STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285134	A. Building B. Wing	11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Elkhorn	20275 Hopper Street Elkhorn, NE 68022

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(5) Based on interview and record review the facility failed to update the medical practitioner of changes in daily weights for 1 (Resident 1) of 3 resident sampled. The facility census was 83. The findings are:Record review of the Facility Policy titled Changes in Resident's Condition or Status dated 08-29-2025 revealed the facility will notify, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. The facility must immediately inform the resident and consult the resident's physician when there is a need to alter treatment significantly (That is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment.Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 09-19-2025 revealed the facility staff assessed the following about the resident:-date of admission [DATE].-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact.-required extensive assistance with dressing, hygiene and bed mobility.-required total assistance with transfers, toileting and bathing.-had a diagnosis of Heart Failure. Record review of Resident 1's Order Summary (OS) printed on 11-06-2025 revealed an order for 08-28-2025 for a daily weight call for any weight increase of 1-5 lbs. Record review of Resident 1's MAR for September 2025 revealed an order dated 08-28-2025 for daily weights, call the physician for any weight increases of 1- 5 lbs. The September MAR also revealed the following weights:09-03-2025-weight 171.4 pounds (lbs.).09-04-2025-weight 180 lbs. (a gain of 8.6 lbs. in one day).09-11-2025 hospitalized .Review of the residents medical record that included Progress notes, Faxes, Practitioners orders revealed there was no indication the facility staff had notified the practitioner of Resident 1's weight gain. Record review of Resident 1's OS printed on 11-06-2025 revealed an order dated 9-18-2025 for daily weights, call the physician for any weight increase of 1 to 5 lbs.Record review of Resident 1's MAR for September revealed an order dated 09-17-2025 for daily weights, call for any weight increase of 1 to 5 lbs. Further review revealed the following dates and weights:09-18-2025-weight 164.1 lbs. 09-19-2025-weight 170.8 lbs. (a gain of 6.7 lbs.)09-22-2025-weight 166.8 lbs.09-23-2025-weight 170.7 lbs. (a gain of 3.9 lbs.)09-25-2025-weight 166.7 lbs.09-26-2025-weight 170.5 lbs. (a gain of 3.8 lbs.)09-28-2025-no weight listed09-30-2025-weight NA An interview conducted with the Director of Nursing (DON) on 11-06-2025 at 1:15 PM confirmed Resident 1 had an order to call the physician with any weight increase of 1 to 5 lbs., and the physician was not updated on the weight increase from 09-03-2025 and 09-04-2025 of 8.6 lbs. and should have been.An interview with the DON on 11-06-2025 at 1:10 PM confirmed Resident 1's practitioner had not been notified of the 6.7 lbs. weight increase between 09-18-2025 and 9-19-2025, the 3.9 lbs. weight increase between 9-22-2025 and 09-23-2025 and the 3.8 lbs. increase between 09-25-2025 and 09-26-2025 and should have been.

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H). Based on observation, interview and record review, the facility failed to follow physician's orders, for daily weights and fluid restrictions for 1(Resident 1) of 3 residents sampled. The facility census was 83. The findings are:A. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 09-19-2025 revealed the facility staff assessed the following about the resident:-date of admission [DATE].-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -required extensive assistance with dressing, hygiene and bed mobility.-required total assistance with transfers, toileting and bathing. -had a diagnosis of Heart Failure. Record review of Resident 1's Order Summary (OS) printed on 11-06-2025 revealed an order dated 06-18-2025 for daily weights. Record review of Resident 1's Medication Administration Record (MAR) for June 2025 revealed the following dates a weight was not obtained:-06-19-2025 no weight listed. -06-21-2025-no weight listed.-06-24-2025- no weight listed. Record review of Resident 1's Progress Notes (PN) for 06-24-2025 at 4:02 PM revealed Resident 1 had 3 plus edema (severe swelling that leaves a depression after applying pressure to the affected area) to bilateral lower extremities up to the hips. Record Review of Resident 1's PN dated 06-24-2025 at 5:52 PM revealed Resident 1 was seen by a medical practitioner and gave orders to send Resident 1 to the emergency room (ER). Record review of Resident 1's Nursing Home to Hospital Transfer Form (NHHTF) dated 06-24-2025 revealed the reason for the transfer to the ER was fluid overload. Record review of Resident 1's Continuum of Care Transfer Report (CCTR) dated 06-25-2025 revealed Resident 1 returned from the hospital for acute-on-chronic heart failure (a person with long-standing, chronic heart failure experiences a sudden and severe worsening of symptoms, requiring immediate medical attention). Record review of Resident 1's PN dated 07-08-2025 revealed Resident 1 went to the hospital for a planned surgery. Record review of Resident 1's PN dated 07-21-2025 revealed Resident 1 had returned from the hospital. Record review of Resident 1's After Visit Summary (AVS) dated 07-21-2025 revealed the reason for the hospitalization was a diagnosis of a nonhealing amputation stump. Record review of Resident 1's Physician's Visit Report (PVR) dated 08-01-2025 revealed orders for No Salt in food and daily weights. Record review of Resident 1's MAR for August 2025 revealed the following dates a weight was not obtained:-08-02-2025- no weight listed.-08-03-2025 - no weight listed.-08-07-2025- no weight listed.-08-08-2025- no weight listed. -08-09-2025-hospitalized Review of Resident 1's Medical record that included PN , faxes, weight list and nutritional notes revealed there was no indications the facility staff obtained the weight for the above dates. Record review of Resident 1's PN dated 08-08-2025 revealed Resident 1 was at an appointment, and the physician was sending Resident 1 to the hospital directly from their office. Record review of Resident 1's Emergency Department Provider Notes (EDPN) dated 08-08-2025 revealed Resident 1 was being admitted for Congestive Heart Failure (CHF), fluid volume overload, electrolyte disturbance, and pulmonary edema (swelling in the lungs). Record review of Resident 1's Clinical Census printed on 11-04-2025 revealed Resident 1 returned from the hospital on [DATE]. Record review of Resident 1's OS printed on 11-06-2025 revealed an order dated 08-28-2025 for daily weights call for any weight increase of 1-5 lbs Record review of Resident 1's MAR for September 2025 revealed an order dated 08-28-2025 for daily weights, call the physician for any weight increases of 1- 5 lbs. The September MAR also revealed the following weights:09-03-2025-weight 171.4 pounds (lbs.).09-04-2025-weight 180 lbs. (a gain of 8.6 lbs. in one day) 09-11-2025 hospitalized Record review of Resident 1's PN dated 09-11-2025 revealed Resident 1's family member requested Resident 1 be sent to the ER for evaluation and treatment of Covid and Pneumonia, as Resident 1 was out of it and needed help eating supper last night. Further review of the PN revealed Resident 1 was sent to the hospital. An interview with the Director of Nursing (DON) on 11-06-2025 at 1:10 PM confirmed Resident 1's practitioner had not been notified of the weight increase of 8.6 lbs. between 09-03-2025 and 09-04-2025 and should have been. Record review of Resident 1's Continuum of Care Transfer Report (CCTR) dated 09-17-2025 revealed the reason for admission was acute-on-chronic respiratory failure, acute-on-chronic heart failure and Covid. Record review of Resident 1's OS printed on 11-06-2025 revealed an order dated 09-17-2025 for daily weight-Call with any weight increases of 1-5 lbs. Record review of Resident 1's MAR for September revealed an order dated 09-17-2025 for daily weights, call for any weight increase of 1 to 5 lbs. Further review revealed the following dates and

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.09(H)(vi)(3)(g). Based on observation, interview and record review the facility failed to ensure residents were assisted with respiratory equipment and treatments for 1(Resident 1) of 3 residents sampled. The facility census was 83. The findings are:Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 09-19-2025 revealed the facility staff assessed the following about the resident:-date of admission [DATE].-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -required extensive assistance with dressing, hygiene and bed mobility.-required total assistance with transfers, toileting and bathing. -had a diagnosis of Heart Failure. Record review of Resident 1's Clinical Physician Orders (CPO) printed 11-06-2025 revealed an order dated 07-31-2025 for Oxygen with Bilevel Positive Airway Pressure (BiPAP: a treatment for sleep apnea that uses a machine to pump air through a mask to keep a person's airway open while they sleep) apply when sleeping or napping and at bedtime. Record review of Resident 1's Treatment Administration Record (TAR) for September 2025 revealed an order dated 07-21-2025 for BiPap while sleeping or napping and on the following dates the Bipap was not applied:-Evening shift on 09-02-2025, 09-04-2025, 09-05-2025, 09-06-2025, 09-07-2025 and 9-10-2025. -Night shift on 09-04-2025, 09-05-2025, 09-07-2025. Record review of Resident 1's PN dated 09-11-2025 revealed Resident 1's family member requested Resident 1 be sent to the ER for evaluation and treatment of Covid and Pneumonia, as Resident 1 was out of it and needed help eating supper last night. Further review of the PN revealed Resident 1 was sent to the hospital. Record review of Resident 1's CPO printed on 11-06-2025 revealed an order dated 09-17-2025 for BiPAP apply when sleeping/napping and at bedtime. Record review of Resident 1's TAR for September 2025 revealed an order dated 09-17-2025 for BiPAP apply when sleeping/napping and on the following dates the BiPAP was not applied:-Day shift- 09-28-2025.-Evening shift- 09-20-2025, 09-23-2025, 09-25-2025, 09-28-2025.-Night shift- 09-22-2025, 09-27-2025, 09-28-2025, 09-30-2025. Record review of Resident 1's TAR for October 2025 revealed an order dated 09-17-2025 for BiPAP apply when sleeping/napping and on the following dates the BiPAP was not applied:-Day shift- 10-04-2025, 10-25-2025, 10-26-2025-Evening shift- 10-05-2025, 10-08-2025, 10-14-2025, 10-22-2025, 10-29-2025.-Night shift -10-01-2025, 10-05-2025, 10-08-2025, 10-09-2025, 10-13-2025, 10-22-2025, 10-29-2025, 10-31-2025. Record review of Resident 1's Physician's Visit Report (PVS) dated 10-23-2025 revealed the reason for the visit was a follow up with Pulmonology and under the progress notes and comments section revealed:-BiPap mask leak is high. Please put mask on nightly and during naps and make sure it does not have a leak. An interview conducted on 11-05-2025 with Resident 1 revealed when the staff put the mask on me I have air blowing in my eyes. An observation on 11-06-2025 at 3:50 AM revealed Resident 1 was in bed with eyes closed and the BiPAP mask was lying on the bedside table not in use. An interview conducted on 11-06-2025 at 4:00 AM with Resident 1 reveals the staff did not put the BiPAP mask on last night. An interview with the Medication Aide (MA) D at 4:15 AM revealed Registered Nurse (RN) B was updated that Resident 1 was not wearing the BiPAP mask. Furthermore, MA D confirmed only the nurses could apply the BiPAP mask. An interview with RN B on 11-06-2025 at 4:10 AM revealed RN B had not been updated that Resident 1 was not wearing the BiPAP mask and had not applied or reapplied the mask during the shift and was not familiar with Resident 1. An interview with MA D on 11-06-2025 at 4:15 AM revealed RN C was the nurse that MA D informed of Resident 1 not having the BiPAP mask on. An interview conducted with RN C on 11-06-2025 revealed RN C had not been informed of Resident 1 not wearing the BiPAP mask and had not applied or reapplied the mask during the shift. An interview conducted with MA D on 11-06-2025 at 4:25 AM revealed Resident 1 had the BiPAP mask on when MA D administered a pain medication at 1:48 AM and Resident 1 would not put the mask back on after that. An interview with the Director of Nursing on 11-06-2025 at 10:00 AM confirmed RN B was Resident 1's nurse and should have ensured Resident 1 had the BiPAP mask on and if Resident 1 refused to wear the BiPAP mask, the refusal should have been documented and wasn't.