

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/08/2026
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of O'Neill		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 North Harrison Street O' Neill, NE 68763	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 (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 0684 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Some	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 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), (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Some	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 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: (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Some	-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. -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. (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Some	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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number 175 NAC 12-006.09(J)(i)(1)Based on observation, record review and interview; the facility failed to implement nutrition measures to prevent ongoing weight loss for Residents 1 and 14. The sample size was 3 and the facility census was 45. Findings are:A. Review of the facility policy Weight and Height Measurement last updated 10/25/21 revealed if a resident gained or lost three or more pounds the resident needed to be reweighed with nurse supervision. If the nurse verified the weight change, then the nurse would notify the physician and nursing leadership. B. Review of Resident 14's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 3/12/26 revealed the resident was admitted on [DATE]; diagnoses included Non-Traumatic Brain Dysfunction, Schizophrenia (a serious mental health condition that affects how people think, feel and behave), Disorder, and Stroke; had severe cognitive impairment; required assistance with setup for eating, and was dependent with oral hygiene, toileting, dressing, and personal hygiene; consumed a mechanically altered diet; and had a weight loss and was not a prescribed weight-loss regimen. Review of Resident 14's Care Plan last revised 6/4/26 revealed the resident had a severe cognitive impairment due to a traumatic brain injury, had behaviors of wandering and staff were to cue the resident to places such as the dining room; was dependent on staff for dressing, grooming, oral cares, and toileting; required set-up assistance with eating; received a mechanical soft diet with thickened liquids and had the potential for altered nutrition and was to receive supplements per the physician orders. Review of the facility form Weights and Vital Summary dated 6/4/26 revealed Resident 14's weights: -12/2/25 (day of admission) 142.3 pounds (lbs); -12/23/25 142.3lbs.; -1/22/26 134.4lbs. (loss of 7.9lbs or 5.55% in 30 days); Record review of Resident 14's practitioners ordered, progress notes, faxes, Registered Dietician assessments revealed there was no indications Resident 14's significant weight loss had been evaluated and interventions implemented to prevent further weight loss. Further review of the facility form Weights and Vital Summary dated 6/4/26 revealed Resident 14's weights: -2/24/26 130.6lbs.; -3/25/26 126.2 lbs. (loss of 16.1lbs or 11.31% in 92 days); -4/22/26 122.4 lbs.; (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-5/13/26 119.8lbs -5/27/26 (176 days after admission) 120.4lbs (loss of 21.9lbs or 15.39% since admission). Review of Resident 14's Mini Nutritional assessment dated [DATE] revealed a score of 7 which indicated the resident was malnourished. There were no nutritional interventions documented in the assessment. Review of the facility form RD (Registered Dietician) report dated 3/11/26 revealed Resident 14 had a weight loss of 5.4% at 30 days and 12.8% at 90 days after admission with recommendations to start Ensure 4 ounces (oz) every day and the resident's physician was updated through a fax. Review of the RD reports until 6/4/26 revealed no further documentation or follow up for Resident 14's weight loss. There was no documentation that the effectiveness of the Magic Cup had been evaluated. Review of Resident 14's Medication Administration Record (MAR's) for March, April, and May in 2026 revealed an order for a Magic Cup twice a day at noon and 7:00 PM with a start date of 1/31/26. There was no documentation to show the resident was to receive an Ensure supplement. Review of Resident 14's Progress Notes from March 1, 2026 through June 4, 2026 revealed an entry on 3/12/26 at 11:35 AM by the RD that included a recommendation for Ensure 4 oz daily. There was no further documentation by the RD, Dietary Manager, or the Nursing Department related to the ongoing weight loss, Ensure supplementation, or an evaluation of the effect of the Magic Cup supplement. The following observations were made regarding Resident 14: -On 6/1/26 at 12:05 PM the resident was in the sitting room in the front lobby next to the dining room sitting in a recliner. The resident left the area at 12:10 PM. The resident re-entered the dining room at 12:20 PM and went directly to their seat. The resident was served lunch right away and the resident ate most of the meal and drank 1/2 of their thickened juice. There was no evidence that a magic cup or ensure was given to the resident. At 12:25 PM the resident left the dining room again and at 12:30 PM a staff member re-directed the resident back to the dining room table. The resident left the dining room as soon as the staff member walked away. -On 6/1/26 at 12:35 PM The resident was in the resident room resting in the resident bed. There was no evidence of Ensure or a Magic Cup in the resident's room. -On 6/2/26 from 8:05 AM to 8:25 AM The resident was wandering in and out of the dining room, to their room and back to the dining room. Numerous staff redirected the resident back to the dining room and encouraged the resident to eat. The resident did eat all of the breakfast meal during this time period. There were no observations of Ensure or a Magic Cup to have been served to the resident. -On 6/2/26 at 8:35 AM The resident was in their room lying in the resident bed. There were no observations of a Magic Cup or Ensure in the resident room. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	identified Resident 1 was receiving dialysis (treatment which removes waste, extra fluids, and toxins from the blood when the kidneys are not working properly); required assistance with eating/drinking; weight was 143 lbs. and the resident had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. The resident was not on a prescribed weight-loss regimen. Review of Resident 1's current Care Plan last revised on 1/14/26 revealed the resident was at risk for altered nutrition related to diagnosis of Myasthenia Gravis (chronic disorder which affects communication between nerves and muscles leading to muscle weakness and difficulty swallowing), chronic kidney disease/end stage renal disease and diabetes. The following interventions were identified: -1/14/26 initiated fortified food/drink at meals for additional calories. -alert the RD of any changes to skin integrity, significant health changes or decrease in appetite/intakes. -monitor for changes in acceptance of diet and meals. -monitor weight as ordered. Review of the Weights and Vital Summary Form for Resident 1 revealed the following weights: -12/1/25 156 lbs. -1/5/26 144 lbs. (down 12 lbs. or a loss of 8% in 1 month). -1/22/26 140 lbs. (down an additional 4 lbs. in 17 days). Review of a Provider Communication Form from the RD to the resident's Primary Care Provider (PCP) dated 1/28/26 revealed a new recommendation for Glucerna (nutritional supplement with added protein and calories) to be given twice a day until the resident's weight stabilized. The form also indicated the resident was already receiving fortified food/drinks at meals. Review of the residents' MAR dated 2/2026 revealed the resident was to receive the Glucerna at 10:00 AM and at 2:00 PM for weight loss. Further review of the MAR revealed at 10:00 AM the resident refused or was out of the facility and was not offered the supplement 26 out of 28 days. The resident was documented as receiving the supplement on 2/7 and on 2/19 but there was no documentation as to how much supplement was offered and how much the resident had consumed. Review of the documentation for the 2:00 PM administration revealed the resident did not receive or was not available for administration of the supplement 26 out of 28 days. The supplement was provided on 2/6 and on 2/19 but there was no documentation as to how much supplement was offered and how much the resident had consumed. Review of Consulting Dietician Activity Reports for 2/2026 revealed the RD was at the facility on 2/2/26, 2/11/26, and on 2/25/26. Further review revealed no evidence the RD evaluated Resident 1's (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	weight loss or the effectiveness of the weight loss interventions developed. Review of the residents' MAR for 3/2026 revealed at 10:00 AM the resident refused or was unavailable for administration of the nutritional supplement on 23 out of 31 days. The resident received the supplement on 3/8, 3/13, 3/14, 3/15, 3/27, 3/28, 3/29 and on 3/31 but there is no documentation as to how much of the supplement the resident received/consumed. Documentation of the 2:00 PM administration revealed the resident refused or was not available on 23 out of 31 days. The resident received the supplement on 3/8, 3/13, 3/14, 3/15, 3/27, 3/28, 3/29 and on 3/31 but there is no documentation as to how much of the supplement the resident received/consumed. Review of Resident 1's medical record revealed no evidence the resident was assessed by the RD from 3/1/26 to 3/20/26. Review of a Progress Note by the RD on 4/2/26 at 3:43 PM revealed the resident's current body weight was 143 lbs. and the resident had a significant weight loss of 12.3% at 180 days. The RD identified the resident was routinely refusing the Glucerna which was to be provided twice a day. A new recommendation was made to discontinue the Glucerna and to start nutritional supplements Boost Breeze or Ensure Clear 240 cc twice a day. Review of the residents' MAR dated 4/2026 revealed the resident continued to receive the Glucerna nutritional supplement. At 10:00 AM and at 2:00 PM the resident was unavailable or the resident refused the nutritional supplement on 29 out of 30 days. The resident accepted the supplement at 10:00 AM and at 2:00 PM on 4/24 but there is no documentation as to how much of the supplement the resident received/consumed. Review of the residents' MAR dated 5/2026 revealed the resident continued to receive the Glucerna twice a day. The resident refused or was not available at 10:00 AM on 28 out of 31 days. The resident received the supplement on 5/8, 5/16 and on 5/22 but there was no documentation as to the amount of the nutritional supplement the resident was provided and/or consumed. In addition, the resident refused or was not available at 2:00 PM for 28 out of 31 days. The resident received the supplement on 5/8, 5/16 and on 5/21 but there was no documentation as to the amount of the nutritional supplement the resident was provided and/or consumed. Review of the resident's medical record from 4/3/26 to 6/2/26 revealed no evidence the RD assessed the resident's ongoing weight loss or that the RD's recommendation on 4/2/26 to discontinue the Glucerna and to start a different nutritional supplement was ever implemented. Review of Resident 1's Weights and Vitals Summary Form revealed the resident's weight on 6/1/26 was 148 lbs. Review of a list dated 6/4/26 of residents who were to receive fortified food/fluids revealed no evidence Resident 1 was identified on the list. During an interview on 6/2/26 at 2:42 PM, the Nurse Consultant and the Administrator indicated the RD was to assess residents with a weight loss on a monthly basis and ensure recommendations were (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	followed and that they were effective. In addition, they indicated it was difficult to determine the resident's weight status due to the resident receiving dialysis three times a week. Interview with the DM on 6/4/26 at 10:15 AM confirmed the following regarding Resident 1: -a history of ongoing weight loss. -the RD had made a recommendation on 1/28/26 to start the resident on Glucerna twice a day and for the resident to receive fortified foods/drinks. -refused the supplement or did not receive as the resident was not available on multiple occasions throughout 2/2026, and 3/2026. -no evidence the RD assessed the resident from 1/28/26 to 4/2/26. -4/2/26 the RD recommended the Glucerna be discontinued due to multiple refusals and to start Boost Breeze or Ensure Clear. -there was no evidence the RD's recommendations were followed and the resident continued to be offered the Glucerna. -the RD had not assessed the resident since 4/2/26. -there was no evidence the facility had been providing the resident with fortified food/drinks.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Licensure Reference Number 175 NAC 12-006.02(I)Based on record review and interview; the facility failed to ensure the Quality Assurance Performance Improvement (QAPI) plan was effective in addressing recently identified deficient practice and preventing repeat deficient practice with similar concerns. This had the potential to affect all facility residents. The facility census was 45. Findings are: Review of the facility policy Quality Assurance and Performance Improvement Plan (QAPI)/ and Assurance (QAA) dated 5/23/23 revealed the facility developed a process for conducting quality activity and identification and correction of deficiencies as well as opportunities for improvement through continuous attention to quality of care, quality of life, and resident safety. -Principles of the system included outcomes of quality of life and quality of care, accountability for professional performance and practice, identification of process and system gaps, identification of root cause of concerns, timely and clinically sounds services, and a culture that supported performance accountability. -The program encompassed all segments of care and services and aimed for safety and high quality with all clinical interventions, while emphasizing resident autonomy and choices. -Opportunities for improvement identification included but was not limited to the use of regulatory requirements to define and measure goals.-The facility Administrator and DON were designated as the governing body of the QAPI/QAA program and developed a culture that involved staff, resident, and family input, assured adequate resources, developed and completed training as needed, created an atmosphere of comfort that promoted comfort in identifying and reporting problems and opportunities for improvement. -Opportunities for improvement were continuously identified and addressed through monitoring of survey results, complaint investigations, self-reports, identified clinical care concerns, staff competency, errors related to medications, hospitalizations, resident satisfaction, quality measures, and adverse events. -The facility goal was to provide the highest practicable resident services, identification of strengths and weaknesses through consistent monitoring and evaluations. Evaluations were completed with a goal of addressing and improving quality of services provided. Review of the most recent standard survey conducted for the facility dated 5/6/25 revealed citations for resident rights, changes in resident conditions, restraints (chemical/psychotropic medications), quality of care, medication storage, infection control and antibiotic stewardship. During an interview on 6/4/26 at 10:00 AM Registered Nurse (RN)-K who routinely attends the facility QAPI meetings, confirmed the QAPI team discussed previous survey citations through the Plan of Correction (POC) dates and if further concerns were identified, however RN-K was unsure if those concerns had continued to be monitored. During an interview on 6/8/26 at 12:20 PM the facility Administrator confirmed the facility had not employed a long-range QAPI process to ensure that deficient practices identified at the last standard survey on 5/6/25 continued to be monitored through the facility QAPI program. The Administrator further confirmed that concerns related to the previously cited deficient practice (resident rights concerns for comprehensive informed consent for psychotropic medications, quality of care concerns, concerns with gradual dose reductions or documented contraindications for reductions of psychotropic medications/chemical restraints, drug storage concerns, infection control concerns, and antibiotic stewardship) concerns remained.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E)Based on record review and interview; the facility failed to obtain the required comprehensive (including an appropriate diagnosis for use, potential affects, adverse effects and alternate treatment options) informed consent for the use of psychotropic (substance that affects how the brain works, altering a person's mood, thoughts, feelings, or behavior) medications for Residents 2, 3, 4, 14, and 29. The sample size was 5 and the facility census was 45. Findings are: A. Review of the facility Resident's Rights undated policy revealed the facility residents had the right to be fully informed, the right to complain, the right to participate in one's own care, the right to make independent choices, the right to privacy and confidentiality, the right to transfer and discharge, the right to respect, dignity, and freedom, and the right to visits. B. Review of the facility policy Use of Psychotropic Medication(s) with a revision date of 4/21/25 revealed the following: -The facility ensured residents only receive psychotropic medications when other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint. -Psychotropic medications were used only when a practitioner determined that the medication was appropriate to treat specific, diagnosed, and documented conditions and the medication was beneficial to the resident, as demonstrated by monitoring and documentation or the resident's response. -Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative were informed in advance of the risks and benefits or the proposed care, including any 'black box (warning indicating a particular medication may have severe reactions, the potential for preventable harm, and/or strict usage restrictions) warnings in advance, and treatment alternatives.-Resident had the opportunity to accept or decline the initiation or increase of a psychotropic medication. -The facility documented the resident or resident representative was informed of the risks and benefits, and other treatment options. C. Review of Resident 29's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated5/14/26 revealed the resident had taken antipsychotic and antidepressant medication. There were no documented behaviors. The resident had diagnoses including Alzheimer's dementia, anxiety, depression, and a psychotic disorder. Review of Resident 29's Care Plan dated 12/27/25 revealed the resident had a mood problem related to dementia, anxiety, delusions, and bipolar disorders. The resident took antidepressant and antipsychotic medications, and staff were to observe/document/report adverse effects. Review of Resident 29's Informed Consent for Psychopharmacological (scientific study of how medications and psychoactive drugs affect the mind, brain, and behavior) Medications dated 7/25/24 revealed the resident's current medications included Seroquel (antipsychotic medication), and Lexapro (antidepressant medication). However, there were no indications for what diagnoses or symptoms the resident was receiving the medication, no evidence of potential effects or adverse (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effects, and/or alternate non-pharmacological treatment options. During an interview on 6/4/26 at 2:00 PM the DON (Director of Nursing) confirmed the facility consents for use of psychotropic medications were not comprehensive and did not include the following: 1). for which symptoms and/or diagnosis/conditions the residents were being treated, 2). potential effects, 3). potential adverse effects, and/or 4). alternate non-pharmacological treatment options. 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, and depression. The following was assessed regarding the resident: -cognitively intact. -no behaviors exhibited. -received antipsychotic, antidepressant, anti-anxiety, and opioid medications. Review of Resident 4's undated Informed Consent for Psychopharmacological Medications revealed the resident's medications included Abilify (antipsychotic medication) 5 milligrams (mg) daily, Lexapro (antidepressant medication) 20 mg daily and Klonopin (used to treat anxiety) 0.25 mg twice a day. However, there were no indications for what diagnoses or symptoms the resident was receiving the medications, evidence of potential effects or adverse effects, and/or alternate non-pharmacological treatment options. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed the resident received Abilify 1 mg daily with a start date of 5/31/25, Klonopin 0.25 mg twice a day with a start date of 4/3/24 and Lexapro 20 mg daily with a start date of 3/26/20. During an interview on 6/3/26 at 3:00 PM, the Registered Nurse (RN) Consultant confirmed that Resident 4's Informed Consent for Psychopharmacological Medications was undated and did not correctly identify the current dosages of the medications the resident was receiving. In addition, the form did not include for which symptoms and/or diagnosis/conditions the resident was being treated, potential effects, potential adverse effects, and/or alternate treatment options. E. Review of Resident 2's MDS dated [DATE] revealed the resident was admitted [DATE]; was cognitively intact; had delusional (having false or unrealistic beliefs or opinions) behaviors; diagnoses included: Non-Traumatic Brain Dysfunction, Anxiety, Bipolar Disorder, and Schizophrenia (a serious mental health condition that affects how people think, feel and behave); and received Antipsychotic, Antianxiety and Antidepressant medications. Review of Resident 2's Care Plan with a revision date of 3/20/26 revealed the resident had a mood disorder and received antidepressant, antianxiety, and antipsychotic medications related to schizophrenia, anxiety disorder, and bipolar disorder. Staff were to monitor, document and report (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adverse effects. Review of the facility forms Informed Consent for Psychopharmacological Medications dated 10/31/24 revealed the resident's current medications included Haldol (antipsychotic medication), Seroquel, Venlafaxine (antidepressant medication, Klonopin (antianxiety medication) and Ativan (antianxiety medication). There was no evidence of documentation for which diagnoses the medications were given, potential side effects or alternative non-pharmacological treatment options. Interview on 6/4/26 at 12:30 PM with the Registered Nurse (RN) Consultant confirmed the psychotropic medication consents did not have symptoms, behaviors or diagnoses included for which the facility was administering the medications, potential side effects and/or alternative non-pharmacological treatment options. F. Review of Resident 3's MDS dated [DATE] revealed the resident was admitted [DATE]; was cognitively intact; did not exhibit any behaviors; was independent with dressing, toileting and hygiene; had diagnoses of Dementia, Anxiety, Psychotic Disorder, Schizophrenia, and Post-Traumatic Stress Disorder; and received antipsychotic, antianxiety and antidepressant medications. Review of Resident 3's Care Plan last revised 6/1/26 revealed the resident had a mood disorder and received psychotropic medications related to anxiety, delusional disorder and schizophrenia. Staff were to observe and report any adverse side effects. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed the resident received the following psychotropic medications: -Celexa (an antidepressant medication); -Lorazepam (an antianxiety medication); and -Loxapine (an antipsychotic medication). Review of the facility form Informed Consent Psychopharmacological Medications dated 3/24/25 revealed no evidence of documentation for which diagnoses the medications were given, potential side effects or alternative non-pharmacological treatment options. G. Review of Resident 14's MDS dated [DATE] revealed the resident was admitted [DATE]; had severe cognitive impairment; had behaviors of rejection of care, wandering, and other behaviors not directed towards others; required staff assistance with oral hygiene, toileting, and dressing; diagnoses included: Non-Traumatic Brain Dysfunction, Schizophrenia, and Stroke; and received Antipsychotic, Antianxiety, and Antidepressant medications. Review of Resident 14's Care Plan last revised 6/4/26 revealed the resident had a mood disorder and received psychotropic drugs related to schizophrenia, depression and anxiety. Staff were to observe, document and report adverse effects. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed the resident received the following psychotropic medications: -Buspirone (anti-anxiety) with a start date of 12/2/25; -Mirtazapine (anti-depressant) with a start date of 2/27/26; and -Olanzapine (anti-psychotic) with a start date of 2/27/26. Review of Resident 14's Medical Record revealed no evidence the facility obtained informed consent for psychotropic medications prior to administration. Interview on 6/4/26 at 12:30 PM with the RN Consultant confirmed staff were to obtain informed consent prior to the administration of antipsychotic medications. Further interview confirmed the facility did not have any evidence of documentation that informed consent was obtained prior to the administration of antipsychotic medications for Resident 14.		

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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. Licensure Reference Number 175 NAC 12-006.12 (D)(i)Based on observation, record review and interview; the facility failed to provide safe storage of drugs as: 1) Medications were left on top of the medication cart and unattended, 2) The medication cart was left unlocked with no staff in attendance. This had the potential to affect any mobile resident passing by the medication cart. The facility census was 45.Finding are:A. Review of the facility policy Medication Storage in the Facility with a revised date 11/18 revealed the following:-Medication and biologicals were stored safely, securely, and properly. The medication supply would be accessible only to licensed facility personnel, pharmacy personnel or facility personnel lawfully authorized to administer medications.-Medication rooms, carts, and medication supplies were locked when not attended by people with authorized access. B. An observation on 6/3/26 at 8:00 AM revealed the following:-The medication cart was parked in the hall by the activity room door unlocked and unsupervised with residents ambulating or pushing self in a wheelchair by the medication cart. The following medications were on top of the medication cart:-Preservision (eye vitamin) pills (18 pills).-Iron pills (8 pills).-Multivitamin tablets (15 tablets).-Folic Acid (treats anemia) pills (10 pills).-Senna (laxative) tablets (18 tablets).-Colace (stool softener) capsules (24 capsules).-Aleve (relieves minor aches and pains) (11 pills).-Loratadine (antihistamine) 10 milligram (mg) tablets (5 tablets).-Fish Oil (supports heart health) 500 mg capsules (21 capsules).-Tylenol 325 mg tablets (50 tablets).-Tylenol 650 mg tablets (38 tablets).-Half a bottle of Miralax (laxative).-Acetaminophen 500 mg tablets (42 tablets). -At 8:15 AM (the medication cart was unlocked, unsupervised with medications on top of the cart for 15 minutes) Registered Nurse (RN)-K walked up to the cart to administer medications to residents.-At 8:45 AM RN-K confirmed that when completing the medication pass RN-K would keep the stock medications on top of the medication cart. An interview with RN-K completed on 6/3/26 at 12:40 PM confirmed the following:1) Medications were to be locked when not in the view of a nurse.2) The medication cart was to be locked when not in the view of the nurse administering medications.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 006.11 (E)Based on observation, record review and interview; the facility staff failed to store, prepare and serve food in a manner to prevent the potential for cross contamination and/or food borne illness. These practices had the potential to affect all residents who were served meals from the kitchen. The facility census was 45.Findings are:A. Review of the facility policy Food Storage reviewed 2021 revealed the following:-Leftover food must be used within 7 days or discarded per the 2017 Federal Food Code. -All refrigerated foods would be covered, labeled, dated and routinely monitored to ensure that leftovers would be consumed by their safe use by dates or discarded. Review of the facility policy Cleaning and Sanitation of Dining and Food Service Areas reviewed 2021 revealed the following:-The food and nutrition service staff would maintain the cleanliness and sanitation of the dining and food service areas through compliance with written and comprehensive cleaning schedule.-A cleaning schedule would be posted for all cleaning tasks and staff would initial the tasks when completed. Review of the undated facility Daily Cleaning Checklist revealed staff were to clean the exterior and handles of the walk-in cooler, walk-in freezer and drink refrigerator. Discard expired items. Review of the undated facility Weekly Cleaning Checklist revealed staff were to wipe off shelves weekly. Review of the 2022 version of the Food Code revealed the following:2-402.11 Food employees should wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair that were designed and worn to effectively keep hair from contacting exposed food, clean equipment, utensils, linens and unwrapped single service and single use articles.4-601.11 Nonfood contact surfaces equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris. B. An observation conducted during the initial kitchen tour on 6/1/26 from 8:15 AM to 9:15 AM revealed the following prepared outdated food items in the walk-in refrigerator:-A container of chicken salad dated 5/16/26, (16 days between 5/16/26 to 6/1/26).-A container of tuna salad dated 5/19/26, (13 days between 5/19/26 to 6/1/26).-A container of lemon meringue pudding dated 5/20/26, (12 days between 5/20/26 to 6/1/26).-A container of banana pudding dated 5/24/26, (8 days between 5/24/26 to 6/1/26).- At 8:15 AM the Dietary Manager (DM) was in the kitchen preparing sandwiches for the noon meal and did not have a beard restraint on.-At 11:45 AM on 6/1/26 the window blind covering the window across from the grill area had a thick layer of brown particles covering the blinds. The window was open blowing air through the blind; hamburgers were being cooked on the grill area. The DM did not have a beard restraint on when preparing a lettuce salad.-At 12:20 PM a silver-colored wire shelf that was above an open loaf of white bread, an open container of 1) peanut butter, 2) lettuce and 3) tomatoes, was covered with a thick layer of brown particles. Observations completed during the follow-up kitchen sanitation tour on 6/2/26 from 8:05 AM to 8:30 AM revealed the following:-The DM did not have a beard restraint on when serving the breakfast meal.-A large trash can lid was leaning against clean pans. C. An interview on 6/1/26 at 9:30 AM with the DM confirmed that leftover foods were to be disposed of after 7 days of being prepared or opened. An interview with the DM on 6/1/26 at 1:30 PM confirmed that the kitchen staff had a daily, weekly and monthly cleaning list. The daily and weekly cleaning checklist had not been completed for March, April, May and June 2026. The window blinds and shelves should be cleaned weekly. An interview on 6/2/26 at 9:00 AM with the Administrator confirmed that dietary staff were to wear hair restraints including beard and mustache and the trash can lid should not be touching clean items.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09.18Based on observations, interview, and record review the facility failed to ensure the facility infection control program was implemented including the use of Enhanced Barrier Precautions ((EBP) -infection control measure in which the use of Personal Protective Equipment (PPE)-specialized gear, clothing, or barrier worn by individuals to protect themselves from hazards such as infection and prevent the spread of infection to others) and Hand Hygiene during the provision of care for Residents 1,4,2,7, and 12. The sample size was 12 and the facility census was 45. Findings are: A. Review of the facility policy Hand Hygiene dated 11/13/24 revealed the facility used proper hand-washing techniques to protect against the spread of infection. Cleaning hands reduced the spread of potentially deadly germs to the resident and reduced the risk of healthcare provider infection. Hand hygiene occurred multiple times during a single care episode following indications, before care or touching of a resident, before putting on and taking off gloves, after contact with body fluids or contaminated surfaces, when hands were visibly soiled, and before moving from a soiled body site to a clean site. B. Review of the facility policy Enhanced Barrier Precautions dated 11/13/24 revealed the policy of the facility was to implement EBP for the prevention of transmission of Multidrug-Resistant Organisms (MDRO's-organisms that over time have become resistant to medications/antibiotics/antifungals that previous were effective in killing that bacteria/fungi). EBP was an infection control intervention designed to reduce the transmission of MDRO's through targeted gown and glove use during high contact resident care. PPE use was followed for residents with chronic wounds, indwelling medical devices, or for those residents infected or colonized (bacteria that are present but not causing harm or illness) with a Center for Disease Control (CDC)-targeted MDRO's. High contact resident care activities included, dressing, bathing, transferring, providing hygiene, changing linens, toileting assistance, device care, and wound care. EBP were used for the duration of a resident's stay in the facility, or until resolution of the wound, or discontinuation of the device that placed the resident at increased risk. C. Review of Resident 12's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 4/23/26 revealed the resident's bladder function was not assessed due to the presence of an indwelling bladder catheter. Review of Resident 12's Care plan dated 2/4/26 revealed the resident had an indwelling urinary catheter for a diagnosis of urinary retention and EBP was to be used during care of the catheter. During an observation of the provision of care for Resident 12 on 6/2/26 at 1:00 AM Nurse Aid (NA)-H and Registered Nurse (RN)-I (Hospice provider) donned gloves but no gowns and then repositioned the resident from the left side to the right side, then checked the resident's skin under an incontinence brief and noted an irregular rash that appeared to be healing on the right hip and thigh area that (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extended upward toward the resident's mid-lower back. No open areas were observed. The resident was also noted to have a urinary catheter with a drainage bag secured to the resident's left leg. A sign on the residents' door indicated the resident was to be on Enhanced Barrier Precautions. During an interview on 6/2/2026 11:10 AM Interview with Nurse Aide (NA)-G confirmed the NA was aware Resident 12 was on EBP which included the use of gowns and gloves during high contact care episodes including repositioning the resident in bed, however NA-G confirmed not wearing a gown as required. Further interview confirmed despite being aware of EBP the NA rarely had time to put on a gown and had not been monitored by supervising staff to ensure gown use was being implemented. During an interview on 6/4/26 at 2:30 PM Register Nurse (RN)-K confirmed staff were to wear both gown and gloves during catheter and other high contact care provision for Resident 12. D. Review of Resident 2's MDS dated [DATE] revealed the resident was admitted [DATE]; was cognitively intact; was independent with oral hygiene, dressing, and toileting; diagnoses included renal disease, anemia, diabetes, anxiety, bipolar disorder and schizophrenia; received 51% or more of nutrition by feeding tube and received 501 cubic centimeters (cc) of fluids by feeding tube. Review of Resident 2's Care Plan last revised 3/20/26 revealed the resident required a feeding tube for nutrition and hydration related to esophageal strictures; the resident was dependent on staff for the tube feedings, medications, and water flushes; and the resident was on enhanced barrier precautions and staff were to use PPE during cares with the feeding tube. The following observations were made regarding Resident 2: -On 6/1/26 at 10:30 AM The resident was resting in bed with their eyes closed. There was an EBP sign on the residents door, a caddy with PPE was on the residents bathroom door and trash cans to place used PPE in were next to the door on the inside of the room. -On 6/2/26 at 8:30 AM The EBP sign remained on the resident's door, caddy with supplies and trash cans remained inside of the resident's room. -On 6/3/26 at 8:00 AM The EBP sign was noted on the resident's door to the room, a caddy with PPE supplies and the trash cans remained in the resident's room. -On 6/3/26 at 12:00 PM with Licensed Practical Nurse (LPN)-O revealed LPN-O performed hand hygiene, obtained supplies and entered Resident 2's room. LPN-O placed a barrier on the resident's bedside table then placed the supplies on the table. LPN-O performed hand hygiene and applied gloves. No gown was observed to be worn. The resident pulled their feeding tube out from under their shirt and handed it to LPN-O. LPN-O's pants and scrub top were touching the residents bed linens. LPN-O, still not wearing a gown, administered the residents nutrition, water and medications. LPN-O's clothing continued to be touching the residents bed linens throughout the entire treatment. When finished, LPN-O cleaned up their supplies and removed their gloves then exited the resident room. Interview on 6/4/26 at 12:30 PM with the RN Consultant confirmed the resident was supposed to be (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on EBP and PPE should have been worn during cares with the feeding tube. E. Review of Resident 7's MDS dated [DATE] revealed the resident was admitted on [DATE]; was cognitively intact; was independent with dressing, transfers, and hygiene and was dependent with toileting; had an indwelling catheter; and had diagnoses of renal disease, anxiety, depression, psychotic disorder and respiratory failure. Review of Resident 7's Care Plan last revised 4/2/26 revealed the resident had an indwelling catheter; was independent with dressing, eating, grooming, oral cares, and transfers and was dependent with toileting; and had diagnoses of anxiety, depression, urinary incontinence, weakness and pain. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed Resident 7 had the following orders: -change the foley catheter monthly with a start date of 2/23/26; -enhanced barrier precautions due to the indwelling foley catheter dated 12/23/26; -ensure catheter cares were completed every shift dated 12/17/26; and -monitor foley catheter output every shift. The following observations were made of Resident 7: -On 6/1/26 at 2:15 PM the resident was sitting in the resident room in a wheelchair with eyes closed. The resident had an EBP sign on the door. An empty supply caddy was noted to be hanging off the bathroom door and there was a trash can right outside of the bathroom with a yellow hazardous bag inside. -On 6/2/26 at 8:25 AM An EBP sign was noted on the resident's door and the PPE caddy on the bathroom door was still empty. -On 6/3/26 at 9:40 AM observation with NA-C. The EBP sign remained on the residents door. The resident was lying in bed. NA-C performed hand hygiene and put on gloves. NA-C did not put a gown on. NA-C still not wearing a gown assisted the resident to roll from their back to the right side to pull their pants down. NA-C's clothing was touching the resident's bed linens. NA-C still not wearing a gown performed catheter cares with appropriate glove changes. When finished, NA-C removed their gloves, performed hand hygiene, applied new gloves then proceeded to empty Resident 7's catheter while still not wearing a gown. NA-C completed appropriate glove changes and hand hygiene throughout the observation. When finished, NA-C cleaned up their supplies and performed hand hygiene upon exiting the resident room. Interview on 6/4/26 at 12:30 PM with the RN Consultant confirmed PPE should be worn with all cares including catheter cares and emptying of the catheter bag for Resident 7. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. 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 Resident 4's current Care Plan with a revision date of 4/24/26 revealed the resident was on EPB due to an indwelling urinary catheter. Interventions included notifying the physician of any signs of an active infection and using EBP during cares with the catheter. 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. A sign had been placed on the outer doorframe of the resident's room which indicated the resident was on EBP. A storage caddy was hanging from the bathroom door which contained disposable gloves and gowns. -6/2/26 at 10:07 AM, the resident was seated in a wheelchair in the resident's room. Bath Aide (BA)-F without completing hand hygiene and without use of gloves or an isolation gown, positioned a walker in front of the wheelchair and placed a gait belt on the resident. A privacy bag with the urinary catheter drainage bag was tied to a brace under the seat of the wheelchair. BA-F removed the privacy 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. Still without use of disposable gown or gloves, BA-F lowered the resident's slacks and removed an incontinence brief from the resident. A shower chair was behind the resident and the resident was lowered onto the chair. Without performing hand hygiene, NA placed on clean gloves but still did not utilize a gown, removed the drainage bag from the privacy bag, and removed the edema wear/leg wraps to the resident's bilateral lower legs. BA-F removed gloves and still without completing hand hygiene placed on clean gloves then positioned the resident to begin the shower. BA-F failed to utilize a disposable gown throughout the observation. During an interview on 6/2/26 at 11:02 AM, BA-F confirmed the resident had an indwelling urinary catheter and was to be on EBP. BA-F further confirmed failure to use the required PPE when giving the resident a shower/handling the resident's catheter and to perform hand hygiene before beginning cares with the resident, before putting on clean gloves and when removing soiled gloves.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on record review and interview; the facility failed to implement their Antibiotic Stewardship Plan to ensure antibiotics had a defined duration of use to prevent potential adverse consequences for Residents 28, 29, and 48. The sample size was 12 and the facility census was 45. Findings are: A. Review of the facility Antibiotic Stewardship Plan dated 11/13/24 revealed the facility plan optimized the treatment of infections by ensuring that residents who required antibiotics, were prescribed the appropriate antibiotic, reducing the risk of adverse effects, including the development of antibiotic resistance organisms, from unnecessary or inappropriate antibiotic use, and to improve resident outcomes. This included surveillance, monitoring and preventative measures to improve outcomes. Antibiotics were prescribed for the correct indication, dose and duration to appropriately treat the resident while also attempting to reduce the development of resistive organisms. B. Review of Resident 29's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 5/14/26 revealed medication taken included antibiotics. The resident was frequently incontinent of bladder, involuntary of bowel and was dependent for toileting hygiene. Review of Resident 29's Care Plan with a revision date of 2/25/26 revealed no evidence that the resident was being treated with an antibiotic for any active infection. Review of Resident 29's Order Summary Report dated 6/3/26 revealed the resident had an order for the antibiotic Cephalexin 500mg daily for prophylaxis for Urinary Tract Infections (UTI's) started on 4/29/26, however there was no defined duration for use or scheduled review date. Review of Resident 29's Medication Administration Record (MAR) dated June 2026, revealed the resident received the antibiotic Cephalexin 500mg daily starting 4/29/26. During an interview on 6/4/26 at 2:10 PM the DON (Director of Nursing) confirmed Resident 29's Cephalexin was an antibiotic ordered for prophylaxis (prevention of infection) due to the resident's chronic UTI's, however there was no stop or review date in accordance with the facility Antibiotic Stewardship Program. C. Review of Resident 28's Order Summary Report dated 6/4/26 revealed the resident had an order for the antibiotic Trimethoprim 100 mg daily for prophylactic initiated 9/3/25, however there was no defined duration for use. Review of Resident 28's MAR dated 6/1/26 revealed the resident received the antibiotic Trimethoprim 100 mg daily starting 9/3/25. Review of Resident 28's Care Plan with a revision date of 3/12/26 revealed no evidence that the resident was being treated with an antibiotic for an active infection. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Review of Resident 48's Order Summary Report dated 6/4/26 revealed that the resident received the antibiotic Minocycline Hydrochloride 100 mg by mouth two times a day for osteomyelitis (painful infection and inflammation of the bone) initiated 6/1/26, however there was no defined duration for use. Review of Resident 48's MAR dated 6/1/26 revealed that the resident received the antibiotic Minocycline Hydrochloride 100 mg by mouth two times a day starting 6/1/26. Review of Resident 48's Care Plan revealed that the resident was admitted on [DATE] with the diagnosis of Alzheimer's disease. No evidence was found that the resident was being treated for an active infection. An interview with the DON on 6/4/26 at 10:55 AM confirmed that Resident 28's Trimethoprim was an antibiotic ordered for prophylaxis and Resident 48 received the antibiotic Minocycline Hydrochloride for osteomyelitis, however there was not stop date for the antibiotics. The antibiotic orders did not meet the facilities Antibiotic Stewardship program.		

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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 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 (continued on next page)		

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Licensure Reference Number 175 NAC 12-006.09A Based on record review and interview; the facility failed to complete an updated Preadmission Screening and Resident Review (PASRR-federally mandated screen used to ensure persons with SMI (Serious Mental Illness), DD (Developmental Disability), or Related Conditions (RC) are appropriately placed in facilities that are able to provide needed specialized services) when Resident 5 was diagnosed with Bipolar Disorder and Schizophrenia. The sample size was 12 and the facility census was 45. Findings are: Review of Resident 5's Level 1 PASARR screen dated 1/29/25 revealed the resident had trouble concentrating, persistence and pacing such as serious difficulty maintaining sustained focus or attention for a long period of time to permit task completion or structures activity. In addition, the resident had a diagnosis of Dementia/Neurocognitive Disorder, Alzheimer's Disease, or an Organic Disorder. There was no indication the resident had signs of a SMI, DD, or RC. Review of Resident 5's Care Plan with a revision date of 2/5/25 revealed the resident had a traumatic response to seeing self in the mirror. In addition, the resident had a history of a Traumatic Brain Injury (TBI), Alzheimer's Dementia with agitation, Depression, Bipolar Disorder and Schizophrenia. There was no evidence the resident had a PASARR level 2 (further assessment conducted to determine if the resident was appropriately placed in the facility and if the resident required any additional specialized services) screen. Review of a Note to the Attending Physician/Prescriber for Resident 5 dated 2/25/25 requested a diagnosis for the use of the antipsychotic medication Risperdal had a documented response that the resident had a diagnosis of Schizophrenia, and agitation/aggression associated with Schizophrenia and/or Bipolar Mania. Review of a Note to the Attending Physician/Prescriber for Resident 5 dated 4/10/25 requested a diagnosis for the use of the antipsychotic medication Risperdal had a documented response that the resident had a diagnosis of Bipolar, agitation/aggression associated with Schizophrenia or Bipolar Mania and a Delusional Disorder. Review of Resident 5's Medication Administration Record (MAR) dated June of 2026 revealed the resident took the antipsychotic medication Risperidone to treat agitation and aggression related to Bipolar Disorder, the antidepressant medication Sertraline to treat depression, and the anti-anxiety medication lorazepam to treat restlessness. During an interview on 6/2/26 at 12:55 PM the Social Services Director (SSD) confirmed Resident 5's PASARR was not reviewed when the resident was diagnosed with Schizophrenia and/or Bipolar Disorder to determine if the resident required a Level 2 assessment. During an interview on 6/4/26 at 2:15 PM the Register Nurse (RN) Consultant confirmed the facility did not have a written policy for PASARR assessments, however the facility followed Federal regulations and guidelines and should have completed a new assessment when Resident 5 was diagnosed with Schizophrenia and Bipolar Disorder.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E)Based on record review and interview; the facility failed to develop and implement and/or review and revise a Comprehensive Care Plan for resident 7's Enhanced Barrier Precautions. The sample size was 3 and the facility census was 45.Findings are:Review of the facility policy Comprehensive Care Plan last updated 12/3/25 revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident and included the following:-the comprehensive care plan would be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) assessment:-any services that would otherwise be furnished, but were not provided due to the resident exercising their rights;-resident specific interventions that reflected the resident's needs and preferences;-the comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment; and-the care plan would be updated in a timely manner to ensure that services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of Resident 7's MDS dated [DATE] revealed the resident was admitted on [DATE]; was cognitively intact; was independent with dressing, transfers, and hygiene and was dependent with toileting; had an indwelling catheter; and had diagnoses of renal disease, anxiety, depression, psychotic disorder and respiratory failure. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed Resident 7 had the following orders:-change the foley catheter monthly with a start date of 2/23/26;-Enhanced Barrier Precautions (EBP) due to the indwelling foley catheter dated 12/23/26;-ensure catheter cares were completed every shift dated 12/17/26; and-monitor foley catheter output every shift. Review of Resident 7's Care Plan last revised 4/2/26 revealed the resident had an indwelling catheter; was independent with dressing, eating, grooming, oral cares, and transfers and was dependent with toileting; and had diagnoses of anxiety, depression, urinary incontinence, weakness and pain. There was no evidence of documentation that the resident had EBP implemented. Interview on 6/4/26 at 10:00 AM with Registered Nurse- K revealed the resident did have an indwelling catheter. Further interview confirmed the resident was on EBP and that EBP was not included in Resident 7's Care Plan.		

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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 (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Accura Healthcare of O'Neill		STREET ADDRESS, CITY, STATE, ZIP CODE 1102 North Harrison Street O' Neill, NE 68763	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05Based on record review and interview; the facility failed to complete Gradual Dose reductions or have documented contraindications for Resident 3's antidepressant. The sample size was 5 and the facility census was 45. Findings are:A. Review of the facility policy Use of Psychotropic Medication(s) with a revision date of 4/21/25 revealed the following:-the facility ensured residents only receive psychotropic medications when other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint; -psychotropic medications were used only when a practitioner determined that the medication was appropriate to treat specific, diagnosed, and documented conditions and the medication was beneficial to the resident, as demonstrated by monitoring and documentation or the resident's response;-prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative were informed in advance of the risks and benefits or the proposed care, including any "black box (warning indicating a particular medication may have severe reactions, the potential for preventable harm, and/or strict usage restrictions) warnings in advance, and treatment alternatives;-residents had the opportunity to accept or decline the initiation or increase of a psychotropic medication;-the facility documented the resident or resident representative was informed of the risks and benefits, other treatment options; and-residents who use psychotropic medications would receive gradual dose reductions, unless clinically contraindicated. B. Review of Resident 3's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 4/30/26 revealed the resident was admitted [DATE]; was cognitively intact; did not exhibit any behaviors; was independent with dressing, toileting and hygiene; had diagnoses of Dementia, Anxiety, Psychotic Disorder, Schizophrenia, and Post-Traumatic Stress Disorder; and received antipsychotic, antianxiety and antidepressant medications. Review of Resident 3's Care Plan last revised 6/1/26 revealed the resident had a mood disorder and received psychotropic medications related to anxiety, delusional disorder and schizophrenia. Staff were to observe and report any adverse side effects. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed Resident 3 received Celexa (an antidepressant medication) and Lorazepam (an antianxiety medication).Review of the following facsimiles (fax) related to Resident 3 revealed:-on 12/3/25 a Gradual Dose Reduction (GDR) was sent to the provider for Celexa. The provider denied a request for a GDR. The provider documented Keep Same. There was no evidence that a resident specific clinical rationale was documented; and-on 12/3/25 a GDR was sent to the provider for Lorazepam. The provider denied the request for the GDR. The provider documented Keep Same. There was no evidence that a resident specific clinical rationale was documented. Interview on 6/4/26 at 12:30 PM with the Registered Nurse (RN) Consultant confirmed the resident was receiving psychotropic medications of antidepressant and antianxiety. Further interview confirmed there was no evidence a clinical rationale for the contraindicated GDR was documented.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on observation, record review and interview; the facility failed to administer immunizations as requested to 1 of 5 sampled residents. The facility census was 45. Findings are: Review of Resident 14's Acknowledgement of Vaccination Consent for Influenza, Pneumovax, and Covid revealed that the resident's guardian signed a consent on 12/4/25 for Resident 14 to receive the Influenza vaccine, the Pneumococcal vaccine and the Covid vaccine. Review of Resident 14's admission Order Clarification Order revealed that the physician signed an order on 12/5/25 stating to administer the Pneumovax, Influenza and Covid vaccine. Review of Resident 14's Immunization Record revealed that the resident had not received the Influenza, Pneumovax and Covid vaccine. An interview on 6/4/26 at 10:15 AM with the Director of Nursing confirmed that Resident 14 had not received the Pneumovax, Influenza and Covid vaccine ordered on 12/5/25.		

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F 0605 Level of Harm - Potential for minimal harm Residents Affected - Many	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G)Based on record review and interview; the facility failed to complete gradual dose reductions or have documented contraindications for antipsychotic medications for Residents 3 and 4. The sample size was 5 and the facility census was 45. Findings are:A. Review of the facility policy Use of Psychotropic Medication(s) with a revision date of 4/21/25 revealed the following: -the facility ensured residents only receive psychotropic medications when other nonpharmacological interventions were clinically contraindicated. Additionally, these medications should only be used to treat the resident's medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint; -psychotropic medications were used only when a practitioner determined that the medication was appropriate to treat specific, diagnosed, and documented conditions and the medication was beneficial to the resident, as demonstrated by monitoring and documentation or the resident's response; -prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative were informed in advance of the risks and benefits or the proposed care, including any 'black box (warning indicating a particular medication may have severe reactions, the potential for preventable harm, and/or strict usage restrictions) warnings in advance, and treatment alternatives; -residents had the opportunity to accept or decline the initiation or increase of a psychotropic medication; -the facility documented the resident or resident representative was informed of the risks and benefits, other treatment options; and -residents who use psychotropic medications would receive gradual dose reductions, unless clinically contraindicated. B. Review of Resident 3's Minimum Data Set (MDS- a federally mandated assessment tool used in Care Planning) dated 4/30/26 revealed the resident was admitted [DATE]; was cognitively intact; did not exhibit any behaviors; was independent with dressing, toileting and hygiene; had diagnoses of Dementia, Anxiety, Psychotic Disorder, Schizophrenia, and Post-Traumatic Stress Disorder; and received antipsychotic, antianxiety and antidepressant medications. Review of Resident 3's Care Plan last revised 6/1/26 revealed the resident had a mood disorder and received psychotropic medications related to anxiety, delusional disorder and schizophrenia. Staff were to observe and report any adverse side effects. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed Resident (continued on next page)		

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F 0605 Level of Harm - Potential for minimal harm Residents Affected - Many	3 received Loxapine (an antipsychotic medication) with a start date of 3/31/25. Review of the facsimile (fax) related to Resident 3 revealed on 8/6/25 a Gradual Dose Reduction (GDR) was sent to the provider for Loxapine. The provider denied a request for a GDR. There was no evidence that a resident specific clinical rationale was documented. Interview on 6/4/26 at 12:30 PM with the Registered Nurse (RN) Consultant confirmed the resident was receiving an antipsychotic medication and further interview confirmed there was no evidence a clinical rationale for the contraindicated GDR was documented. C. 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, and depression. The following was assessed regarding the resident: -cognitively intact. -no behaviors exhibited. -received antipsychotic, antidepressant, anti-anxiety, and opioid medications. Review of Resident 4's current Care Plan last revised 3/6/26 revealed the resident had a recurrent depressive disorder, mixed anxiety disorder, and mood disorder. Staff were to monitor and document target behaviors; educate the resident of the possible outcomes of not complying with cares and treatments; provide opportunities for choices; and allow time to talk and express feelings. Review of the facility form Order Summary Report with active orders as of 6/3/26 revealed the resident received Abilify (an antipsychotic medication) 1 milligram (mg) daily with a start date of 5/31/25. Review of the Recommendation History Report from the Consultant Pharmacist with Monthly Medication Reviews (MMR) revealed a recommendation on 1/2/26 for a GDR of the residents' Abilify 1 mg daily to reach the minimum effective dose. If the GRD was denied a request was made for documentation by the Primary Care Provider (PCP) that the risk versus the benefits were considered with individualized rationale for why the medications was medically necessary at the current dose. Review of the Consultant Pharmacist MMR dated 2/2/26 revealed no response was found in the resident's medical record regarding the recommendation of a GDR for the Abilify 1 mg daily made on 1/2/26. Review of the Consultant Pharmacist MMR dated 3/2/26 revealed Resident 4's PCP had still not addressed a GDR of the resident's Abilify 1 mg daily. Interview on 6/3/26 at 3:00 PM with the RN Consultant confirmed the resident continued to receive Abilify 1 mg daily. The Consultant Pharmacist had made recommendations for a dose reduction of the medication on 1/2/26, 2/2/26 and again on 3/2/26 but there was no evidence the resident's PCP had addressed the pharmacists' recommendations.		

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Licensure Reference Number 175 NAC 12-006.04A3b Based on record review and interview, the facility failed to ensure background checks through the State Nurse Aide registry were completed on 2 of 5 sampled employees. The facility census was 45 with a total sample size of 25. Findings are:A. Review of the facility policy titled Vulnerable Adult updated 10/19/22 revealed the facility supported zero tolerance for resident abuse, neglect, mistreatment, and/or misappropriation of resident property. All potential employees were to receive a background check and verification of certification status for nursing assistants. The facility would not employee or otherwise engage individuals who:-had been found guilty of abuse, neglect, exploitation. Misappropriation of property or mistreatment by a court of law.-had a finding entered into the State Nurse Aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.-had a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. B. Review of 5 employee files on 6/2/26 revealed no evidence Van Driver-U (hired 4/15/26) and Universal Worker-V (hired 4/29/26) had background checks completed through the State Nurse Aide registry at the time they were hired. During an interview on 6/3/26 at 9:28 AM the Business Office Manager confirmed the facility was not checking the Nurse Aide/Medication Aide Registry for negative finding for all newly employed staff.		