

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

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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 07/16/2026
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.			
(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** License Reference Number 175 NAC 12-006.09(I) Based on record reviews, interviews and observations, the facility staff failed to: evaluate risks and hazards, identify causative factors, thoroughly investigate, implement interventions to reduce risks and hazards, implement new interventions to help reduce risks, monitor effectiveness and/or modify interventions all related to falls for 4 (Resident 3, 4, 5, and 6) of 5 sampled residents. The facility staff identified a census of 46. A record review of the facility's Fall Prevention Program with a revision date of 01/2026 revealed the following: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. a. The risk assessment categorizes residents according to low, moderate, or high risk. b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the (specify location) the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. 5. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling, (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or resident education ix. Therapy services referral 7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. 8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed. 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 assessments and actions. g. Obtain witness statements in the case of injury. A record review of the facility's undated What to do When a Resident has a Fall document revealed the following: 1. Assess the resident while they are still on the floor. (Vitals, ROM, check if legs are symmetrical, check neuros (neurological) 2. After assessed, lift resident with a Hoyer and 2 staff members unless they are able to do it on their (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	own. 3. If there is an injury call the Director of Nursing (DON) immediately. If there is no injury, a text may be made instead. 4. IF the resident is on any anticoagulation medications and they hit their head, notify the medical director and DON. Start neuro checks. 5. Complete a risk assessment. Go to clinical, then to risk assessment, click new and search the residents name. Select the type of incident and save. Fill out all areas including immediate action taken. 6. In the action taken section ensure you document the intervention. This intervention is what will prevent them from falling in the same (or a similar) way again. If there are no witnesses to the fall, neuro checks must be completed. This is not optional unless the medical director has ordered to stop neuro checks. 7. Update the Care Plan. A. A record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 5/21/2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE] -Brief Interview of Mental Status (BIMS) was 13 out of 15. A BIMS score of 13 indicates the resident was cognitively intact. -Resident 3 was setup/clean up assistance from facility staff with eating. - Resident 3 was supervision or touching assistance from facility staff with oral hygiene and wheel 50 feet. - Resident 3 was partial/moderate assistance from facility staff with rolling, sit to lying and lying to sitting on the side of the bed. - Resident 3 was substantial/maximal assistance from facility staff with toileting hygiene, upper body dressing, lower body dressing, putting on and taking off footwear, personal hygiene, sit to stand and chair to bed transfer. - Resident 3 was dependent on staff with all other self-care and mobility needs. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Disease (a progressive, incurable lung disease that restricts airflow and makes breathing difficult), Chronic Heart Failure (a long-term condition where the heart muscle weakens or stiffens, preventing it from pumping blood efficiently), and Chronic Kidney (when the kidneys are damaged and cannot filter blood properly, causing waste to build up). A record review of Resident 4's Minimum Data Set (MDS &ndash; a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 05/14/2026, revealed Resident 4 had a Brief Interview for Mental Status (BIMS &ndash; a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) score of 3, indicating the resident had severe cognitive deficits. A record review of Resident 4's nursing progress notes (legal and clinical documents that track a patient's health status, the care provided and their response to interventions) by Licensed Practical Nurse (LPN) D revealed Resident 4 had an unwitnessed fall on 06/7/2026 at 1:55 PM. A record review of Resident 4's Care Plan (CP &ndash; a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care), revealed there were no new interventions put in place after Resident 4's fall on 06/17/2026. An interview on 07/15/2026 at 2:20 PM with the DON confirmed they did not do a fall investigation for Resident 4's fall on 06/17/2026 and therefore did not find any causative factors for Resident 4's fall. An interview on 07/15/2026 at 2:20 PM with the DON confirmed every fall requires new interventions to be placed on a residents care plan. The DON confirmed there were no new interventions placed on the care plan for Resident 4's Fall on 6/17/2026. D. A record review of Resident 6's admission Record revealed Resident 6 was admitted to the facility on [DATE] with the following diagnoses: History of falling, Hepatic failure (a condition caused when large parts of the liver become damaged), Alcoholic Cirrhosis of liver with ascites (an advanced stage of alcoholic-related liver disease where fluid leaks into the abdominal cavity), reduced mobility, Severe Protein-Calorie Malnutrition (a life threatening deficiency of macronutrients and energy), and traumatic subdural hemorrhage (bleeding caused by a head injury between your brain and your skull) without loss of consciousness. A record review of Resident 6's Minimum Data Set (MDS &ndash; a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 06/10/2026 revealed Resident 6 had a Brief Interview for Mental Status (BIMS &ndash; a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) score of 15, indicating Resident 6 was cognitively intact. A record review of Resident 6's nursing progress notes (legal and clinical documents that track a (continued on next page)		

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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 12-006.18 Based on observations, interviews and record reviews, the facility staff failed to complete hand hygiene between glove changes for 2 (Residents 5 and 6) of 3 resident sample, complete glove changes when moving from a contaminated surface to a clean surface for 1 (Resident 5) of 1 sample resident, failed to put on personal protective equipment when administering tube feeding for 1 (Resident 7) of 1 sample resident, failed to secure a gown when providing catheter cares for 1 (Resident 5) of 1 sample resident and failed to have EBP signs on the doors for 1 (Resident 5) of 2 sample resident. The facility staff identified a census of 46. Record Review of the facility's policy Enhanced Barrier Precautions with a revision date of 1/2026 revealed the following: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC but may be considered epidemiologically important. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) ii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room). d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. f. Provide education to residents and visitors. g. Do not restrict room placement or out-of-room activities due to enhanced barrier precautions. h. See Table 1 for implementing contact versus enhanced barrier precautions for more information. 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters h. Wound care: any skin opening requiring a dressing. Record Review of the facility's Hand Hygiene policy with a revision date of 2/1/2018 revealed the following: Policy: Staff involved in direct resident contact will perform hand hygiene procedures to prevent the spread (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of infection to other personnel, residents, and visitors. 2. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 3. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations: b. The use of gloves does not replace hand washing. Wash hands after removing gloves. Record review of the facility's undated Hand Hygiene Table revealed the following: -When coming on duty -Between resident contacts -After handling contaminated objects -Before applying and after removing personal protective equipment (PPE), including gloves -Before preparing or handling medications -Before performing resident care procedures -Before and after providing care to resident in isolation -After handling items potentially contaminated with blood, body fluids, secretions, or excretions -When, during residents care, moving from a contaminated body site to a clean body site -After assistance with personal body functions (e.g., elimination, hair grooming. Smoking) -Before going off duty -When in doubt A. A record review of Resident 7's admission record revealed the resident was admitted on [DATE] with the following diagnoses: Paralysis of vocal cords and larynx (a condition where nerve impulses to the voice box are disrupted, preventing the vocal cords from opening and closing properly),Hemiplegia (total or severe paralysis affecting only one side of the body), protein-calorie malnutrition (a severe (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition caused by inadequate intake or absorption of protein and calories), and Dysphagia (difficulty swallowing). A record review of Resident 7's Minimum Data Set (MDS &ndash; a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 7/2/2026 revealed Resident 7 had a Brief Interview for Mental Status (BIMS &ndash; a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) of 13, revealing Resident 7 has mild cognitive impairment. A record review of Resident 7's Care Plan (CP &ndash; a personalized, actionable document that outlines a patient's health needs, goals, and specific interventions to manage their care) revealed Resident 7 required tube feeding (a method of receiving liquid nutrition) due to dysphagia and vocal cord paralysis. A record review of Resident 7's Medication Administration Record (MAR) for July 2026 revealed the following order: TwoCal HN (a high nutrition tube feed formula) 240ml via Peg tube (percutaneous Endoscopic Gastrostomy &ndash; a flexible feeding tube placed directly into the stomach through the abdominal and used to deliver liquid nutrition) 5 times daily. Flush with 100ml (milliliters- a unit of measurement) water before and after each feeding. An observation on 7/14/2026 at 10:15 AM of Licensed Practical Nurse (LPN) B completing the administration of a tube feed formula bolus (a method of delivering liquid nutrition or formula, which is a specialized liquid food designed for people who cannot safely eat or swallow, into a feeding tube in single, relatively large doses at scheduled times, multiple times a day) to Resident 7. LPN B was observed pouring tube feed into a syringe attached to a g tube (gastric tube-a surgically inserted through the abdomen directly into the stomach, typically to deliver nutrition, hydration or medications) for Resident 7. LPN B was wearing gloves but was not wearing a gown. An interview on 07/14/2026 at 10:25 AM with LPN B confirmed they were not aware they were supposed to wear a gown for administering tube feedings and confirmed they had not worn a gown when they had administered the tube feed bolus. LPN B confirmed this was a breach of the Enhanced Barrier Precautions for infection control and was a potential source for cross contamination (the physical transfer of harmful bacteria, viruses, allergens or toxins from one surface, person or food to another). An interview on 07/15/2026 at 11:15 AM with the Regional Director of Nursing (RDON) confirmed staff members are required to wear a gown when providing tube feeding, in accordance with the EBP guidelines. The RDON confirmed not wearing a gown while administering tube feeding is a breach of infection control. B. A record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for care planning) dated 6/8/2026 revealed the facility staff assessed the following about the resident: - admitted to the facility on [DATE] - Brief Interview of Mental Status (BIMS) was 2 out of 15. A BIMS score of 2 indicates the resident had severe cognitive impairment. - Resident 5 was setup/clean up assistance from facility staff with rolling and lying to sitting on the side of the bed - Resident 5 was supervision/touching assistance from facility staff with eating, partial/moderate with sit to lying, chair to bed transfer. - Resident 5 was substantial/maximal assistance from facility staff with tub/shower transfer, toilet transfer, sit to stand, upper body dressing, lower body dressing, putting on and taking off footwear. - Resident 5 was dependent on facility staff for all other self-care and mobility needs - Resident 5 had diagnosis of stroke, cerebrovascular accident, non-Alzheimer's dementia, and difficulty walking. An observation on 7/14/2026 at 3:50 PM of (LPN) B performing catheter care for Resident 5. LPN B gathered sterile packets of gauze 4 x 4's, a bottle of sterile water and gloves. LPN B knocked on Resident 5's, waited for acknowledgement and entered the room. LPN B placed the supplies on Resident 5's bedside table, opened the sterile gauze packets without touching their contents, and poured sterile water over the gauze. LPN B entered the bathroom and washed their hands. LPN B did not have a clean gown in the room, so they exited the room, obtained a gown from Resident 1's room and returned to Resident 5's room. LPN B had touched Resident 5's door on entering and exiting, touched Resident 1's door on entering and exiting, opened a set of plastic drawers in Resident 1's room and removed a gown before returning to Resident 5's room. LPN B did not use hand sanitizer or wash their hands when they returned to the room. LPN B put their arms in the gown but did not tie the gown ties behind them. LPN B donned gloves, used their gloved hands to close the door, pull the privacy curtain around the bed, pull the blankets off the resident, assist the resident to pull down their pants, unfasten their brief and move it out of the way. LPN B's gown slid down their arms and had to be shrugged back into place. LPN B changed gloves without using hand sanitizer. LPN B picked up a wet 4x4 in their right hand, grasped the base of Resident 5's penis with their left hand and then used their gloved right hand, which was still holding the wet 4x4, grabbed a trash can to place beside the bed. LPN B then used the contaminated 4x4 to wipe the head of Resident 5's penis in a circular motion. LPN B discarded the soiled gauze and repeated the cleaning with a clean gauze 4x4. LPN B discarded the soiled gauze, stabilized the catheter tube with their left hand, and used a clean gauze to wipe the catheter tube moving from the genitalia towards the bag. LPN B discarded the gauze, refastened the residents briefs and replaced (gender) pants. LPN B removed their gown and gloves, discarded the trash, and exited the room. LPN B used hand sanitizer after exiting the room. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 7/14/2026 at 4:05pm with LPN B confirmed they did not use hand hygiene when they returned to Resident 5's room with a clean gown. LPN B confirmed they donned (put on) a gown and gloves without performing hand hygiene. LPN B confirmed they had closed the door, closed the privacy curtain, and touched the residents blankets and clothing before performing catheter care and had not used hand hygiene or changed gloves. LPN B confirmed they had used their gloved right hand, which was holding a wet 4x4, to relocate a trash can and they did not discard the 4x4, change gloves or use hand hygiene before cleaning Resident 5's penis. LPN B confirmed these actions could cause cross contamination for Resident 5 as LPN B moved from a dirty to clean area each time. LPN B confirmed they did not know there were supposed to use hand hygiene between glove changes. An observation on 7/16/2026 at 7:14 AM Licensed Practical Nurse (LPN)- A after entering Resident 5's room revealed LPN-A completed hand hygiene, closed the curtain, put on gloves, grabbed the trash can and placed it next to the residents bed, did not complete hand hygiene or change gloves and proceeded to open supplies. LPN-A removed Resident 5's sock, did not complete hand hygiene or change gloves and cleansed the wound area, painted the wound area with betadine, and removed gloves. LPN- A labeled and dated the dressing, did not complete hand hygiene. An observation on 7/16/2026 at 7:14 AM revealed that there was no EBP sign on Resident 5's door or in Resident 5's room. An observation on 7/16/2026 at 10:31 AM revealed that there was no EBP sign on Resident 5's door or in Resident 5's room. In an interview on 7/16/2026 at 7:26 AM LPN-A confirmed that hand hygiene and glove changes were not completed for Resident 5 while moving from a contaminated surface to a clean surface and should have been. LPN-A confirmed that hand hygiene was not completed between glove changes and should have been. In an interview on 7/16/2026 at 10:31 AM, Director of Nursing (DON) confirmed that there is no EBP sign on Resident 5's door or behind the door and there should be. C. A record review of Resident 6's admission Record revealed Resident 6 was admitted to the facility on [DATE] with the following diagnoses: History of falling, Hepatic failure (a condition caused when large parts of the liver become damaged), Alcoholic Cirrhosis of liver with ascites (an advanced stage of alcoholic-related liver disease where fluid leaks into the abdominal cavity), reduced mobility, Severe Protein-Calorie Malnutrition (a life threatening deficiency of macronutrients and energy), and traumatic subdural hemorrhage (bleeding caused by a head injury between your brain and your skull) without loss of consciousness. A record review of Resident 6's Minimum Data Set (MDS &ndash; a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 06/10/2026 revealed Resident 6 had a Brief Interview for Mental Status (BIMS &ndash; a standardized assessment used in nursing homes to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assess cognitive function, specifically memory and orientation) score of 15, indicating Resident 6 was cognitively intact. An observation on 7/14/26 at 12:20 PM of wound care provided by RN C for Resident 6. RN C gathered the supplies, which consisted of sterile 4 x 4 gauze packets, individual vials of normal saline and a bordered mepilex dressing, knocked and entered Resident 6's room. RN C placed the supplies on the bedside dresser and opened the dressing packets without touching the contents. RN C initialed and dated the exterior of the bordered mepilex. RN C donned (put on) a gown and gloves but did not use hand sanitizer or wash their hands. RN C assisted Resident 6 to pull down their brief and expose the open area. RN C removed their gloves and donned clean gloves without using hand sanitizer. RN C opened 4 vials of normal saline solution and soaked a pack of gauze pads with it. RN C used the gauze 4 x 4's to clean Resident 6's wound, located on the sacrum, and discarded each gauze pad after wiping the area. RN C changed gloves, without using hand sanitizer. RN C placed their gloved right hand on Resident 6's right hip and used their left hand to attempt to place the mepilex on the open area. The adhesive edge of the dressing flipped over and adhered to the dressing. RN C used both hands to separate the adhesive areas, touching the inside of the dressing with their soiled right glove and placed the dressing over the wound bed. RN C replaced Resident 6's briefs, discarded the trash and exited the room using hand sanitizer on the way out of the room. An interview on 7/14/2026 at 11:55 AM with RN C confirmed they had not used hand sanitizer or washed their hands between glove changes when providing wound care to Resident 6. RN C reported they were not aware it was a requirement. RN C did not discard the residents dressing after touching the inside of the adhesive with a soiled glove. RN C confirmed touching the dressing and then placing it on Resident 6's open wound was a source of cross contamination and a breach of infection control. An interview on 7/15/2026 at 11:15 AM with the Regional Director of Nursing (RDON) and interim Infection Preventionist confirmed it is the facility expectation that hand sanitization is completed between glove changes and glove changes are required when going from a contaminated area to a clean area. The RDON confirmed touching the inside of a dressing with a contaminated glove is a breach of infection control. The RDON confirmed going from a dirty (contaminated) area to a clean area, for example, touching doors, curtains, blankets and then touching a resident without performing hand hygiene and changing gloves is a source of cross contamination. RDON confirmed touching a trash can and then performing catheter care without performing hand hygiene and changing gloves is a source of cross contamination and a breach in infection control.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. License Reference Number 175 NAC 12-006.09(H) The facility failed to ensure a provider was contacted to provide pain management for Resident 4. The facility has a census of 46.A record review of the facility's Pain Management policy dated 04/2019 and reviewed 02/2025 revealed the following:Policy:The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences.Recognition:In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will:Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g., after a fall, change in behavior or mental status, new pain, or an exacerbation of pain)Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 2. Facility staff will observe nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to:Change in gait (e.g., limping), skin color, vital signs (e.g., increased heart rate, respirations, and/or blood pressure), perspiration.Loss of function or inability to perform activities of daily living (ADLs) (e.g., rubbing a specific location of the body, or guarding a limb or other body partsFidgeting, increased or recurring restlessnessFacial expressions (e.g., grimacing, frowning, fright or clenching of the jaw)Behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities.Difficulty eating or loss of appetite.Weight lossDifficulty sleeping (insomnia)Negative vocalizations (e.g., groaning, crying, whimpering, or screaming)Decline in activity level.Skin ConditionsPain Assessment:The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain.Based on professional standards of practice, an assessment of evaluation of pain by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident.Reviewing the residents current medical conditions (e.g., pressure injuries, diabetes with neuropathic pain, immobility, infections, amputation, oral health conditions, post CVA, venous and arterial ulcers, and multiple sclerosis)Identifying key characteristics of pain.Duration of painFrequencyLocationTimingPattern (e.g., constant, or intermittent)Radiation of painImpact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood)Pain management and treatment:Based on the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professions and the resident and/or the resident's representative will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. A record review of Resident 4's admission Record revealed they were admitted to the facility 02/16/2026 with the following diagnoses:Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills) with late onset, Cognitive communication deficit (a disorder that affects the ability to communicate effectively),dementia with other behavioral disturbance, Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease that (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restricts airflow and makes breathing difficult), Chronic Heart Failure (a long-term condition where the heart muscle weakens or stiffens, preventing it from pumping blood efficiently), and Chronic Kidney (when the kidneys are damaged and cannot filter blood properly, causing waste to build up). A record review of Resident 4's Minimum Data Set (MDS - a federally mandated, standardized assessment tool used in Medicare/Medicaid-certified nursing homes to evaluate a residents functional, medical, psychosocial and cognitive status) dated 05/14/2026, revealed Resident 4 had a Brief Interview for Mental Status (BIMS - a standardized assessment used in nursing homes to assess cognitive function, specifically memory and orientation) score of 3, indicating the resident had severe cognitive deficits. A record review of a progress note dated 6/28/2026 by Registered Nurse (RN) C revealed the aide had reported to the nurse that the resident had not been eating for several days, has been moaning a lot and has on occasion said their back hurts. RN C placed a call to the provider but was unable to leave a message as the office is closed on weekends. RN C alerted the Director of Nursing (DON) for follow up with this on Monday (06/29/2026) when the office has the phone on. A record review of Resident 4's Order Summary revealed Resident 4 had an order for Acetaminophen 500mg tablets. Take 2 tablets (1,000mg) by mouth four times daily as needed. A record review of Resident 4's Medication Administration Record revealed Resident 4 did not receive any PRN pain medication on 06/28/2026. A record review of a fax from the DON to Resident 4's provider revealed the DON had informed the provider of the residents significant decline on 06/30/2026. An interview on 7/14/2026 at 1:25 PM with RN C confirmed a nurse assistant had reported Resident 4 was in pain. RN C reported they had tried to contact the Resident's provider, but it was Sunday and the phone was off. RN C confirmed they had passed the request to the DON to contact the Resident's Physician on Monday. In relation to the resident pain. RN C confirmed they did not give the resident any PRN pain medication and they did not attempt to contact the facility's attending provider. An interview on 7/15/2026 at 2:20 PM with the DON confirmed they had received notification of Resident 4's increased pain, and the request to contact Resident 4's provider on 06/28/2026. The DON confirmed they did not contact the provider until 06/30/2026. When asked why they waited to contact the provider, the DON replied, I was just so busy on the floor that I forgot to do it until the 30th. The DON confirmed they should have contacted the provider on the 29th as requested.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review the facility staff failed to include the resident profile in the facility assessment and failed to update the facility assessment annually. The facility staff identified a census of 46. Findings are: A record review on 7/16/2026 11:04 AM of the facility assessment revealed the following: -Overview of the Assessment Tool: This is an optional template provided for nursing facilities, and if used, it may be modified. Each facility has flexibility to decide the best way to comply with this requirement. -The tool is organized into three parts: resident profile section that includes the numbers, disease/conditions, physical and cognitive disabilities, acuity, and ethnic/culture/religious factors that impact care. Further record review of the facility assessment revealed it did not contain the resident profile section that includes the numbers, disease/conditions, physical and cognitive disabilities, acuity, and ethnic/culture/religious factors that impact care. In an interview on 7/16/2026 11:49 AM, Director of Nursing (DON) confirmed that the resident profile is not in the facility assessment binder and should be. DON confirmed that the facility assessment binder is missing pages 3, 4, 5, and 6 and should not be. DON confirmed that the facility assessment has not been updated and should be.		

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility staff failed to have patient transportation agreements with outside agencies and dialysis centers. The facility staff identified a census of 46. Findings are: A record review of the facility's provided document titled Dialysis Transportation Services with effective date of 01/2026 revealed that the facility had unsigned patient transfer agreement with zTrip [NAME]. A record review of the facility's provided document titled Dialysis Transportation Services with effective date of 01/2026 revealed that the facility had unsigned patient transfer agreement with Oceans Drive Transportation. In an email communication on 7/16/2026 at 1:37 PM, Regional Director of Operations (RDO) said that signed copies of the patient transportation agreements were in the facility survey binder, and staff was to get them and scan them to the RDO so the RDO can email them to the survey team. In an email communication on 7/16/2026 at 1:54 PM, RDO confirmed that the signed patient transportation agreements will be provided once the RDO has access to them. In an interview on 7/16/2026 at 3:11 PM, Director of Nursing confirmed that there was no evidence of patient transportation agreements. On 7/21/2026 at 1:00 PM the survey team had still not received the signed patient transportation agreements.		