review of the Consultant Pharmacists MMRs for Resident 14 revealed the following: -On 11/12/24 at 1:19 PM a letter was sent to the resident's physician with a recommendation for a GDR of the resident's Buspar (medication used to treat anxiety) and Remeron (medication used to treat depression). -On 12/10/24 at 1:44 PM a follow up letter was sent with a recommendation for a GDR of the Buspar and the Remeron. -On 1/14/25 at 5:31 PM a letter was sent again to the resident's prescriber about a GDR for the resident's Buspar and Remeron. A record review of a Note to the Attending Physician/Prescriber from the Consultant Pharmacist dated 1/14/25 for Resident 14 revealed a recommendation to review the resident's orders for Buspar 10 mg daily and Remeron 15 mg daily for potential GDRs. The physician/prescriber returned the note on 1/17/25 and no GDR was identified. Further review revealed there was no evidence that a clinical rationale had ever been provided by the prescriber as to why the GDR was clinically contraindicated. A record review of an MMR by the Consultant Pharmacist on 4/8/25 at 1:08 PM for Resident 14 revealed a note had been sent to the physician regarding a potential GDR for the resident's Buspar and Remeron. During an interview on 5/6/25 at 9:40 AM, the DON confirmed the following related to Resident 14's psychotropic medications: -Current orders for Buspar 10 mg daily for mood, Remeron 15 mg at HS for insomnia and Prozac 20 mg daily for depression. -On 11/12/24 the Consultant Pharmacist made a recommendation for GDR of the resident's Buspar and Remeron. -On 12/10/24 a follow up letter was sent to the provider by the pharmacist regarding a GDR for the Buspar and Remeron. -On 1/14/25 another follow up letter was sent to the provider by the pharmacist regarding a GDR for Buspar and Remeron. -On 1/17/25 the physician addressed the Consultant Pharmacist recommendations, and no dose reduction was ordered. Further review revealed there was no clinical rationale as to why the GDRs were contraindicated. -On 4/8/25 another letter was sent to the physician from the Pharmacist regarding a potential GDR for the Buspar and Remeron. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/10/25 no GDRs were ordered and there was no clinical rationale as to why the dose reductions were clinically contraindicated.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42360 Licensure Reference Number 175 NAC 12-006.12(D)(vi) Based on observation, interview and record review, the facility failed to ensure insulin pens for 4 (Residents 5, 8, 10, and 14) of 6 sampled residents were dated when opened to ensure the insulin was not given beyond the recommended effective date. The facility census was 45. Findings are: A record review of the facility's undated Medication Storage policy revealed the facility policy ensured all medications housed on the premises were stored in the pharmacy and/or the medication rooms according to the manufactures recommendations, and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. A record review of the facility policy Storage of Medications Requiring Refrigeration Policy dated April 2025 revealed the following: -The facility assured proper and safe storage of medications to prevent potential alteration or medication by exposure to improper temperatures. -The facility provided safe and effective storage of all drugs consistent with state and federal requirements and within professional standards of practice. -Staff observed proper storage and labeling requirements for all medications during daily task performance and demonstrated safety regarding medication integrity. -The facility dated any multi-use vials when they were first accessed and discarded them within 28 days unless the manufacturers specified differently. During observation of the facility medication carts on 5/1/25 from 11:33 AM-11:57 AM multi-dose insulin pens for Residents 5, 8, 10, and 14 did not contain dates indicating when they had been first accessed or opened. A record review of the undated facility list of Insulin Dependent residents revealed the facility had 6 resident who received insulin injections. A. A record review of Resident 5's Care Plan revealed the resident had Diabetes Mellitus, had the potential for fluctuating blood sugar levels and received sliding scale insulin (insulin given based on blood glucose monitoring levels/results). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 5's Medication Administration Record (MAR) dated April 2025 revealed the resident had orders for Glargine insulin that was given twice daily, and Novolog insulin up to three times daily based on blood glucose levels. B. A record review of Resident 8's Care Plan dated 4/30/24 revealed the resident had Diabetes Mellitus with fluctuating blood sugars and received scheduled insulin. A record review of Resident 8's MAR dated April 2025 revealed the resident received Glargine insulin twice daily. C. A record review of Resident 10's Care Plan dated 12/11/24 revealed the resident had Diabetes Mellitus and the potential for fluctuating blood sugars. A record review of Resident 10's MAR dated April 2025 revealed the resident received Insulin Aspart up to 4 times a day based on blood glucose levels. D. A record review of Resident 14's Care Plan dated 2/4/25 revealed the resident had Diabetes Mellitus, potential fluctuating blood glucose levels, and received scheduled and sliding scale insulin. A record review of Resident 14's MAR dated April 2025 revealed the resident received Glargine insulin twice daily and Novolog Insulin up to 3 times daily. During an interview on 05/1/25 at 11:34 AM with Licensed Practical Nurse (LPN)-H confirmed that all insulin was to be dated when opened to prevent the insulin from being used past 28 days and confirmed that Residents 5, 8, 10, and 14's insulins had not been dated when opened. During an interview on 5/5/25 at 2:30 PM the Director of Nursing confirmed that all insulin was to be dated when opened and used within 28 days, or discarded, and not dating insulin could result in the insulin being used past the recommended days of use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.18(B) Based on observations, interviews, and record reviews; the facility failed to prevent the potential for cross contamination related to 1) the completion of perineal hygiene for Resident 23; 2) the performance of hand hygiene and the changing of gloves during toileting/incontinence cares for Residents 23 and 18; 3) utilization of required Personal Protective Equipment (PPE, includes clothing, gloves, face shields, goggles, facemasks, respirators, and other equipment to protect front-line workers from injury, infection, or illness) during cares for Residents 5 and 18 who were on Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)); and 4) cleaning/disinfecting the mechanical lift between resident uses for Resident 23, 34, 40 and 31. The total sample size was 19 and the facility census was 45. Findings are: A record review of the facility policy Perineal Care Policy updated September 2024 revealed it was the practice of this facility to provide perineal care to all incontinent residents during routine baths and as needed to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown. Perineal care referred to the care of external genitalia and the anal area. The following process was identified: -perform hand hygiene and put on gloves. -if the perineum was grossly soiled, turn the resident to the side, remove fecal material with toilet paper, and discard. -cleanse buttocks and anus, front to back, scrotum to anus, using a separate washcloth or wipe for each stroke. -thoroughly dry -reposition the resident to a supine position. Change gloves if soiled and continue perineal care. For males: -gently rinse penis, and with wet washcloth or wipe and apply perineal cleanser. -retract the foreskin if applicable, hold the shaft of the penis with one hand and with the other hand begin cleansing the tip of the penis at the urethral meatus using a circular motion and working outward. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-replace foreskin if applicable and cleanse the shaft of the penis using downward strokes toward the scrotum. Use separate section of the washcloth or new disposable wipe with each stroke. Cleanse the scrotum using a clean portion of the washcloth, new washcloth, or new disposable wipe with each stroke. -remove gloves and discard then perform hand hygiene For females: -wet the washcloth or wipe and apply perineal cleanser. -separate the resident's labia with one hand, cleanse the perineum with the other hand by wiping from the front to the back. -clean the urethral meatus and vaginal orifice using a clean portion of the washcloth or a new disposable wipe with each stroke. -pat dry. Additional Considerations: the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning clean gloves and immediately after removing gloves. A record review of the facility policy Hand Hygiene dated May 2024 revealed all staff were to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene was to be performed when indicated, using the proper technique consistent with accepted standards of practice: -when hands were visibly soiled. -between resident contacts. -after handling contaminated objects. -before applying and after removing PPE including gloves. -before and after handling medications. -before and after handling clean or soiled dressings, linens, etc. -before performing resident care procedures. -after handling items potentially contaminated with blood, body fluids, secretions, and excretions. -when during personal care, moving from a contaminated body site to a clean body site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Cleaning and Disinfection of Resident-Care Equipment Policy dated 2/2024 revealed resident care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment can be a source of indirect transmission of pathogens. Reuseable resident care equipment was to be cleaned and disinfected in accordance with current infection control recommendations to break the chair of infection. The following procedure was identified: -each user was responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. -staff were to wear gloves when cleaning/disinfecting equipment. -use only EPA-registered disinfectant with kill claims for the common organisms found in the facility. If the equipment was exposed to residents on Transmission Based Precautions (TBP) staff were to verify the disinfectants were registered for use with the relevant organism. -verify the disinfectant was compatible with the equipment. -follow manufacturer's directions/recommendations for cleaning equipment. A. A record review of Resident 23's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 3/12/25 revealed the resident was admitted [DATE] with diagnoses of cancer, atrial fibrillation, dementia, and malnutrition. The following was assessed regarding Resident 23: -short and long-term memory loss with severely impaired decision-making skills. -required staff assistance with toileting hygiene, showering/bathing, dressing, personal hygiene, bed mobility and transfers. -frequently incontinent of bowel and bladder. During an observation of cares on 5/1/25 at 8:30 AM, Nurse Aide (NA)-D and NA-E entered Resident 23's room, who remained in bed. Without washing hands or performing hand hygiene, staff placed on clean gloves and gowns. The resident wore only a disposable urinary incontinence brief which was visibly soiled with urine. NA-D proceeded to remove the incontinence brief, and identified the resident was also incontinent of feces. NA-D used pre-moistened cleansing cloths to remove the feces from the resident's buttocks and removed soiled gloves but failed to perform hand hygiene before placing on clean gloves. NA-D placed a clean urinary incontinence brief on the resident without performing perineal cares to the resident's external genitalia despite the resident's urinary incontinence. The resident was then assisted to the side of the resident's bed and was transferred with the mechanical sit-to-stand lift (a mobile lift that allows for patient transfers from a seated position to a standing position. This lift is designed to support only the upper body of the resident and requires the resident to have some weight-bearing capability) to the resident's wheelchair. Staff then propelled the mechanical lift out of the resident's room and positioned in the corridor. Staff failed to clean/disinfect the lift after use for Resident 23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/25 at 9:30 AM, NA-E and NA-D confirmed the following: -hand hygiene should have been completed when entering the resident's room, before placing on clean gloves and when removing soiled gloves. -staff failed to provide complete perineal hygiene despite the resident's bowel and bladder incontinence. -staff failed to clean the mechanical lift after the resident was transferred out of bed and it should have been cleaned/disinfected before the staff placed in the corridor for use with another resident. B. A record review of Resident 31's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of previous stroke, high blood pressure, hemiplegia (paralysis on 1 side of the body), seizure disorder, and depression. The following was assessed for Resident 31: -cognitively intact. -depending on staff for assist with toileting hygiene, showering/bathing, dressing, transfers, and bed mobility. -occasionally incontinent of urine. During an observation on 5/1/25 at 11:01 AM, Resident 31 was transferred from a bedside commode to a wheelchair by NA-F and NA-D with use of the mechanical sit-to-stand lift. The staff then positioned the lift in the corridor outside of the resident's room. Staff failed to cleanse/disinfect the lift before exiting the resident's room. During an interview on 5/1/25 at 10:45 AM, NA-D and NA-F confirmed they did not clean/sanitize the sit-to-stand mechanical lift after use for Resident 31 and before use for subsequent residents. In addition, staff confirmed the lift should have been cleaned/disinfected between resident uses. C. A record review of Resident 34's MDS dated [DATE] revealed the resident had diagnoses of Alzheimer's disease, dementia, anxiety and depression. The following was assessed for Resident 34: -cognition was severely impaired. -depending on staff for assistance with transfers and bed mobility. During an observation on 5/1/25 at 10:10 AM, Resident 34 was transferred from a wheelchair to the bed by NA-F and NA-G with the use of the mechanical full body lift. NA-G removed the mechanical lift from the room and positioned the lift in the hall outside of Resident 34's room. Staff failed to cleanse/disinfect the mechanical lift before exiting the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/1/25 at 11:30 AM, NA-G confirmed that the mechanical lift did not get cleansed/disinfected after use for Resident 34 and before use on subsequent residents. NA-G confirmed that the mechanical lift should have been cleansed/disinfected before exiting the room. D. A record review of Resident 40's MDS dated [DATE] revealed the resident had a diagnosis of dementia. The following was assessed for Resident 40: -cognition was severely impaired. -dependent on staff for assistance with bed mobility and transfers. During an observation on 5/1/25 at 10:50 AM, Resident 40 was transferred from a wheelchair to the bed by NA-F and NA-G with the use of the mechanical full body lift. NA-F removed the mechanical lift from the room and positioned the lift in an empty room outside of Resident 40's room. Staff failed to cleanse/disinfect the mechanical lift before exiting the room. During an interview on 5/1/25 at 11:45 AM, NA-F confirmed that the mechanical lift did not get cleansed/disinfected after use for Resident 40 and before use on subsequent residents. NA-F confirmed that the mechanical lift should have been cleansed/disinfected before exiting the room. 45739 E. A record review of the facility policy Enhanced Barrier Precautions (EBP) dated September 2024 revealed the following: -an order would be obtained for enhanced barrier precautions wound be obtained for residents with wounds or an indwelling medical device (urinary catheters/feeding tubes) or if they had an infection or colonization with a Center's for Disease Control (CDC) targeted Multi-Drug-Resistant Organism (MDRO) when contact precautions did not otherwise apply, -gloves and gowns would be available near or outside the resident room, -Personal Protective Equipment (PPE) for EBP was only necessary when performing high-contact care activities, -PPE would be discarded prior to exit of the room, -high-contact resident care activities included: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care, -MDRO's targeted by the CDC included Methicillin-Resistant-Staphylococcus Aureus (MRSA), and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-EBP wound be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. A record review of Resident 18's MDS dated [DATE] revealed the resident was cognitively intact, required assistance with dressing and transfers, and had diagnoses of high blood pressure, a history of MDRO, and depression. A record review of Resident 18's Care Plan, last revised 4/15/25 revealed the resident required assistance with activities of daily living and was on EBP for having a history of MSRA. Observation on 5/1/25 at 7:45 AM there was a sign located on Resident 18's door to the room indicating that the resident required PPE while assisting the resident. During an observation on 5/6/25 at 9:15 AM, Medication Aide (MA)-L was pushing Resident 18 in the wheelchair to the resident's room. The PPE caddy was located on the back of the resident's door to the room, and there were trash cans to dispose of the PPE after removal and before exiting the resident room near the door. No hand hygiene was observed to be performed. MA-L applied a gait belt to the resident once in the resident room and the resident self-propelled the wheelchair into the bathroom. MA-L, while not wearing any PPE, assisted the resident to standing. The resident grabbed onto the grab bar and pivoted to be positioned over the toilet. MA-L applied gloves, but no gown, then pulled the resident's underwear and pants down. The resident sat on the toilet. The resident had a bowel movement and when the resident was finished, MA-L still wearing the same pair of gloves and no gown, provided perineal cares using pre-moistened wet wipes. While continuing to wear the same pair of soiled gloves with no gown, MA-L pulled the residents underwear and pants up. MA-L assisted the resident to transfer back to the wheelchair by holding onto the gait belt. MA-L continued to wear the soiled gloves and removed the resident's gait belt and put it into a bag on the back of the wheelchair. MA-L removed their gloves and did not perform hand hygiene and assisted the resident to back out of the bathroom. MA-L then assisted the resident out of the resident room towards the facility door. No hand hygiene was observed to be completed. Interview with MA-L on 5/6/25 at 9:20 AM confirmed PPE was not utilized during high-contact cares and that hand hygiene was not completed at appropriate intervals. F. A record review of Resident 5's MDS dated [DATE] revealed the resident had a serious mental illness, was cognitively intact, was independent with activities of daily living, had an indwelling catheter, had diagnoses of renal disease, neurogenic bladder (a condition where a problem in the brain, spinal cord, or peripheral nerves disrupts the signals that control bladder function and can lead to difficulty emptying the bladder or holding urine), diabetes, anxiety, bipolar disorder, and schizophrenia, had 2 or more falls without injuries and 1 with a major injury, and had a feeding tube. A record review of Resident 5's Care Plan, last revised 4/29/25 revealed the resident had an indwelling catheter, a feeding tube, required assistance with transfers and had EBP in place. Observation on 4/30/25 at 9:40 AM there was a sign located on Resident 18's door to the room indicating that the resident required PPE while assisting the resident. (continued on next page)

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	05/06/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation 5/1/25 at 11:10 AM Licensed Practical Nurse (LPN)-H had the resident's medications and water to flush the feeding tube in a basin that LPN-H had placed at the foot of Resident 5's bed on top of the bedspread. The Registered Nurse (RN)-C placed a handful of gloves onto the foot of the bed near the basin. LPN-H and RN-C, while not wearing any PPE, assisted to move Resident 18 up in bed. LPN-H while continuing to not wear any PPE or gloves, assisted the resident to pull the feeding tube out from underneath their clothing. LPN-H performed hand hygiene and applied a gown without tying the gown and applied gloves. LPN-H administered the resident's medications, feeding and water flushes without concerns. When completed, LPN-H removed their gloves and performed hand hygiene. While continuing to wear the gown, LPN-H grabbed the basin off the resident's bed and exited the room then went to the medication cart and put the basin on top of the medication cart without using a barrier. LPN-H while continuing to wear the gown, obtained medication cards from the medication cart and placed them back into the cart. LPN-H then walked back to the resident's room and removed the gown and placed it into the appropriate receptacle and performed hand hygiene. LPN-H then walked back to the medication cart, grabbed the basin without cleaning the medication cart and went into the medication room. Interview with LPN-H on 5/1/25 at 11:20 AM confirmed PPE was not doffed when exiting Resident 5's room and a barrier should have been placed before placing the basin on the medication cart. Observation on 5/5/25 at 2:10 PM MA-J entered Resident 5's room and applied gloves. MA-J obtained a graduate, an alcohol swab and 2 paper towels from the resident's bathroom. MA-J placed the paper towels down on the floor and placed the graduate on top. MA-J continuing to only wear gloves, emptied the resident's catheter bag into the graduate. MA-J clamped and then cleaned the spout of the drainage bag with alcohol. MA-J picked up the graduate and the barrier and went into the resident's bathroom. MA-J emptied the graduate into the toilet and rinsed the graduate with water before placing it on the back of the toilet. MA-J threw the paper towels away, removed their gloves and performed hand hygiene. An interview on 5/5/25 at 2:10 PM with MA-J revealed MA-J stating that PPE was not needed to drain the resident's catheter. Interview on 5/6/25 at 1:00 PM with the DON and the Administrator confirmed PPE should be worn with high-contact cares and hand hygiene should be completed after removing gloves and when exiting the resident room. 51391

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	05/06/2025

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 42360 Licensure Reference Number 175 NAC 12-006.18 Based on record review and interview; the facility failed to implement an Antibiotic Stewardship (coordinated plan aimed at optimizing antibiotic use to prevent resistance, unnecessary exposure, and adverse outcomes) Plan to identify if the facility use of antibiotic was within the criteria defined to prevent the overuse or unnecessary use, of antibiotics and/or to prevent potential adverse outcomes. This had the potential to affect all residents residing within the facility. The facility census was 45. Findings are: A record review of the facility Antibiotic Prescribing Practices dated 10/2019 revealed that antibiotic use protocols, including prescribing practices, were implemented as part of the facilities Antibiotic Stewardship Program for the purpose of optimizing treatment of infections and reducing adverse effects associated with antibiotic use. A record review of the facility Antibiotic Stewardship Policy dated 3/2023 revealed the facility implemented an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The program's purpose was to optimize the treatment of infections while reducing adverse events associated with antibiotic use. The facility Infection Preventionist led the Antibiotic Stewardship Program with administrative support, coordinated antibiotic stewardship activities, maintained documentation and served as a staff resource. The program utilized protocols and a system to monitor antibiotic use, including completing infection screening evaluations, laboratory testing in accordance with standard of practice, and monitoring antibiotic use including data collection forms, process, and outcome measures. A record review of the facility's Infection Surveillance dated May 2024 through May 2025 revealed no culture (identifying present bacteria for analysis) results, no pathogen (an organism causing disease) data, and no review to determine if antibiotic use/prescribing criteria had been met. During an interview on 5/1/25 at 2:43 PM the Infection Preventionist (IP) confirmed the facility had not identified, tracked, or trended the organisms identified through laboratory testing to determine if antibiotic use was appropriate or meeting the identified treatment criteria for antibiotic use.