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	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)Based on record review, observations and interviews, the facility failed to implement interventions to protect from potential elopement for 4 (Residents 1, 2, 4, and 5) of 5 sampled residents. The facility staff identified a census of 49.Findings are:Licensure Reference Number 175 NAC 12-006.09(I) Based on record review, observations and interviews, the facility failed to implement interventions to protect from potential elopement for 4 (Residents 1, 2, 4, and 5) of 5 sampled residents. The facility staff identified a census of 49. Findings are: A. Record review of facility policy entitled Elopement Prevention and Management dated revised 11/12/2019 revealed facility staff would complete the following: -2. Review evaluations and risk factor data. -3. Determine if the resident/patient is at risk for elopement. -4. Include resident/patient and family/responsible party in development of the Plan of Care. -5. Develop individualized interventions which may include, but are not limited to the following: electronic monitoring/alarm systems; environmental modifications; protected list of names and photographs of those at risk for elopement; psychosocial interventions; regular rounds; resident/patient and family education; staff interventions; and structured group activities. Record review of Resident 1's admission Record (AR) revealed the facility admitted the resident on 06/17/2025. Further review of the AR identified Resident 1 had diagnoses of Alzheimer's disease (a degenerative brain disease of unknown cause that usually starts in late middle age or in old age, that results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood) and psychosis (a serious mental illness characterized by defective or lost contact with reality often with hallucinations or delusions). Record review of Resident 1'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 04/30/2026 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 00. According to the MDS manual, a score of 00 indicated the resident had severe cognitive impairment. Further review of the MDS identified Resident 1 wandered daily. Record review of Resident 1's Progress Notes revealed Resident 1 eloped the facility on 06/17/2026. The local police department returned Resident 1 to the facility. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285109	A. Building B. Wing	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 1's Elopement Risk dated 06/17/2026 identified the resident was at risk for elopement. Record review of a sign displayed at the Memory Care Unit (MCU) medication on 06/22/2026 revealed all thirteen residents who resided in the MCU were on 15-minute checks until further notice. Further review of the sign instructed staff to document the 15-minute checks thoroughly. Record review of Resident 1's Every 15 Minute Check Sheet dated 06/19/2026, 06/21/2026, and 06/22/2026 revealed there was no documentation for each of the 15-minute checks from 12:15 AM through 5:45 AM. In interviews on 06/22/2026 at 7:41 AM, 8:01 AM and 8:34 AM, Medication Aide (MA)-A confirmed the sign that hung at the medication cart was hung up after Resident 1 eloped on 06/17/2026. MA-A further confirmed the 15-minute checks were not documented from 12:15 AM through 5:45 AM on 06/21/2026 and 06/22/2026. MA-A reported the 15-minute checks began after Resident 1 eloped the facility. In an interview on 06/22/2026 at 2:40 PM, the Regional Director of Nursing (RDON) confirmed missing documentation on the 06/19/2026 15-minute check sheet. During a follow-up interview on 06/23/2026 at 8:04 AM, the RDON confirmed it was expected that staff would fill out the 15-minute check sheet as the 15-minute checks were completed. B. Record review of Resident 2's AR revealed the facility admitted the resident on 06/03/2025. Further review of the AR identified Resident 2 had diagnosis of Alzheimer's Disease with early onset. Record review of Resident 2's MDS dated [DATE] revealed the resident had a BIMS score of 01. According to the MDS manual, a score of 01 indicated the resident had severe cognitive impairment. Further review of the MDS identified Resident 2 wandered for four to six days out of the seven-day review period. Record review of Resident 2's Elopement Risk dated 06/17/2026 identified the resident was at risk for elopement. Record review of Resident 2's Every 15 Minute Check Sheet dated 06/19/2026, 06/21/2026, and 06/22/2026 revealed there was no documentation for each of the 15-minute checks from 12:15 AM through 5:45 AM. In an interview on 06/22/2026 at 8:01 AM, Medication Aide (MA)-A confirmed the 15-minute checks were not documented from 12:15 AM through 5:45 AM on 06/21/2026 and 06/22/2026. In an interview on 06/22/2026 at 2:40 PM, the Regional Director of Nursing (RDON) confirmed missing documentation on the 06/19/2026 15-minute check sheet. During a follow-up interview on 06/23/2026 at 8:04 AM, the RDON confirmed it was expected that staff would fill out the 15-minute check sheet as the 15-minute checks were completed. (continued on next page)

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	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of Resident 5's AR revealed the facility admitted the resident on 02/27/2025. Further review of the AR identified Resident 5 had a diagnosis of dementia (a usually progressive condition marked by the development of multiple cognitive deficits [such as memory impairment, aphasia, and the inability to plan and initiate complex behavior]). Record review of Resident 5's MDS dated [DATE] revealed the resident had a BIMS score of 09. According to the MDS manual, a score of 09 indicated the resident had moderately impaired cognition. Record review of Resident 2's Every 15 Minute Check Sheet dated 06/19/2026, 06/21/2026, and 06/22/2026 revealed there was no documentation for each of the 15-minute checks from 12:15 AM through 5:45 AM. In an interview on 06/22/2026 at 8:01 AM, Medication Aide (MA)-A confirmed the 15-minute checks were not documented from 12:15 AM through 5:45 AM on 06/21/2026 and 06/22/2026. In an interview on 06/22/2026 at 2:40 PM, the Regional Director of Nursing (RDON) confirmed missing documentation on the 06/19/2026 15-minute check sheet. During a follow-up interview on 06/23/2026 at 8:04 AM, the RDON confirmed it was expected that staff would fill out the 15-minute check sheet as the 15-minute checks were completed. D. A record review of the facility's Elopement Prevention and Management policy dated 11/12/2019 revealed the facility would complete admission evaluations. The staff would review and risk factor data, determine if resident was at risk, develop a care plan, develop interventions which may include electronic monitoring, environmental modifications, protected list of names and photographs of those at risk, psychosocial interventions, regular rounds, resident and family education, staff interventions, and structured group activities. The current protected list of names and photographs of residents identified at risk would include the name, description, height, weight, age, and pertinent medical information. A record review of Resident 4's Clinical Census dated 06/09/2026 revealed the resident was admitted on [DATE]. A record review of Resident 4's Medical Diagnosis dated 06/23/2026 revealed the resident had diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side (partial loss of movement or complete paralysis of the right side after a stroke), Unspecified Symptoms And Signs Involving Cognitive Functions Following Cerebral Infarction (thinking and memory difficulties after a stroke), Primary Insomnia (difficulty falling and staying asleep), Anxiety, Depression, Nicotine Dependence. A record review of Resident 4's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 05/22/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 1 which indicated the resident was severely cognitively impaired (difficulty thinking and comprehending). The resident required partial/moderate assistance with eating and oral hygiene (cleaning) and substantial/maximal with (continued on next page)

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	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing, toileting hygiene, dressing, footwear, and personal hygiene. The resident required partial/moderate assistance with all mobility and transfer needs except tub/shower transfer was substantial/maximal assistance. The resident used a wheelchair. It did not reveal the resident had behaviors including wandering. The resident was not on a wander/elopement (leaving the facility without staff knowledge) alarm. A record review of Resident 4's admission Assessment / readmission Bundle 6212024V1 – V2 dated 03/06/2026 revealed the resident was at risk for elopement based on the current assessment. A record review of Resident 4's Clinical – Assessment list dated 06/23/2026 revealed on 05/22/2026 an Elopement Risk assessment was completed, and the resident had a score of 19 which indicated the resident was at risk for elopement. On 06/17/2026 an Elopement Risk assessment was completed, and the resident had a score of 21 which indicated the resident was at risk for elopement. A record review of Resident 4's Quarterly / Comprehensive Bundle v3 * dated 06/05/2026 revealed the resident was at risk for elopement based on the current assessment. A record review of the facility's Updated Elopement risk 6-17-2026 dated 06/17/2026 revealed Resident 4 was on the list for being at risk for elopement. A record review of Resident 4's Progress Notes dated 06/23/2026 revealed on 05/22/2026 at 9:35 AM the resident was seen by staff trying to leave the facility out the front door. The facility contacted the resident's primary care physician (PCP) to get an order for a wander guard (a device placed on the resident or wheelchair that will set off an alarm if the resident attempts to exit a facility), but it did not reveal the PCP ordered a wander guard. The Progress Notes did not reveal that the resident refused a wander guard or that the resident and family had been educated on the risk versus benefits of a wander guard. A record review of RR of the facility's Fw: FM 5-22 email dated 06/23/2026 from the facility's Regional Director of Nursing (RDON) revealed the facility requested an order for a wander guard from the PCP as the resident continued to try to elope. The PCP requested additional documentation, but it did not reveal the PCP ordered a wander guard. A record review of Resident 4's Care Plan Report with a print date of 06/23/2026 revealed the resident had a Focus area of the resident was at risk for elopement with opportunity that had a created date of 05/22/2026 and revised date of 05/22/2026. Interventions included: Consider any pattern of exit seeking need or behavior to alter (change) resident schedule, treatment, medications or environment to manage behavior and ENSURE SAFETY. Date Initiated 05/22/2026, Revision on 06/10/2026 Explained wander guard placement to a specific resident's family member and Power of Attorney (POA)(person designated to make financial or healthcare decisions for a resident) and he/she verbalized understanding. Date Initiated 05/22/2026, Revision on 05/22/2026. Wander guard to wheelchair with resident's consent. Date Initiated 06/22/2026, Revision on 06/22/2026. The Care Plan Report did not reveal a focus area or interventions for the resident's elopement risk (continued on next page)

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	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prior to 05/22/2026. A record review of Resident 4' s Clinical Physician Orders dated 06/23/2026 did not reveal that a wander guard was ordered until 06/22/2026. An observation on 06/22/2026 at 8:39 AM with the facility's Director of Nursing (DON) revealed Resident 4 did not have a wander guard on the resident or the wheelchair. An observation on 06/22/2026 at 3:50 PM revealed that Resident 4 was sitting in a wheelchair by the nurse's station and the resident did not have a wander guard on. In an interview on 06/22/2026 at 3:50 PM, Resident 4 confirmed the resident had tried to leave the facility and doesn't want to be there. In an interview on 06/22/2026 at 8:39 AM, the DON confirmed Resident 4 did not have a wander guard on because the resident refused it, the resident was the resident's own person and did not have a POA. In an interview on 06/22/2026 at 9:09 AM, the DON confirmed Resident 4 refused to have a wander guard on. In an interview on 06/22/2026 10:17 AM, the Social Services Director (SSD) confirmed Resident 4's BIMS were all 0 because the resident was hard to understand until the SSD redone the BIMS on 06/18/2026 and the SSD determined it was 15. The SSD confirmed the resident was not considered and elopement risk because the resident was of sound mind and the resident was the resident's own person. The SSD confirmed Resident 4 was exit seeking and refused a wander guard. In an interview on 06/22/2026 at 12:27 PM, Registered Nurse (RN)-B confirmed RN-B was not aware of anything the facility had that included a description and photographs of the residents at risk for elopement. In an interview on 06/22/2026 at 3:53 PM, RN-B confirmed Resident 4 did not have a wander guard on. RN-B confirmed there was nothing in place to stop the resident from getting out of the facility other than the resident's mobility limitations. In an interview on 06/22/2026 at 4:10 PM, Medication Aide (MA)-C confirmed Resident 4 was an elopement risk and the resident hangs out by the front door. MA-C confirmed staff have to keep an eye on the resident. In an interview on 06/22/2026 at 4:10 PM, Nursing Assistant (NA)-D confirmed NA-D thought Resident 4 had good safety awareness, the resident knew what not to do but still does it. NA-D confirmed the resident recently tried to leave the gray doors by the nurse's station and NA-D had to redirect the resident. NA-D had seen Resident 4 try to leave the building through the front doors. NA-D confirmed there were times the staff could not watch the resident, especially on nights and weekends. In an interview on 06/22/2026 at 4:20 PM, the DON confirmed staff rounded on the residents every 2 hours and staff always knew where Resident 4 was. Staff could always see the resident and could see the resident from the nurse's station. The DON confirmed that the fact the resident had attempted to leave twice made the resident high risk for elopement. The DON confirmed the resident's primary (continued on next page)

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	06/23/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care physician (PCP) refused to sign the order for a wander guard because the resident was the resident's own responsible party. The DON confirmed the DON was not aware if the facility staff or PCP educated the resident or the resident's family on the risk versus benefits of not wearing a wander guard. In an interview on 06/23/2026 at 6:49 AM, NA-E confirmed Resident 4 was having issues with smoking about a month ago and tried to leave the building out of the front door. In an interview on 06/23/2026 at 10:01 AM, the DON confirmed the resident had tried to get out of the building to smoke a vape. The current elopement interventions in place for Resident 4 were monitoring and need-based checks. The DON confirmed the SSD was trying to get placed in Omaha. The DON confirmed the regular monitoring was not documented anywhere. The regular monitoring and need-based checks were not different than a resident that was not at risk of elopement received. In an interview on 06/23/2026 at 9:14 AM, Resident 4 confirmed by shaking the residents head no if the resident ever refused to allow the staff to put a bracelet or wander guard on. In an interview on 06/23/2026 at 9:19 AM, Resident 4's PCP confirmed the PCP did not order a wander guard for the resident because Resident 4 made the resident's own decision and does not attempt to go out the door. The PCP confirmed the PCP had been notified that the resident was at risk for elopement on 05/22/2026 and recently and that the resident attempted to exit the facility on 05/22/2026. The PCP confirmed that the PCP did not educate on the risk versus benefits of not wearing a wander guard. The PCP confirmed on 06/22/2026 the facility contacted PCP and said the resident agreed to a wander guard bracelet, so the PCP honored it and ordered a wander guard on 06/22/2026. In an interview on 06/22/2026 at 12:32 PM, the DON confirmed there was just a list of resident's at risk of elopement, but it did not contain photos or descriptions. In an interview on 06/23/2026 at 10:50 AM, the DON confirmed the facility did not have risk versus benefit education on Resident 4 for the wander guard. The DON confirmed the facility contacted the PCP on 05/22/2026 and requested a wander guard and the PCP did not order one. The DON confirmed the facility did not put any elopement interventions in place after the resident was initially assessed to be at risk for elopement on 03/06/2026 until the resident attempted to elope on 05/22/2026. The DON could not confirm that the resident did refuse the wander guard, but confirmed the PCP refused to sign a wander guard order.