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	05/13/2026

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 record review and interview, the facility failed to notify the residents practitioner when pain and antibiotic medication were unavailable for 2 (Resident 2 and 3) of 3 residents sampled. The facility census was 93. The findings are: A. Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-20-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored at a 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required limited assistance bed mobility.-required extensive assistance with bathing and dressing.-required total assistance with toileting and transfers.-had a diagnosis of osteomyelitis (a serious infection and inflammation of the bone that can lead to bone death if untreated) of the left foot and ankle.Record review of Resident 2's Order Summary (OS) printed on 05-12-2026 revealed an order for Ciprofloxacin 250 mg tablet, give 1 tablet at bedtime for prophylaxis related to a chronic ulcer of the left heel and midfoot with necrosis (irreversible death of cells and living tissue caused by external factors such as infection, toxins or trauma) of the bone. Record review of Resident 2's Medication Administration Record for May 2026 revealed for the administration of Ciprofloxacin 250 mg, give 1 tablet at bedtime revealed the facility staff documented ?7' on 05-02-2026 and the facility documented ?10' on 05-03-2026 and 05-07-2026 and there was no documentation of administration on 05-05-2026 and 05-06-2026. Record review of Resident 2's Progress Notes (PN) dated 05-02-2026 revealed Ciprofloxacin 250 mg tablet was on order. Record review of Resident 2's PN dated 05-04-2026 revealed Ciprofloxacin 250 mg tablet was not available. Record review of Resident 2's PN dated 05-07-2026 revealed Ciprofloxacin 250 mg tablet awaiting arrival from the pharmacy. Record review of Resident 2's PNs revealed no notes regarding Ciprofloxacin 250 mg tablet administration on 05-03-2026, 05-05-2026 and 05-06-2026. An interview conducted on 05-13-2026 at 3:30 PM with the Assistant Director of Nursing (ADON) and the Regional Nurse Consultant (RNC) confirmed Resident 2's practitioner was not notified when Ciprofloxacin supply ran out and should have been.B.Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-15-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required extensive assistance with bed mobility.-required total assistance with toileting, bathing, dressing and transfers.-had pain frequently that occasionally effected sleep and frequently interfered with therapy and almost constantly interfered with day-to-day activities. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 04-13-2026 revealed Resident 3 expresses pain and Resident 3 will express pain relief through the review date. Interventions listed on the care plan was to evaluate the effectiveness of pain interventions and to give pain medication as ordered. Record review of Resident 3's Hospital Discharge Orders (HDO) dated 04-13-2026 revealed Resident 3 had an order for a Butrans Transdermal Patch (BTP: a 7-day patch used to treat severe, chronic pain requiring (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around-the-clock opioid treatment) 7.5 milligram (mg) apply 1 patch once a week and an order for oxycodone 2.5 mg tablet every 4 hours as needed (prn) for pain. Record review of Resident 3's Medication Administration Record (MAR) for May 2026 revealed the facility staff documented ?7' on 05-09-2026 for the administration of the BTP 7.5 mg. Record review of Resident 3's Progress Notes (PN) dated 05-09-2026 revealed the BTP 7.5 mg was not available and contacted the pharmacy to reorder. An interview conducted with Resident 3 on 05-12-2026 at 11:00 AM revealed the facility had run out of Resident 3's BTP on 05-09-2026 and had run out of oxycodone 2.5 mg on 05-10-2026. An interview was conducted on 05-12-2026 at 2:45 PM with Licensed Practical Nurse (LPN) A confirmed that Resident had ran out of the BTP on Saturday and had ran out of oxycodone on Sunday and medications could not be obtained from the EMS because the pharmacy is closed on the weekend to obtain an authorization code to unlock the EMS. An interview conducted on 05-13-2026 at 3:35 PM with the ADON and RNC confirmed Resident 3's practitioner was not notified when the Resident 3's pain medications ran out and should have been.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Licensure Reference Number NAC 175 12-006.05(G). Based on record review and interview the facility failed to ensure as needed psychotropic medications were re-evaluated by the medical practitioner for rationale and duration of continued use beyond 14 days for 1 (Resident 1) of 3 residents sampled. The facility census was 93. The findings are:A. Record review of the facility policy titled Pharmacy Services and Medication Regimen Review dated 09-15-2025 revealed the facility maintains the resident's highest practicable level of physical, mental and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director and the director of nursing. The pharmacist must report any irregularities to the attending physician and the facility's medical director and the director of nursing, and these reports must be acted upon. The facility must develop and maintain policies and procedures for the monthly drug regimen review that include time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.B. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 02-13-2026 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required limited assistance with bathing, lower body dressing and transfers. Record review of Resident 1's Order Summary (OS) printed on 05-12-2026 revealed an order dated 02-12-2026 for diazepam 10 milligram tablet give 1 tablet every 8 hours as needed for anxiety with no stop date. Record review of Resident 1's Medication Administration Record (MAR) for May 2026 revealed an order for diazepam 10 mg give 1 tablet every 8 hours as needed for anxiety without a stop date. Record review of Resident 1's Pharmacy Consultation Report (PCR) dated 03-25-2026 revealed the facility's pharmacist comment was Resident 1 has an order for as needed (prn) order for an anxiolytic, without a stop date: Diazepam 10 mg take 1 tablet every 8 hours prn for anxiety. The PCR also revealed the pharmacist recommended discontinuing the Diazepam prn and if the medication cannot be discontinued at this time, then provide and document the indication for use, the intended duration of therapy, and the rationale for the extended period.Further review of the PCR revealed at the bottom of the page a note was written declined by provider with no date, signature or notation. Record review of Resident 1's faxed signed copy of the PCR dated 03-25-2026 revealed Resident 1's provider had accepted the pharmacist's recommendation, please implement as written with the provider signature dated 04-14-2026, but did not indicate whether to discontinue the diazepam or provide the rationale and intended duration for continued use and the facility had faxed the PCR back to the provider for clarification. An interview with the Assistant Director of Nursing (ADON) and the Regional Nurse Consultant (RNC) confirmed the pharmacy recommendation did not provide the rationale and duration of the PRN diazepam and should have followed up with the provider in 3 to 5 days of not receiving clarification and didn't.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H). Based on interview and record review the facility failed to ensure pain medication was available for pain management for 1 (Resident 3) of 3 residents sampled. The facility census was 93. The findings are:A. Record review of the facility policy titled Medication Shortages/Unavailable Medications dated 08-01-2024 revealed upon discovery that the Facility has an inadequate supply of a medication to administer to a resident, the facility staff should immediately initiate action to obtain the medication from the Pharmacy. If the medication shortage is discovered at the time of medication administration, the facility staff should immediately notify the Pharmacy. If the medication is unavailable during normal Pharmacy hours: the facility nurse should call the pharmacy to determine the status of the order, if the medication has not been ordered, the facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, the nurse should obtain the medication from the Emergency Medication Supply (EMS) to administer the dose. If the medication is not available in the EMS, facility staff should notify the pharmacy and arrange for a STAT delivery, if medically necessary. If the medication is unavailable and discovered after normal pharmacy hours: a facility nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the EMS, the nurse should call the Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: emergency delivery or use of an emergency third party pharmacy. If an emergency delivery is unavailable the nurse should contact the attending physician to obtain new orders or directions for alternate administration. If the nurse is unable to obtain a response from the attending physician in a timely manner, the nurse should notify the nursing supervisor and contact the facility's Medical Director for alternate orders/directions. B. Record review of the Facility EMS formulary exchanged on 05-06-2026 revealed the EMS contained 8 oxycodone 5 milligram tablets. C. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 04-15-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required extensive assistance with bed mobility.-required total assistance with toileting, bathing, dressing and transfers.-had pain frequently that occasionally effected sleep and frequently interfered with therapy and almost constantly interfered with day-to-day activities. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 04-13-2026 revealed Resident 3 expresses pain and Resident 3 will express pain relief through the review date. Interventions listed on the care plan was to evaluate the effectiveness of pain interventions and to give pain medication as ordered. Record review of Resident 3's Hospital Discharge Orders (HDO) dated 04-13-2026 revealed Resident 3 had an order for a Butrans Transdermal Patch (BTP: a 7-day patch used to treat severe, chronic pain requiring around-the-clock opioid treatment) 7.5 milligram (mg) apply 1 patch once a week and an order for oxycodone 2.5 mg tablet every 4 hours as needed (prn) for pain. Record review of Resident 3's Medication Administration Record (MAR) for May 2026 revealed the facility staff documented ?7' on 05-09-2026 for the administration of the BTP 7.5 mg. Record review of Resident 3's Progress Notes (PN) dated 05-09-2026 revealed the BTP 7.5 mg was not available and contacted the pharmacy to reorder. An interview conducted with Resident 3 on 05-12-2026 at 11:00 AM revealed the facility had run out of Resident 3's BTP on 05-09-2026 and had run out of oxycodone 2.5 mg on 05-10-2026. An interview was conducted on 05-12-2026 at 2:45 PM with Licensed Practical Nurse (LPN) A confirmed that Resident had ran out of the BTP on Saturday and had ran out of oxycodone on Sunday and medications could not be obtained from the EMS because the pharmacy is closed on the weekend to obtain an authorization code to unlock the EMS. A follow-up interview was conducted with Resident 3 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 05-13-2026 at 9:30 AM and Resident 3 reported a pain level was a ?9' on a scale from 0 to 10(0 being no pain and 10 being the worst pain ever) on Sunday and could tolerate a pain level at a 5-6 and revealed that (gender) thought the facility had an emergency medication kit but was not given anything for pain other than Tylenol. An interview was conducted on 05-13-2026 at 2:25 PM with the Assistant Director of Nursing (ADON) and the Regional Nurse Consultant (RNC) confirmed Resident 3 did not receive the BTP on 5-9-2026 and had ran out of oxycodone 2.5 mg on 5-10-2026 and confirmed the pharmacy is available on weekends and the nurse should have called the pharmacy and received authorization to obtain the medication from the EMS.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D). Based on record review and interview, the facility failed to ensure residents were free of significant medication errors for 1(Resident 2) of 3 residents sampled. The facility census was 93. The findings are:A. Record review of the facility policy titled Administration of Medications dated 09-09-2025 revealed the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnosis and signs and symptoms. A medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with:-the prescriber's order;-manufacturer's specifications regarding the preparation and administration of the medication or biological-accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each state, and current commonly accepted health standards established by national organizations, boards and councils. A significant error means one which causes the resident discomfort or jeopardizes his or her health and safety. B. Record review of the facility policy titled Medication Shortages/Unavailable Medications dated 08-01-2024 revealed upon discovery that the Facility has an inadequate supply of a medication to administer to a resident, the facility staff should immediately initiate action to obtain the medication from the Pharmacy. If the medication shortage is discovered at the time of medication administration, the facility staff should immediately notify the Pharmacy. If the medication is unavailable during normal Pharmacy hours: the facility nurse should call the pharmacy to determine the status of the order, if the medication has not been ordered, the facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication schedule, the nurse should obtain the medication from the Emergency Medication Supply to administer the dose. If the medication is not available in the Emergency Medication Supply (EMS), facility staff should notify the pharmacy and arrange for a STAT delivery, if medically necessary. If the medication is unavailable and discovered after normal pharmacy hours: a facility nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the Emergency Medication Supply, the nurse should call the Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: emergency delivery or use of an emergency third party pharmacy. If an emergency delivery is unavailable the nurse should contact the attending physician to obtain new orders or directions for alternate administration. If the nurse is unable to obtain a response from the attending physician in a timely manner, the nurse should notify the nursing supervisor and contact the facility's Medical Director for alternate orders/directions. C. Record review of the facility's EMS formulary with an exchange date of 05-06-2026 revealed 8 tablets of Ciprofloxacin 500 milligram (mg) were available and 8 tablets of Ciprofloxacin 250 mg were available. C. Record review of Resident 2's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-20-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-Brief Interview of Mental Status (BIMS) was scored at a 13. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required limited assistance bed mobility.-required extensive assistance with bathing and dressing.-required total assistance with toileting and transfers.-had a diagnosis of osteomyelitis (a serious infection and inflammation of the bone that can lead to bone death if untreated) of the left foot and ankle. Record review of Resident 2's Order Summary (OS) printed on 05-12-2026 revealed an order for Ciprofloxacin 250 mg tablet, give 1 tablet at bedtime for prophylaxis related to a chronic ulcer of the left heel and midfoot with necrosis (irreversible death of cells and living tissue caused by external factors such as infection, toxins or trauma) of the bone. Record review of Resident 2's Medication Administration Record for May 2026 revealed for the administration (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Ciprofloxacin 250 mg, give 1 tablet at bedtime revealed the facility staff documented ?7' on 05-02-2026 and the facility documented ?10' on 05-03-2026 and 05-07-2026 and there was no documentation of administration on 05-05-2026 and 05-06-2026. Record review of Resident 2's Progress Notes (PN) dated 05-02-2026 revealed Ciprofloxacin 250 mg tablet was on order. Record review of Resident 2's PN dated 05-04-2026 revealed Ciprofloxacin 250 mg tablet was not available. Record review of Resident 2's PN dated 05-07-2026 revealed Ciprofloxacin 250 mg tablet awaiting arrival from the pharmacy. Record review of Resident 2's PNs revealed no notes regarding Ciprofloxacin 250 mg tablet administration on 05-03-2026, 05-05-2026 and 05-06-2026. An interview conducted on 05-13-2026 at 1:35 PM with the Regional Nurse Consultant (RNC) revealed when a medication is not available the facility staff should call the pharmacy to order the medication and obtain authorization to get the medication out of the EMS. If the medication is not available in the EMS then the attending provider should have been called and if unable to contact the attending provider then the Medical Director should be called. An interview conducted on 05-13-2026 at 2:25 PM with the Assistant Director of Nursing (ADON) and the RNC confirmed Resident 2's Ciprofloxacin 250 mg was not administered from 05-02-2026 through 05-07-2026 and the pharmacy should have been notified and either had the drug delivered or obtained the medication from the EMS. An interview conducted on 05-13-2026 at 3:55 PM with the ADON and the RNC confirmed the omission of Ciprofloxacin 250 mg was a medication error.