STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285124	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Neligh	1100 T Street Neligh, NE 68756

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Licensure Reference Number 175 NAC 12-006.05(S)Based on record review and interview; the facility failed to ensure Resident 32 received dignified care when staff did not respond in a timely manner to a request for assistance with toileting. The sample size was 22 and the facility census was 30.Findings are: A. Review of the facility policy Vulnerable Adult dated 12/30/2025 revealed the following:-The facility had zero tolerance for resident abuse, neglect, mistreatment, and/or misappropriation of property. The facility reported maltreatment of vulnerable adults to protect adults who were dependent upon others for their care. -Abuse was defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.-Abuse included deprivation by an individual or caretaker of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. -Instances of abuse, included verbal, sexual, physical, and mental abuse.B. Review of Resident 32's Care Plan with a revision date of 1/30/26 revealed the resident had a history of a stroke, bladder incontinence related to immobility, wore an incontinence product to protect the skin and maintain dignity, and had self-care performance deficits including dependence on staff for transfers and toileting hygiene. Review of Resident 32's Grievance Form dated 1/23-1/24/26 revealed that on Friday night (1/23) the resident requested to go to the bathroom and staff (un-named) told the resident that they could not do that, so the resident messed self and the spouse of Resident 32 reported the resident felt humiliated. In addition, on Saturday (1/24) the resident sat on the toilet for 15-20 minutes waiting for assistance. Further review revealed the facility confirmed that staff members (un-named) made those comments and were given verbal warnings. During an interview on 5/6/26 at 3:00 PM the facility Administrator confirmed that a resident reporting feeling humiliated was a dignity concern, and staff were to treat residents with dignity at all times. Staff education including Residents Rights, was completed at the time of hire and annually. Further interview confirmed that Resident 32's concern that involved lack of staff response to a request for assistance with toileting resulting in unnecessary incontinence was a dignity concern.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)Based on observation, record review and interview; the facility failed to ensure the building was clean and in good repair. The facility census was 30.Findings are: A. Review of the facility deep clean checklist, undated, revealed that cleaning vents and light fixtures was one of the tasks on the checklist to deep clean a room. B. Observation of resident rooms on 5/4/26 at 9:00 AM revealed resident rooms B42, C12, C14, D17, D22, D26, D27 and ACU 6 vents in the bathroom had a heavy layer of gray fuzzy layer covering the vent. C. Record review of the April 2026 Calendar, Resident Rooms Deep Cleaned, revealed that room B42 was deep cleaned on 4/10/26, room C12 was deep cleaned on 4/2/26 , room C14 was deep cleaned on 4/11/26, room D17 was deep cleaned on 4/14/26, room D22 was deep cleaned on 4/21/26, room D26 was deep cleaned on 4/13/26, room D27 was deep cleaned on 4/8/26 and room ACU 6 was deep cleaned on 4/13/26. D. An interview with the Housekeeping Aide-L confirmed that cleaning the bathroom vents was not part of the deep cleaning of the room. Further interview confirmed that the bathroom vents were wiped off but not routinely cleaned. E. Review of the Facility Assessment (document used to determine needed resources necessary to care for facility residents during day to day operations and emergencies) including the physical environment, equipment, services, and other physical plan considerations necessary to care for the resident population, dated 5/15/24 revealed the facility department managers or designees, followed procedures for maintaining inventory, and assessing the condition of equipment. Preventative maintenance and cleaning schedules were in place per manufacturer recommendations. F. During the course of the survey from 5/4/26 through 5/6/26 multiple environmental concerns identified were identified including the following: -very soiled and stained baseboards that were pulling away from the drywall in areas in halls B and D.-Dry wall gouges in hall D next to rooms [ROOM NUMBERS]. -All room entry door frames had heavily chipping paint as did the bathroom door frames in halls B and D. -The floor next to an exit door in the ACU hallway was heavily soiled and a trap door/crawl space door on the floor at the same entry had sunken in, making the floor unlevel and the area was covered by a rug. -Hallway's B and D had chipping paint on the lower half of the walls throughout both halls. -Drywall corners were deteriorated and peeling away next to both nurses' stations. G. On 5/7/26 at 10:04 AM during a tour and interview with the facility Administrator the following environment concerns were observed and confirmed. Chipping/peeling paint on the lower half of the hallway walls in halls B and D, chipping and peeling paint on the entry doors and bathroom doors of the resident rooms in halls B and D, gouged and deteriorated dry wall in the hallways in both halls B and D, and on the corners of both nurses' stations. There were areas of heavily soiled flooring and a dipping crawl space door in the ACU hallway near the exit door creating a tripping hazard in need of repair. The facilities lack of repair was not creating a homelike environment.