

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/18/2025
NAME OF PROVIDER OR SUPPLIER  Prestige Care Center of Nebraska City		STREET ADDRESS, CITY, STATE, ZIP CODE  1420 North 10th Street Nebraska City, NE 68410	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.04(F)(i)(5)Based on record review and interview, the facility failed to notify the pulmonary specialist of medication changes as directed by the primary care provider for 1 (Resident 2) of 3 sampled resident. The facility staff identified a census of 41.The findings are:Record review of a facility policy entitled Notification of Changes dated revised 3/2025 revealed: -The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. -Circumstances requiring notification include: 3. Circumstances that require a need to alter treatment. This may include: -a. New treatment. -b. Discontinuation of current treatment due to: -i. Adverse consequences. -ii. Acute condition. -iii. Exacerbation of a chronic condition.Record review of Resident 2's admission Record revealed the facility admitted the resident on 9/9/2025.Record review of Resident 2's Medical Diagnosis printed 10/14/2025 revealed Resident 2 had diagnoses which included chronic obstructive pulmonary disease (COPD, pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation), methicillin resistant staphylococcus aureus infection (bacteria resistant to antibiotic methicillin and other types of antibiotics), and resistance to multiple antibiotics.Record review of Resident 2's admission MDS dated [DATE] revealed a BIMS score of 15. According to the MDS manual, a score of 15 indicated the resident had intact cognition. Further review of the MDS identified the following: -Resident 2 had behavioral symptoms directed towards others for one to three days of the assessment period. -Resident 2 received oxygen therapy.Record review of Resident 2's Medication Administration Record (MAR) dated September 2025 revealed an order for doxycycline (an antibiotic medication) 100 milligrams (mg) one capsule by mouth twice daily for five days dated 9/29/2025, with the first dose to be administered at 6:00 AM on 9/29/2025. There was no record of the medication being offered or refused on 9/29/2025 at 6:00 AM. The remaining three doses were marked as drug refused.Record review of Resident 2's MAR dated October 2025 revealed the doxycycline was documented as administered at 6:00 AM on 10/1/2025. The remaining doses were documented as drug refused.Record review of Resident 2's Progress Notes (PN) revealed the following: -9/29/2025 revealed Resident 2 had complaints of increased shortness of breath and reported a productive cough of green phlegm. The nurse evaluated the resident to have a moist, non-productive cough and auscultated (listened using a stethoscope) the lungs and noted expiratory wheezes. Resident 2 requested the nurse to update the primary care provider (PCP) and notification was made. -9/29/2025 revealed Resident 2 refused the doxycycline when it was offered and stated it made [gender] sick. -9/30/2025 The resident refused to take ordered antibiotics and reported it made Resident 2's stomach upset. The PCP was notified, and facility staff were awaiting further instructions. -10/1/2025 The resident refused the doxycycline and Resident 2 reported an allergy to the medication. -10/2/2025 The resident refused the doxycycline and Resident 2 reported an allergy to the medication. -10/3/2025 The resident refused the doxycycline and Resident 2 stated [gender] is allergic to the medication. -10/3/2025 Resident 2 called pulmonologist independently and requested medication. The facility received a faxed prescription from the pulmonologist for levofloxacin (an antibiotic medication) 750 mg take one tab daily for seven days. The orders were sent to the pharmacy.Record review of an Advanced Practice Registered Nurse (APRN) progress note dated 10/3/2025 revealed notes regarding the resident's COPD flare. The note showed the APRN assessed the resident on 9/25/2025, but Resident 2 declined treatment for a COPD exacerbation at that time and requested instead that the pulmonary specialist be notified. The pulmonary specialist was notified and subsequently adjusted Resident 2's inhaled medication regimen. Record review of HUCU (a secured messaging system for real-time communication with providers) messages revealed: -9/29/2025 at 3:16 PM facility staff notified the provider of Resident 2's request for antibiotic due to increased shortness of breath. -9/29/2025 at 3:28 PM the APRN reported [gender] saw Resident 2 on 9/25/2025 and witnessed sputum production. Resident 2 declined to be treated at that time. The APRN asked facility staff if the pulmonary specialist was notified and asked if the pulmonary specialist responded. The APRN provided orders for doxycycline 100 mg by mouth twice daily for 5 days, prednisone (a steroid medication) 40 mg by mouth daily for five days, then resume maintenance dose previously ordered, and acidophilus (a probiotic that promotes the growth of good bacteria in the digestive system) or equivalent three times daily before meals for seven days and a chest x-ray with 2 views. -9/29/2025 at 3:30 PM facility staff reported to the APRN the resident</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to complete and submit a five-day written investigation of an allegation of potential neglect for 1 (Resident 3) of 3 sampled residents. The facility staff identified a census of 41.The findings are:Record review of a facility policy entitled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated revised 1/2025 revealed: -2F. The administrator or designee will within five working days of the incident, report sufficient information to describe the results of the investigation, and indicate any corrective actions taken, if the allegation was verified.Record review of Resident 3's Progress Notes revealed: -8/3/2025 Resident 3 was found by staff to be laying in the bathroom on [gender] back. The resident's upper body was in the bathroom and bilateral lower extremities extended out of the bathroom. Resident 3 did not recall how it happened. An assessment was completed by the nurse with no injuries or bruising noted. -8/4/2025 Resident 3 reported that they were getting up for the day and their feet gave out. No obvious injury was noted. Resident 3 was using a cane instead of a walker and did not have non-skid socks on. No obvious injury was noted. Resident 3 was having pain in the right wrist from the previous fall, and an X-ray was ordered. -8/5/2025 Interdisciplinary team met to review resident's fall status. Resident 3 had falls on 8/2/25, 8/3/25, and 8/4/25. The falls resulted in a fracture of the right wrist.Record review of a facility reported incident showed the facility submitted the five-day written report on 8/13/2025.An interview on 10/14/2025 at 2:50 PM with the Regional Director of Operations (RDO) confirmed the report was submitted on day seven, two days later than required.</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09(c)(i)Based on record review and interview, the facility failed to complete an admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) within the required timeframes for 1 (Resident 2) of 1 sampled resident. The facility staff identified a census of 41. The findings are: Record review of a facility policy entitled Assessment Frequency/Timeliness dated revised 9/2025 revealed: -The comprehensive admission assessment will be completed within 14 days after admission, excluding readmissions in which there is no significant change, an admission assessment was completed during the prior stay, the resident was discharged return anticipated and the resident returned within 30 calendar days as described per the MDS Manual instructions. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.20.1 dated October 2025 revealed the MDS completion date should be no later than the 14th calendar day of the resident's admission. Record review of Resident 2's Clinical Census printed on 10/14/2025 revealed the facility admitted Resident 2 on 9/9/2025. Record review of Resident 2's admission MDS dated [DATE] revealed MDS section Z was signed as completed on 10/11/2025. Interview on 10/15/2025 at 11:34 AM with the Regional Director of Operations (RDO) confirmed the MDS was signed as completed on 10/11/2025, 13 days late.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09(1)(i)(3)Based on record review and interview, the facility failed to implement interventions to prevent falls for 1 (Resident 3) of 3 sampled residents; and the facility failed to investigate causal factors and implement interventions to prevent skin tears for 1 (Resident 2) of 1 sampled resident. The facility staff identified a census of 41. The findings are: A. Record review of a facility policy entitled Fall Prevention Program dated revised 7/2025 revealed: -9. When any resident experiences a fall, the facility will: -a. Assess the resident. -b. Complete a post-fall assessment. -c. Complete an incident report. -d. Notify physician and family. -e. Review the resident's care plan and update as indicated. -f. Document all assessment and actions. -g. Obtain witness statements in the care of injury. Record review of Resident 3's admission Record revealed the facility admitted the resident on 12/2/2015. Further review of the admission record showed Resident 3 had diagnoses which included Alzheimer's Disease with late onset, type 2 diabetes mellitus, dementia, macular degeneration, osteoarthritis of the knee, unsteadiness on feet, generalized muscle weakness, and difficulty in walking. Record review of Resident 3's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 8/19/2025 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 1. According to the MDS manual, a score of 1 indicated the resident had severe cognitive impairment. Further review of the MDS revealed Resident 3 required supervision assistance from staff to stand from a seated position, transfer, and walk 10 feet; and Resident 3 required partial/moderate assistance when ambulating 50 feet with two turns. The MDS identified Resident 3 sustained two falls with no injury, and one fall with major injury in the assessment period. Record review of Resident 3's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed the following interventions for falls: -The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, handrails on walls, personal items in reach dated 10/16/2017. -Ensure that the resident is wearing appropriate footwear when ambulating dated revised 11/3/2020. -Be sure the call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance dated revised 11/3/2020. -Anticipate and meet the resident's needs dated revised 11/3/2020. -Ensure has proper footwear or slipper socks dated 8/14/2023. -Trash can was relocated to be out of the way while wandering dated 8/2/25. -Staff to anticipate toileting and bathroom needs as resident does not use the call light for assistance dated 8/3/2025. -Removes socks and shoes dated 8/4/2025. -Wheel chair and checks to make sure has on slipper socks or nonskid footwear dated 8/4/2025. -Toilet at 2:00 AM dated 8/11/2025. Record review of an Un-witnessed Fall (UWF) document dated 8/3/2025 at 4:10 AM revealed Resident 3 was observed by facility staff laying in the bathroom on their back, with the upper body in the bathroom and bilateral lower extremities extending out of the bathroom. Record review of an UWF document dated 8/3/2025 at 7:00 PM revealed Resident 3 was found sitting on the floor facing the doorway in the bathroom. Record review of an UWF document dated 8/4/2025 revealed the resident was getting up for the day and reported [gender] feet went out. Observation on 10/14/2025 at 11:33 AM revealed Resident 3 was sitting in a recliner chair in the dining room. Resident 3 wore tennis shoes that were in good repair. Resident 3 worked on a word search puzzle and watched television. There was no wheelchair observed. Observation on 10/14/2025 at 11:41 AM of Resident 3's room revealed no wheelchair was present in the room. The floor was free of spills, and there was an unobstructed path to the bathroom, and the room exit. Observation on 10/15/2025 at 7:40 AM revealed Resident 3 was asleep in bed with a touchpad call light within reach. Resident 3 was barefooted. A pair of unfolded non-slip socks were observed on the overnight table. Interview on 10/14/2025 at 11:56 AM with Certified Medication Aide (CMA)-A revealed Resident 3 walked with stand-by assistance. CMA-A reported that a wheelchair had not been observed in Resident 3's room, nor had CMA-A used a wheelchair with Resident 3. CMA-A reported that if a wheelchair was needed it could be obtained from the storage hallway. Interview on 10/15/2025 at 11:30 AM with the Regional Director of Operations (RDO) confirmed interventions listed on the care plan dated 8/3/2025 were interventions already listed on the care plan. The RDO further confirmed new interventions were not implemented for three</p>		