STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285126	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Nebraska City, Inc	1800 14th Avenue 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 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. Based on interview and record review the facility failed to notify the practitioner of significant weight loss for 1 (Resident 12) of 1 resident. The facility staff identified a census of 47. Findings are:A.Record review of facility's Weight Recording Policy dated 10/2025 revealed the following; Policy Statement -It is the policy of this facility to routinely monitor weight of all residents/patients. Procedure 1. All residents/patients are weighed upon admission and monthly thereafter, at a minimum. The admit weight will be recorded on the admission assessment.2. More frequent weights (i.e., weekly, daily) will be obtained when need is determined by physician, nursing or dietician. Weights will be recorded in the Electronic Health Record (EHR).3. The primary physician and dietician will be notified of any significant weight loss or gain of five percent (5%) or more in one month, seven-and one-half percent (7.5%) in three months and ten percent (10%) in six months. Nursing will notify the primary physician and document the notification in the medical record of the significant weight loss/gain, at the direction of the Dietician and or the Dietary Coordinator.4. Consideration for resident right refusals and terminal diagnosis will be made on an individual basis.5. In the case of significant weight change from one weight to another, this will result in an automatic re-weight. Significant weight change will be reported to the dietician and or dietary coordinator. B.Record Review of Resident 12's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 1-11-26 revealed the facility admitted the resident on 1-5-26 with diagnoses of Unspecified fracture of T11-T12 (thoracic spine) vertebra, Spinal Stenosis (a narrowing of the spinal canal, placing pressure on the spinal cord and nerves, usually caused by age related degeneration), other intervertebral disc degeneration, thoracolumbar region, and esophageal obstruction; a Brief Interview for Mental Status (BIMS, a standardized 0-15 point tool used in nursing homes to assess cognitive impairment) of 15/15, indicating intact cognition. Further review revealed a weight for Resident 12 of 134 pounds. Record review of EHR form titled vital signs: weights revealed on 1-5-26 Resident 12's weight was 134.4 pounds. Further review of Resident 12's weights revealed on 1-19-26 Resident 12 weighed 128.8 pounds, a loss of 5.6 pounds or a 4.17% weight loss compared to the weight on 1-5-2026. Record review of EHR form titled vital signs: weights revealed on 2-16-26 Resident 12's weight was 118 pounds a loss of 10.8 pounds or a 7.76% weight loss compared to the weight on 1-19-26 and a significant weight loss in 30 days with no evidence the resident was re-weighed. Review of a Nursing Facility Note Physician's Assistant Certified (PAC) with an encounter date of 2-18-26 revealed the practitioner identified a 10-pound weight loss for Resident 12 with a note that if there was no improvement to consider mirtazapine. Review of a form labeled Nutrition Fax sheet dated 2-23-26 revealed a recommendation from the Registered Dietician to the practitioner to add a magic cup or shake with meals due to weight loss. Further review revealed the practitioner signed the form and agreed with the recommendations which was noted by a facility nurse on 2-25-26. Review of the February, March and April 2026 Medication Administration Record (MAR) revealed Resident 12 had taken the magic cup starting February 28- March 5,2026 and refused the Magic Cup/or protein shake from 3-6-26 through 4-13-26 for a total of 38 days and a total of 114 (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurrences with no evidence the facility notified the practitioner. Record review of EHR form titled vital signs: weights revealed on 3-11-26 Resident 12's weight was 112.4 a loss of 5.6 pounds or a 5.39% weight loss compared to the weight on 2-16-26 and a significant weight loss in 30 days. Review of Resident 12's medical record revealed there was no evidence the resident was re-weighed or the provider was notified of the significant weight loss. Record review of EHR form titled vital signs: weights revealed on 3-26-26 Resident 12's weight was 106.2 a loss of 6.2 pounds or a 5.18% weight loss compared to the weight on 3-11-26 and a significant weight loss in 30 days. Review of Resident 12's medical record revealed there was evidence the resident was re-weighed or provider was notified of the significant weight loss. Review of Resident 12's EMR revealed a form titled Event Report, Metabolic/Nutrition Events-Unplanned Weight Loss with an initiation date of 3-31-26 identified Resident 12 as having a loss of 5% or more in the last month or loss of 10% or more in the last 6 months with it marked yes, not on physician prescribed weight loss regimen. Section labeled Notification Guidelines Notify MD (Doctor of Medicine)/NP (Nurse Practitioner)/PA (Physicians Assistant) on or by the next working day for any of the following (May use fax, e-mail or voicemail) for weight loss greater than 5% in 1 month, 10% in 6 months or significant decrease in meal intake over the course of several days with no guideline or notification noted. Interview with Director of Nursing (DON) on 4-14-26 at 10:35 AM confirmed there was no evidence of notification of dietician or practitioner with weight loss event initiated on 3-31-26. Interview with the DON on 4-14-26 at 1:59 PM confirmed there was no evidence of physician notification of weight changes since 2-23-26 and should have been.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a nutritional assessment prevent significant weight loss for 1 (Resident 12) of 1 resident. The facility staff identified a census of 47. Findings are:A.Review of a Nutritional Assessment Policy dated 1-2-24 revealed the following: As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident.Policy Interpretation and ImplementationThe dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition.The nutritional assessment will be conducted by the multidisciplinary team and shall identify but are not limited to the following components:Usual body weight;Current height and weight;A description of the resident's usual intake and appetite;A history of reduced appetite or progressive weight loss or gain prior to admission;Current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors;Advance directives that may influence decision-making regarding nutrition support;General appearance - a description of the resident's overall appearance;The resident's usual route(s) of intake (e.g., oral, enteral, parenteral);Usual meal and snack patterns;Food preferences and dislikes (including flavors, textures, and forms);Food restrictions, including food allergies and cultural or religious practices affecting food choices; andPreferred portion sizes.Current medication regimen, including a list of medications that affect nutrient absorption, appetite, level of consciousness, and/or gastrointestinal function.Current clinical conditions and recent events that may have affected a resident's nutritional status and risk factors;Current laboratory results related to fluid and electrolyte status (BUN, creatinine, serum osmolality); andThe presence of chewing or swallowing abnormalities, i.e., conditions of the mouth, teeth, gums pharynx or esophagus that affect the resident's ability to chew or swallow food.An estimate of calorie, protein, nutrient and fluid needs;Whether the resident's current intake is adequate to meet his or her nutritional needs; andSpecial food formulations. 4.The multidisciplinary team shall identify, upon the resident's admission, quarterly, and as needed due to change of condition the following situations that place the resident at increased risk for impaired nutrition Cognitive or functional decline Chewing or swallowing Pain Medication Environmental Increased need for calories and/or protein Poor digestion or absorption Fluid and nutrient loss Inadequate availability of food or fluids 6. Sources of information for the resident nutritional assessment may include the following: a. Standardized nutrition screening and assessment tools; b. Resident Assessment Instrument (RAI); c. Assessments from other disciplines; d. Observation; e. Resident and family interviews; and f. The resident's current medical record. B.Record review of facility's Weight Recording Policy dated 10/2025 revealed the following: -Policy Statement -It is the policy of this facility to routinely monitor weight of all residents/patients. Procedure 1. All residents/patients are weighed upon admission and monthly thereafter, at a minimum. The admit weight will be recorded on the admission assessment. 2. More frequent weights (i.e., weekly, daily) will be obtained when need is determined by physician, nursing or dietician. Weights will be recorded in Electronic Health Record (EHR). 3. The primary physician and dietician will be notified of any significant weight loss or gain of five percent (5%) or more in one month, seven-and one-half percent (7.5%) in three months and ten percent (10%) in six months. Nursing will notify the primary physician and document the notification in the medical record of the significant weight loss/gain, at the direction of the Dietician and or the Dietary Coordinator. 4. Consideration for resident right refusals and terminal diagnosis will be made on an individual basis. 5. In the case of significant (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight change from one weight to another, this will result in an automatic re-weight. Significant weight change will be reported to the dietician and or dietary coordinator. C.Record Review of Resident 12's admission minimum Data Set (MDS, a federally mandated comprehensive assessment tool to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 1-11-26 revealed the facility admitted the resident on 1-5-26 with diagnoses of Unspecified fracture of T11-T12 (thoracic spine) vertebra, Spinal Stenosis (a narrowing of the spinal canal, placing pressure on the spinal cord and nerves, usually caused by age related degeneration), other intervertebral disc degeneration, thoracolumbar region, and esophageal obstruction; a Brief Interview for Mental Status (BIMS, a standardized 0-15 point tool used in nursing homes to assess cognitive impairment) of 15/15, indicating intact cognition. Further review revealed a weight of 134 pounds. Record review of Resident 12's comprehensive care plan dated 1-18-26 revealed Resident 12 was identified as having a potential for altered nutrition, hydration and weight status related to history of multiple medication use, and complex medical history with a goal the resident to consume 50-75% of most meals and 75-100% of fluids offered. The approach on Resident 12's care plan to meet this goal dated on 1-18-26 was for staff to give a regular diet, weights per MD orders, milk only with cereal, likes cottage cheese, yogurt, mashed and sweet potatoes, fish and chicken, monitor meal intakes, appropriate alternates offered, Labs (laboratory) as ordered, resident refused starting oral supplement. Record review of Resident 12's Electronic Health Record (EHR) to include progress notes, physicians orders, care plan, and MDS revealed there was no nutritional assessment completed to include usual body weight, residents usual intake, history of reduced appetite or progressive weight loss or gain prior to admission, usual meal and snack patterns, current medication regimen, including a list of medication that affect nutrient absorption, appetite, level of consciousness, and or gastrointestinal function, preferred portion sizes, current laboratory results related to fluid and electrolyte status, the presence of chewing or swallowing abnormalities, and whether the resident's current intake is adequate to meet their nutritional needs until 4-9-26, a 3 month time span. Record review of EHR form titled vital signs: weights revealed on 1-5-26 Resident 12's weight was 134.4 pounds. Further review of Resident 12's weights revealed on 1-19-26 Resident 12 weighed 128.8 pounds a loss of 5.6 pounds or a 4.17% weight loss compared to the weight on 1-5-2026. Record review of EHR form titled vital signs: weights revealed on 2-16-26 Resident 12's weight was 118 pounds a loss of 10.8 pounds or a 7.76% weight loss compared to the weight on 1-19-26 resulted in a significant weight loss in 30 days. There was no evidence of the facility re-weighing the resident. Review of a Nursing Facility Note by the facility Physician's Assistant Certified (PAC) with an encounter date of 2-18-26 revealed the following-Weight Loss-10-pound weight loss over the last month, poor appetite and certain preferences for food consistency due to concern from Schatzki ring (a thin benign ring of tissue that forms in the lower esophagus, often causing difficulty swallowing or a sensation of food getting stuck, especially solid food) history -Depression concerns from nursing staff-Dietary Consult-Trial puree food consistency-Has had prior Speech Therapy (ST) consultation-If no improvement consider mirtazapine Review of a form labeled Nutrition Fax sheet dated 2-23-26 revealed a recommendation from the Registered Dietician to the practitioner to add a magic cup or shake with meals due to weight loss. Further review revealed the practitioner signed the form and agreed with the recommendations which was noted by a facility nurse on 2-25-26. Review of the February, March and April 2026 Medication Administration Record (MAR) revealed Resident 12 had taken the magic cup starting February 28- March 5,2026 and refused the Magic Cup/or protein shake from 3-6-26 through 4-13-26 for a total of 38 days and a total of 114 occurrences with no evidence the facility evaluated Resident 12. Record review of EHR form titled vital signs: weights revealed on 3-11-26 Resident 12's weight was 112.4 a loss of 5.6 pounds or a 5.39% weight loss compared to the weight on 2-16-26 and a significant weight loss in 30 days. Review of Resident 12's medical record revealed there was no evidence the resident was we-weighed or evaluation of nutritional needs for significant weight loss was completed. Record review of EHR form titled vital signs: weights revealed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3-26-26 Resident 12's weight was 106.2 a loss of 6.2 pounds or a 5.18% weight loss compared to the weight on 3-11-26 and a significant weight loss in 30 days. Review of Resident 12's medical record revealed there was no evidence the resident was we-weighed or evaluation of nutritional needs for significant weight loss was completed. Record review of EHR form titled vital signs: weights revealed on 3-30-26 Resident 12's weight was 104.8 a loss of 1.2 pounds or 1.88% weight loss compared to the weight on 3-26-26. Review of Resident 12's EMR an Event Report sheet titled, Metabolic/Nutrition Events-Unplanned Weight Loss with an initiation date of 3-31-26 revealed Resident 12 was not on a physician prescribed weight loss regimen. Further review of the Event Report sheet revealed under the section identified as interventions-Immediate measures taken revealed supplements, and snacks was not identified as an intervention. Record review of EHR form titled vital signs: weights revealed on 4-8-26 Resident 12's weight was 110 pounds a weight gain of 5.2 pounds or a gain of 5.57% compared to the weight on 3-30-26. Record review of EHR form titled vital signs: weights revealed on 4-10-26 Resident 12's weight was 105 pounds a loss of 5 pounds or a 4.54% loss compared to the weight on 4-8-26. In an interview with the Administrator on 4-09-2026 at 2:15 PM revealed no nutritional assessment had been completed on Resident 12 until 4-9-26. In an interview with the Dietician on 4-13-26 at 1:07 PM it was revealed the admission nutritional assessment would be expected to be completed within 14 days of the resident's admission [DATE]) and had not been done for Resident 12. In an interview with Administrator on 4/14/26 at 8:15 AM it was confirmed the fax dated 2-23-26 would not meet the criteria of the Nutritional Assessment.