STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285109	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Nebraska City	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12.006.09(J)(iii)Based on observation, interview and record review, the facility failed to prevent dehydration (a condition where the body loses more fluid than it takes it, preventing it from functioning properly) for 1 resident (Resident1) of 3 residents surveyed. The facility had a census of 42. Findings are:A record review of the facility's Hydration Policy, dated 4/2019 and revised on 4/2025 revealed the following: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health.Compliance Guidelines:1. The facility will utilize a systematic approach to optimize the residents hydration status: Identifying and assessing each resident's hydration status and risk factorsEvaluating/analyzing each residents hydration status and risk factorsDeveloping and consistently implementing pertinent approachesMonitoring the effectiveness of interventions and revisiting them as necessary. 2. Identification/assessmentNursing staff shall assess hydration status upon admission and throughout the resident's stay in accordance with assessment protocols.The dietitian will assess hydration as part of the comprehensive nutritional assessment within 72 hours of admission, annually, and upon significant change in condition.3. Evaluation Analysis:The dietitian shall use data gathered from the nutritional assessment to the resident's fluid needs and whether intake is adequate to meet those needs.4. Care plan implementation. The residents goals and preferences regarding hydration will be reflected in the Residents plan of care.5. Monitoring/revision:The resident will be monitored for signs and symptoms of dehydration, fluid overload, and electrolyte imbalance.6. Documentation:Hydration status observations to be recorded in the nurses' notes. Beverage intake and output to be recorded in the meal intake records or Medication Administration Record as indicated. Document any family/physician notifications and responses.A record review of Resident 1's Medical Diagnosis sheet revealed Resident 1 was admitted with the following diagnoses: quadriplegia, C1-C4 incomplete, (partial damage to the cervical spinal cord with paralysis affecting all 4 limbs), Autonomic Dysreflexia (a dangerous, uncontrolled reaction where the body's blood pressure spikes suddenly due to a painful trigger below a spinal cord injury), neuromuscular dysfunction of the bladder (loss of bladder control due to nerve damage), acute cystitis with hematuria (inflammation of the bladder accompanied by bleeding), and moderate protein calorie malnutrition (a condition in which reduced availability of nutrients leads to changes in body composition and function).A record review of Resident 1's admission Minimum Data Set (MDS - a federally mandated clinical assessment tool for residents in Medicare/Medicaid-certified nursing facilities), dated 12/4/2025 confirmed Resident 1 had a Brief Interview for Mental Status (BIMS-a federally mandated cognitive assessment tool) of 15, indicating Resident 1 is cognitively intact. Record review of section GG of the MDS which addresses the functional status of the resident revealed Resident 1 is dependent for all cares (Resident 1 relies on caregivers for all basic needs).A record review of a Nurse progress note, dated 12/9/2025 revealed Resident 1 was sent to the emergency room (ER) for evaluation of a temperature of 104.6 and had dark, cloudy urine with sediment in Resident 1's catheter bag.A record review of a Nurse progress note, dated 12/9/2025 revealed Resident 1 returned from the ER via ambulance. Resident 1 had been diagnosed with a UTI (urinary tract infection), dehydration and had received 2 liters of fluid while in the ER.A record review of Resident1's undated Care plan revealed it did not have a focus area for Hydration.A record review of Resident 1's After Visit Summary for the ER visit on 12/9/2025 revealed Resident 1 had been diagnosed with Dehydration and Inflammation of the bladder. An order to continue to push fluids (encourage a person to drink fluids) was present. The summary was signed and acknowledged by a facility nurse.A record review of Resident 1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2025 revealed there were no orders to monitor Resident1's intake and output of fluid.An observation on 12/16/2025 at 9:01 AM revealed Resident 1 to be lying in bed. Resident 1 was wearing wrist and hand orthoses (a specialized brace to support the wrist, hand, and fingers) due to muscle contractions (a permanent stiff shortening of muscles, tendons and tissues that limit movement) of the wrist and fingers. Resident 1 had a bedside table which contained a large pitcher of water and a straw. A demonstration by Resident 1 confirmed they were unable to pick up the pitcher and drink independently.An observation on 12/16/2025 at 10:30 AM confirmed Resident 1's water pitcher was full of water.An observation on 12/16/2025 at 1:45PM confirmed Resident 1's water pitcher was full of water.An interview on 12/16/2025 at 9:01 AM with Resident 1 confirmed they required assistance with eating and drinking. Resident 1 confirmed they were unable to pick up a water cup and drink from it. Resident 1

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18DBased on observation, interview and record review the facility failed to ensure that staff performed hand hygiene and gloving in a manner to prevent cross contamination when providing cares to 3 of 3 residents surveyed (Residents 1, 2 and 3). The facility had a census of 42. Findings are:A record review of the facility's Hand Hygiene policy dated 4/2019 and revised on 11/2025 revealed the following:All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. This applies to all staff working in all locations within the facility.1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand-hygiene table.Examples include: after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves, before and after handling clean or soiled dressings, linens, etc., before performing resident care procedures, after handling items potentially contaminated with blood, body fluids, secretions or excretions and after assistance with personal body functions and when in doubt.Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves.A record review of the facility's Infection Prevention and Control Program dated 4/2019 and revised 4/2025 revealed the following:All staff are responsible for following all policies and procedures related to the program. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.A.A record review of Resident 1's Clinical Resident Profile sheet revealed Resident 1 was admitted to the facility on [DATE].A record review of Resident 1's undated Medical Diagnosis sheet revealed Resident 1 was admitted with the following diagnoses: quadriplegia, C1-C4 incomplete, (partial damage to the cervical spinal cord with paralysis affecting all 4 limbs), Autonomic Dysreflexia (a dangerous, uncontrolled reaction where the body's blood pressure spikes suddenly due to a painful trigger below a spinal cord injury), neuromuscular dysfunction of the bladder (loss of bladder control due to nerve damage), acute cystitis with hematuria (inflammation of the bladder accompanied by bleeding), and moderate protein calorie malnutrition (a condition in which reduced availability of nutrients leads to changes in body composition and function).A record review of Resident 1's admission Minimum Data Set (MDS - a federally mandated clinical assessment tool for residents in Medicare/Medicaid-certified nursing facilities), dated 12/4/2025 confirmed Resident 1 had a Brief Interview for Mental Status (BIMS-a federally mandated cognitive assessment tool) of 15, indicating Resident 1 is cognitively intact. Record review of section GG of the MDS which addresses the functional status of the resident revealed Resident 1 is totally dependent for all cares (this means Resident 1 relies on caregivers for all basic needs). An observation on 12/17/2025 at 9:45am of catheter care provided to Resident 1 by Registered Nurse (RN) A revealed the following: RN A and Nurse Aide (NA) B entered the room. RN C placed a bed pad, hand sanitizer and gloves on the bedside dresser, unwrapped a catheter bag and a condom catheter attachment using bare hands and without using hand sanitizer. NA B used hand sanitizer, donned gloves and a face shield and emptied the catheter bag which contained 3100ml of urine. NA B washed [gender] hands and donned new gloves. RN A used hand sanitizer and donned gloves. NA B used personal care wipes (pre-moistened, disposable wipes) to provide perineal care (cleaning of the genital and anal areas) before the condom catheter was changed. NA B used a wipe to clean the Resident 1's right groin crease to the base of the perineal and then folded it to use a clean area for a 2nd pass. NA B used a second wipe to repeat the process on the left groin crease. RN A then assisted Resident 1 to roll on their right side and NA B used personal care wipes to clean the perineal area. While RN A was holding Resident 1 on their side they reached to the bedside table to get a cup with a straw per Resident 1's request and assisted the resident to drink from the straw. RN A did not change their gloves or use hand sanitizer. NA B used hand sanitizer and changed gloves before they replaced the bed pad and brief beneath the resident. RN A assisted NA B to reposition Resident 1 in bed. RN A using the same gloves removed the condom catheter attachment from Resident 1's perineal by rolling it down. RN A discarded it in the trash. Resident 1 requested RN A use a wipe to remove the adhesive from the perineal area. The wipes were kept in the top dresser drawer. RN A opened the drawer using the same gloves, removed the wipes from the drawer and closed it