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	12/08/2025

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

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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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Licensure Reference Number 175 NAC 12-006.04(H) Based on observation, interview and record review the facility failed to ensure staff were competent to operate the dishwasher. This had the potential to effect 85 of 86 residents who received foods from the kitchen. The Facility census was 86. The findings are:Record review of the facility's information from Ecolab on the dishwasher revealed the minimum operating temperature during the wash cycle is 120 degrees Fahrenheit (F) and the minimum operating temperature for the rinse cycle is 120 degrees F. An observation conducted on 12-03-2025 at 9:17 AM-10:00 AM revealed Dietary Aid (DA) K was doing dishes in the dishwasher. DA K placed 8 plates and 3 plate covers on a dish rack and put them into the dishwasher, the dishwasher temperature reached 100 degrees F during the wash cycle and 110 degrees F during the rinse cycle. After the dishwasher was done rinsing, DA K removed the dishes from the dishwasher and allowed them to dry. While the dishes were drying DA K placed several cups onto a tray and placed them into the dishwasher the dishwasher reached 100 degrees F during the wash cycle and 110 degrees F for the rinse cycle. DA K then took the plates and dish covers and put them away. DA K returns to the dish room and removes the tray of cups from the dishwasher and takes them from the dish room and places them on the rack under the food preparation table in the kitchen. Then returns to the dish room and places bowls and cups onto a dish rack and places them into the dishwasher. The dishwasher reached 100 degrees F during the wash cycle and 110 degrees F for the rinse cycle. An interview conducted on 12-03-2025 with DA K at 10:00 AM confirmed the dishwasher reached 100 degrees F for the wash cycle and 110 degrees F for the rinse cycle and revealed not knowing what to do if the dishwasher does not reach 120 degrees F. An interview with the Administrator (ADM) on 12-04-2025 at 1:50 PM confirmed DA K had not received training or competency completed for the use of the dishwasher and should have.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview and record review the facility failed to ensure the dishwasher reached the minimum required temperature of 120 degrees and failed to ensure the floor under the dish racks in the dish room were free of debris and dark, waxy build up; and the facility failed to ensure the double convection ovens were clean and free of food debris and hard water buildup. This had the potential to affect 85 of 86 residents who received food from the kitchen. The facility census was 86. The findings are: Record review of the facility's information from Ecolab on the dishwasher revealed the minimum operating temperature during the wash cycle is 120 degrees Fahrenheit (F) and the minimum operating temperature for the rinse cycle is 120 degrees F. Record review of the facility's dishwasher temperature log for October 2025 revealed no temperatures logged for breakfast and lunch after 10-11-2025 and no temperatures were logged for supper after 10-24-2025. Record review of the facility's dishwasher temperature log for November 2025 revealed no temperatures were logged for breakfast and lunch from 11-11-2025 to 11-21-2025, and 11-23-2025, 11-24-2025, and 11-26-2025 to 11-30-2025. The log also revealed no temperatures logged for supper from 11-11-2025 to 11-16-2025 and 11-18-2025, 11-25-2025 and 11-29-2025. A.An observation conducted on 12-03-2025 at 9:17 AM-10:00 AM revealed DA K was doing dishes in the dishwasher. DA K placed 8 plates and 3 plate covers on a dish rack and put them into the dishwasher, the dishwasher temperature reached 100 degrees F during the wash cycle and 110 degrees F during the rinse cycle. After the dishwasher was done rinsing, DA K removed the dishes from the dishwasher and allowed them to dry. While the dishes were drying DA K placed several cups onto a tray and placed them into the dishwasher the dishwasher reached 100 degrees F during the wash cycle and 110 degrees F for the rinse cycle. DA K then took the plates and dish covers and put them away. DA K returns to the dish room and removes the tray of cups from the dishwasher and takes them from the dish room and places them on the rack under the food preparation table in the kitchen. Then returned to the dish room and placed bowls and cups onto a dish rack and put them into the dishwasher. The dishwasher reached 100 degrees F during the wash cycle and 110 degrees F for the rinse cycle. An interview conducted on 12-03-2025 with DA K at 10:00 AM confirmed the dishwasher reached 100 degrees F for the wash cycle and 110 degrees F for the rinse cycle and revealed not knowing what to do if the dishwasher does not reach 120 degrees F. An observation conducted on 12-03-2025 at 10:30 AM with the Kitchen Manager (KM) confirmed the dishwasher temperature reached 110 degrees during the wash cycle and 118 during the rinse cycle and it should be 120 degrees F. B. An observation on 12-01-2025 at 7:21 AM revealed the floor under the dish shelves in the dish room had food debris and a dark waxy build up and the double convection ovens had a waxy build up on the outside where the control knobs were and there was a dark waxy build up and hard water build up around both the upper and lower double doors. An observation on 12-04-2025 at 12:05 PM revealed the floor under the dish shelves in the dish room had food debris and a dark waxy build up. An interview conducted on 12-04-2025 at 12:05 PM with DA K confirmed the dark waxy build up was present on the floor under the dish shelves in the dish room and confirmed the floor needed mopped. An observation on 12-04-2025 at 12:10 PM revealed the double convection oven had a waxy build up on the outside of the oven where the control knobs are and hard water build up and a dark waxy substance was present around both the upper and lower double doors. An interview conducted with the Administrator (ADM) on 12-08-2025 at 8:15 AM confirmed the floor in the dish room had a dark waxy build up and the double ovens had a waxy build up and hard water build up and needed to be cleaned and confirmed that cleaning logs were not retained to ensure consistent cleaning.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number: 175 NAC 12-006.04(B)(ii)(1)Based on record review and interview, the facility failed to ensure 3 [Nurse Aides (NA) C, D, and E] of 5 nurse aides had completed 12 hours of yearly required in-service education. This had the ability to affect all residents that resided in the facility. The facility had a total census of 86 residents.Findings are: A. Record review of a facility Employee list revealed NA C was hired on 5/28/24. Record review of NA C's Inservice education revealed that NA C had completed a total of 3.50 hours of training.B. Record review of a facility Employee list revealed NA D was hired on 5/28/24. Record review of in-service education for NA D had completed a total of 5 hours of training.C. Record review of a facility Employee list revealed NA E was hired on 4/25/23. Record review of in-service education for NA E revealed that NA E completed a total of 3 hours of training. D. Interview on 12/8/25 at 7:58 AM with the Director of Nursing [DON] confirmed that the 12-hour education training requirement had not been completed for NA's C, D, and E. The DON confirmed that the facility did not have an effective system to track the total number of hours to ensure that the 12 hours of education training were met by all staff.

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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 12-006.19(C), 12-006.18(B)Based on observation, record review and interview, the facility failed to ensure soiled linen did not come into contact with staff clothing for Residents 5 and 15, ensure nebulizer kits were cleaned after use for Residents 27 and 63, ensure Resident 6's PAP and PAP mask were clean and off the floor, and ensure Resident 6's PAP machine contained a filter; and the facility staff failed to wear enhanced barrier precautions when providing catheter care for Resident 12. The facility census was 86.Findings are: A. Record review of a facility policy dated 7/5/25 entitled Laundry Services revealed the following information: Facility staff should handle all laundry as potentially contaminated and use standard precautions with the appropriate Personal Protective Equipment. Soiled linen should be handled as little as possible and with a minimum of agitation to prevent gross microbial contamination of the air and of persons handling linen. -Never carry soiled linen against the body -Carefully roll up soiled linen to prevent contamination of air, surfaces and staff. -All soiled linen should be bagged or put into carts at the location used. B. Observation on 12/3/25 between 8:10 AM and 8:20 AM revealed Nursing Assistant [NA] D assisted Resident 5 to dress. NA-D assisted the resident to remove a soiled hospital gown, threw it on the floor and continued to assist the resident to don (put on) a clean shirt. After the resident was dressed and ready to leave the room, NA-D picked up the soiled gown from the floor, placed it underneath the NA's arm against [gender] clothing and assisted the resident to don a jacket. NA-D took the soiled unbagged hospital gown to the soiled utility room and placed into a laundry bin. Interview on 12/03/2025 at 8:20 AM with the NA-D confirmed that the soiled gown was picked up from the floor, placed under [gender] arm and was in contact with [gender] clothing while assisting the resident to don a jacket. NA-D confirmed the gown should have been bagged and should not have come into contact with the NA's clothing. Interview on 12/03/2025 at 1:29 PM with the Director of Nursing [DON] confirmed that soiled linen and clothing should have been bagged and not have come into contact with staff clothing. C. An observation on 12/01/2025 at 8:57 AM revealed NA-F exited room [ROOM NUMBER], Resident 15's room, and walked down the 300 hallway to the laundry hopper room carrying a bag of soiled clothing and a folded stack of soiled bedding directly on NA-F's left forearm. An observation on 12/04/2025 at 8:13 AM revealed NA-G exited the laundry room and walked down (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 200 hallway to the bathhouse with uncovered linens directly against NA-G's left arm. In an interview on 12/04/2025 at 9:00 AM, the facility's Administrator confirmed the staff should not have carried soiled linens or clean towels against the staff's body. D. A record review of the facility's Cleaning and Disinfection of Non-Critical Patient Care Equipment with a reviewed date of 07/15/2025 revealed equipment should be cleaned daily and before and after reuse. An observation on 12/01/2025 at 11:24 AM revealed Resident 27 had a nebulizer (neb) on the bedside table and the nebulizer administration set with mask (neb kit) was draped over the top. The neb kit contained a residual (small, leftover) amount of medication in the cup and facial oils on the mask. An observation on 12/03/2025 at 7:07 AM revealed Resident 27 had a neb on the bedside table and the neb kit was draped over the top. The neb kit contained a full treatment worth of medication in the cup and facial oils on the mask. An observation on 12/03/2025 at 2:06 PM with the charge nurse, Licensed Practical Nurse (LPN)-H revealed Resident 27 had a neb on the bedside table and the neb kit was draped over the top. The neb kit contained a residual amount of medication in the cup and facial oils on the mask. In an interview on 12/03/2025 at 2:06 PM, the charge nurse, LPN-H confirmed Resident 27's neb kit was draped over the neb and had not been cleaned and should have been. E. A record review of the facility's Cleaning and Disinfection of Non-Critical Patient Care Equipment with a reviewed date of 07/15/2025 revealed equipment should be cleaned daily and before and after reuse. An observation on 12/03/2025 at 1:36 PM revealed Resident 63 was lying in bed with a neb on the bedside table and the neb kit was draped over the top. The neb kit contained a residual amount of medication in the cup and facial oils on the mask. An observation on 12/03/2025 at 1:55 PM with LPN-I revealed Resident 63 was lying in bed with a neb on the bedside table and the neb kit was draped over the top. The neb kit contained a residual amount of medication in the cup and facial oils on the mask In an interview on 12/03/2025 at 1:36 PM, Resident 63 confirmed the resident used the nebulizer regularly and just had a treatment that morning. In an interview on 12/03/2025 at 1:55 PM, LPN-I confirmed Resident 63's neb kit was draped over the bedside table and had not been cleaned following the nebulizer treatment that the resident had that morning. F. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's BIPAP (bilevel positive Airway Pressure) / CPAP (Continuous Positive Airway Pressure) Administration Policy with a reviewed date of 09/24/2025 revealed the facility would ensure each resident received respiratory care and services in accordance with professional standards of practice. The reservoir should be emptied daily and left to air dry and cleaned weekly with soap and water. The face mask should be cleaned as needed. A record review of ResMed's How to clean your CPAP equipment dated 2025 revealed CPAP mask cushions should be cleaned daily. The humidifier should be emptied and wiped thoroughly with a clean disposable cloth and allowed to dry daily and cleaned weekly with dishwashing soap or a vinegar water solution. https://www.resmed.com/en-us/sleep-health/resources/cleaning-cpap-equipment/ A record review of Resident 6's Clinical Physician Orders dated 12/02/2025 revealed the resident had an order for Clean CPAP/BIPAP mask with warm soapy water, rinse and air dry as needed and CPAP/BIPAP Clean reservoir with warm soapy water, rinse; set out to dry every day shift every 7 day(s). A record review of Resident 6's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated November and December 2025 revealed the resident wore the PAP every day. An observation on 12/01/2025 at 1:36 PM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST on a tray table on the left side of the bed with water left in the humidifier. There was no filter in the machine. An observation on 12/02/2025 at 1:27 PM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST and mask that was on the floor on the left side of the bed. The mask cushion had facial oils on it. There was water remaining in the humidifier and the machine did not have a filter. An observation on 12/03/2025 at 7:27 AM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST that was on a tray table on the left side of the bed with a mask draped over the machine that contained facial oils. The humidifier still had water in it and there was not a filter in the machine. An observation on 12/03/2025 at 2:06 PM with the charge nurse, Licensed Practical Nurse (LPN)-H revealed Resident 6 had a ResMed Airsense 10 BiLevel ST that was on a tray table on the left side of the bed with a mask draped over the machine that contained facial oils. The humidifier still had water in it and the machine did not have a filter. In an interview on 12/01/2025 at 1:36 PM, Resident 6 confirmed the resident wore the PAP machine every night. In an interview on 12/03/2025 at 2:16 PM, Resident 6's family member was in the room and confirmed the staff does not clean the humidifier and supplies and the family member had talked to the facility and the problem had still not been resolved because the humidifier contained water and the humidifier was nasty. In an interview on 12/03/2025 at 2:06 PM, LPN-H confirmed Resident 6's BiPAP ST mask was draped over the machine, had facial oils on it, and it had not been cleaned. LPN-H confirmed the staff should clean the mask when they take it off in the morning and it had not been done and there was still water in the humidifier. LPN-H confirmed there was not a filter in the machine and should have been. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of the facility policy titled Enhanced Barrier Precautions (EBP) dated 08-19-2025 revealed the facility should use EBP as an additional strategy for residents that meet the following criteria, during high-contact resident care activities. EBP are indicated for residents with an indwelling medical device such as urinary catheters and feeding tubes. Examples of high-contact resident care activities requiring a gown and glove use include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as urinary catheters or feeding tubes, and wound care. Record review of Resident 12's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 10-17-2025 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored as a 14. According to the MDS Manual a score of 13 to 15 indicate a person is cognitively intact. -required limited assistance with bed mobility. -required extensive assistance with dressing, bathing, and transfers -required total assistance with toileting. -had a urinary catheter. An observation conducted on 12-04-2025 at 9:25 AM of Licensed Practical Nurse (LPN) L and Nurse Aid (NA) M providing catheter care and incontinence care for Resident 12 revealed both the LPN L and the NA M did not utilize a gown during the provision of care. An interview with LPN L on 12-04-2025 at 9:30 AM confirmed Resident 12 had a urinary catheter and EBP should have been used and wasn't.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. Licensure Reference Number: 175 NAC 12-007.04(D)Based on observation and interview, the facility failed to ensure that ventilation systems were operational in resident bathrooms in 4 (Rooms 106, 108, 114 and 115) of 15 occupied resident rooms on the 100 hall of the facility. The facility census was 86. Findings are:Observation on 12/4/25 between 9:00 AM to 9:30 AM with the facility Maintenance Supervisor [MS] revealed that the ventilation system did not draw a 1 ply square of toilet paper to the surface of the ventilation cover in resident bathrooms in resident rooms 106, 108, 114 and 115. This indicated that the ventilation system was not working properly on the 100 hall of the facility at the time of the observation. Interview on 12/4/25 at 9:25 AM with the MS confirmed that the ventilation system did not draw a 1 ply square of toilet paper in resident bathrooms in rooms 106, 108, 114 and 115 which indicated that the ventilation system was not working properly on the 100 hall of the facility. The MS confirmed that no routine checks of the ventilation system had been completed to ensure the ventilation systems were operational.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Licensure Reference Number 175 NAC 12-006-05(A)(B)(C)Based on record review and interview, the facility failed to provide notice of resident rights on admission for 1 (Resident 95) of 1 sampled resident. The facility staff identified a census of 86.The findings are:Record review of a facility policy entitled admission Policy dated reviewed 8/28/2025 revealed: - Resident Rights - Before or upon admission the facility will ensure that the resident and/or the resident's representative or interested family member has been informed of the resident's rights and all facility policies governing resident conduct and responsibilities in a language and manner they can understand. - 1. The resident's rights are communicated both orally and in writing with adaptations made to account for visual and hearing impairments (i.e., sign language, large print, Braille copies). - 2. The facility will provide language assistance services such as qualified interpreters for individuals with limited English proficiency, and appropriate auxiliary aids and services to comply with Section 1557. - 3. Written acknowledgement of the explanation of rights and responsibilities is obtained and documented in the admission agreement. - Resident Orientation - 2. Should the resident be medically incapable of understanding his/her rights, the legal guardian/representative for the resident will be required to undergo the orientation process.Record review of Resident 95's admission Record revealed the facility admitted the resident on 1/21/2025. Further review of the admission record identified Resident 95 had diagnoses which included osteomyelitis (an infection and inflammation of the bone, usually caused by bacteria which can cause pain, swelling, and redness), intracranial injury with loss of consciousness (traumatic brain injury), quadriplegia (one affected with partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), and depression.Record review of Resident 95's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 1/24/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11. According to the MDS manual, a score of 11 indicated the resident had moderate cognitive impairment.Record review of Resident 95's Power of Attorney for Health Care (Surrogate) dated 1/14/2025 revealed Resident 95 had identified an individual as agent for health care if Resident 95 was unable to make health care decisions.Record review of Resident 95's electronic health record (EHR) which included progress notes and scanned documents showed the EHR lacked an acknowledgement of receipt of resident rights.An interview on 12/8/2025 at 8:55 AM and 9:20 AM with the Admissions Director (AD) revealed admission paperwork had not been completed at the time Resident 95 was admitted by the facility. The AD confirmed the resident's medical record lacked required documentation that the resident or resident representative received notice of rights on admission.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Licensure Reference Number 175 NAC 12-006.02(H)Based on interview and record review, the facility failed to protect 1 of 1 resident surveyed (Resident 14) during the investigation of an abuse allegation. The facility had a census of 88.Findings are:A record review of Resident 14's undated care plan revealed the following diagnoses: Type 1 Diabetes Mellitus with hyperglycemia (consistently high blood sugar levels due to insufficient insulin production), Anxiety Disorder, Diabetes insipidus (a kidney disorder causing excessive thirst and large amounts of urine), Chronic pain, Adrenocortical insufficiency (a condition where the adrenal glands do not produce enough hormones), spinal stenosis with claudication (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves causing pain, numbness or weakness), depression, suicidal ideation (thoughts of suicide), other speech and language deficits following cerebral infarction (stroke).A record review of Resident 14's Minimum Data Set (MDS - a federally mandated assessment tool that measures the health status in nursing home residents) revealed Resident 14 had a Brief Interview for Mental Status (BIMS - a quick screening tool used in long term care facilities to assess a patients basic cognitive function) of 15, indicating Resident 14 was cognitively intact.A record review of a facility Investigation Note, dated 11/7/2025 revealed the following:On 11/3/2025 around 1:00 PM the facility was made aware of a verbal abuse allegation from Resident 14 regarding a comment that was made to them from the Director of Nursing (DON). The resident felt like they were verbally abused and not wanted in the facility. The comment that was made according to Resident 14 was that the DON stated, you do not belong here, and you have upset all of my staff. The report stated that as an immediate intervention due to the allegation of the resident, the DON was suspended pending investigation. A record review of the facility's Abuse - Reporting and Response Policy and Procedure, issued 10/04/2022 and revised on 10/13/2023 revealed the following:12. If the accused individual is an employee, the alleged perpetrator will be removed from the resident care areas immediately and placed on suspension pending results of the investigation.An interview on 12/1/2025 at 1:45 PM Resident 14 reported the Director of Nursing (DON) publicly humiliated the resident by yelling at them in the hallway several times. Resident 14 reported they were afraid of the DON and of retaliation from staff members. Resident 14 reported these incident occurred on 11/03/25. Resident 14 reported they had filed more than one complaint of neglect and abuse against the DON.An interview on 12/2/25 at 3:20 PM with the DON confirmed they had never been formally suspended during an investigation.

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Life Care Center of Elkhorn	20275 Hopper Street Elkhorn, NE 68022

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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 175 NAC 12-006.05(G)Based on record review and interview, the facility failed to ensure an anti-psychotic medication [a class of medications used to manage symptoms of psychosis such as delusions and hallucinations] was used to treat a medically accepted, diagnosed, specific condition for 1 (Resident 10) of 5 residents reviewed for unnecessary medications. The facility census was 86.Findings are:A. Record review of a facility policy dated 11/19/24 entitled Psychotropic Medication Management revealed the following information:A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:Anti-psychotic, Anti-depressant, Anti-anxiety, and Hypnotic.Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. With regards to psychotropic medications, the regulations additionally require:Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition. The residents' medical record must show documentation of adequate indications for medication use and the diagnosed condition for which the medication is prescribed. B. Record review of Resident 10's Face Sheet revealed an admission date of 2/18/25 with diagnoses that included: Major Depressive Disorder single episode, Dementia in other diseases, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.Record review of Resident 10's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 10/3/25 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 6 which indicated that Resident 10 had severe cognitive impairment. A score of 0-7 indicated severe impairment. The MDS identified diagnoses of Alzheimer's Dementia, Parkinson's and Depression and daily use of antipsychotic medications. Record review of Resident 10's Physician Orders revealed an order dated 10/2/25 for Quetiapine Fumarate [an antipsychotic medication, also named Seroquel] give 1 tablet by mouth at bedtime related to Parkinson's Disease without dyskinesia, without mention of fluctuations. Record review of Resident 10's November 2025 and December 2025 Medication Administration Records revealed that Resident 10 received Quetiapine Fumarate daily as ordered. Record review of a Progress Note for Resident 10 dated 11/21/25 revealed the following note: Patient is on Seroquel [Quetiapine Fumarate] for Dementia with behavioral disturbance. DON [Director of Nursing] to request DC [discontinue] due to no behavior at this time. Interview on 12/03/2025 at1:37 PM with DON confirmed that Resident 10's physician denied the request to discontinue the Quetiapine Fumarate. The DON confirmed that Parkinson's was not a medically accepted diagnoses for the continued use of the antipsychotic medication Quetiapine Fumarate. The DON confirmed that Resident 10 had no other documented, medically accepted diagnoses for the use of the Quetiapine Fumarate.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.2(H)Based on interview and record review, the facility failed to ensure that an abuse allegation for 1 of 1 resident surveyed (Resident 14) was reported to officials within the required time limits. The facility claimed a census of 88.Findings are:A record review of Resident 14's undated care plan revealed the following diagnoses: Type 1 Diabetes Mellitus with hyperglycemia (consistently high blood sugar levels due to insufficient insulin production), Anxiety Disorder, Diabetes insipidus (a kidney disorder causing excessive thirst and large amounts of urine), Chronic pain, Adrenocortical insufficiency (a condition where the adrenal glands do not produce enough hormones), spinal stenosis with claudication (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves causing pain, numbness or weakness), depression, suicidal ideation (thoughts of suicide) and other speech and language deficits following cerebral infarction (stroke).A record review of Resident 14's Minimum Data Set (MDS - a federally mandated assessment tool that measures the health status in nursing home residents) revealed Resident 14 had a Brief Interview for Mental Status (BIMS - a quick screening tool used in long term care facilities to assess a patients basic cognitive function) of 15, indicating Resident 14 was cognitively intact.A record review of the facility's Abuse Reporting and Response Policy and Procedure, revised 04/09/2024 and reviewed 05/07/2025, stated the facility will report alleged violations related to mistreatment, exploitation, neglect or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.A record review of the facility's Abuse and Neglect Policy, issued 10/04/2022 and revised 10/13/2023 revealed the following:Reporting:1. An individual (e.g., A resident, visitor, facility associate) who reports an alleged violation to facility staff does not have to explicitly characterize the situation as abuse, neglect, mistreatment, or exploitation in order to trigger the facility to investigate. Rather, if facility staff could reasonably conclude that the potential exists related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property, then it would be considered reportable and require action.2. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g., bruising and skin tears) will be immediately reported to the administrator and/or director of nursing.a. All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative.b. All residents, families, resident representatives, and visitors are encouraged to immediately report incidents of suspected resident abuse and/or neglect to facility administration.A record review of the Abuse - Identification of Types Policy dated 10/04/2022 reviewed 5/6/2025 revealed the following: Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear shame, agitation, or degradation. Verbal abuse includes the use of oral, written, or gestured communications or sounds, to residents within hearing distance, regardless of age ability to comprehend or disability.a. Examples of mental and verbal abuse include, but are not limited to:Yelling or hovering over a resident, with the intent to intimidate.A record review of an Event note dated 11/13/2025 by the Social Services Director (SSD) revealed Resident 14 had come to the social services office in regard to an encounter with the DON and the ADON. Resident 14 reported they felt their life was in danger and the DON was bullying them. After Resident 14 left the social services office the SSD reported the incident directly to the Executive Director (ED).An interview on 12/1/2025 at 1:45 PM with Resident 14 revealed Resident 14 reported the Director of Nursing (DON) publicly humiliated the resident by yelling at them in the hallway several times. Resident 14 reported they were afraid of the DON and of retaliation from staff members. Resident 14 reported this incident occurred on 11/13/25. Resident 14 reported they had filed a complaint of neglect and abuse against the DON.An interview on 12/1/25 at 5:40 PM with the ED confirmed they reported the first step they (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take when they receive an allegation is to talk to the resident concerned to clarify the situation. In this instance the ED did not investigate the allegation of abuse/bullying and did not report the allegation of abuse/bullying on 11/13/25.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Licensure Reference Number 175 NAC 12-006.2(H)Based on interview and record review, the facility failed to investigate an allegation of abuse for 1 of 1 residents surveyed (Resident 14). The facility had a census of 88.Findings are:A record review of Resident 14's undated care plan revealed the following diagnoses: Type 1 Diabetes Mellitus with hyperglycemia (consistently high blood sugar levels due to insufficient insulin production), Anxiety Disorder, Diabetes insipidus (a kidney disorder causing excessive thirst and large amounts of urine), Chronic pain, Adrenocortical insufficiency (a condition where the adrenal glands do not produce enough hormones), spinal stenosis with claudication (a narrowing of the spinal canal that puts pressure on the spinal cord and nerves causing pain, numbness or weakness), depression, suicidal ideation (thoughts of suicide) and other speech and language deficits following cerebral infarction (stroke).A record review of Resident 14's Minimum Data Set (MDS - a federally mandated assessment tool that measures the health status in nursing home residents) revealed Resident 14 had a Brief Interview for Mental Status (BIMS - a quick screening tool used in long term care facilities to assess a patients basic cognitive function) of 15, indicating Resident 14 was not cognitively impaired.A record review of the facility's Abuse Reporting and Response Policy and Procedure, revised 04/09/2024 and reviewed 05/07/2025, stated the facility will report alleged violations related to mistreatment, exploitation, neglect or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes.A record review of the facility's Abuse and Neglect Policy, issued 10/04/2022 and revised 10/13/2023 revealed the following:Reporting:4. (a) The facility should retain documentation of the report, including what was reported and the date and time the report was made to the State Agency (SA).A record review of the Abuse - Identification of Types Policy dated 10/04/2022 reviewed 5/6/2025 revealed the following: Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear shame, agitation, or degradation. Verbal abuse includes the use of oral, written, or gestured communications or sounds, to residents within hearing distance, regardless of age ability to comprehend or disability.a. Examples of mental and verbal abuse include, but are not limited to:(i) Yelling or hovering over a resident, with the intent to intimidateA record review of an Event note dated 11/13/2025 by the Social Services Director (SSD) revealed Resident 14 had come to the social services office in regard to an encounter with the DON and the ADON. Resident 14 stated they felt their life was in danger and the DON was bullying them. After Resident 14 left the social services office the SSD reported the incident directly to the Executive Director (ED).An interview on 12/1/25 at 5:40 PM with the ED confirmed they reported the first step they take when they receive an allegation is to talk to the resident concerned to clarify the situation. In this instance the ED did not investigate the allegation of abuse/bullying and did not report the allegation of abuse/bullying on 11/13/25. An interview on 12/1/2025 at 1:45 PM Resident 14 reported the Director of Nursing (DON) publicly humiliated the resident by yelling at them in the hallway several times. Resident 14 reported they were afraid of the DON and of retaliation from staff members. Resident 14 reported this incident occurred on 11/13/25. Resident 14 reported they had filed a complaint of neglect and abuse against the DON.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E)(i)Based on record review and interview, the facility failed to develop a Comprehensive Care Plan (CCP, a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) related to prophylactic antibiotic use for Resident 8 and anticoagulant [a blood thinner medication which can increase the risk of bleeding] for Resident 14. The facility sample size was 25. The facility census was 86.Findings are:A. Record review of Resident 8's Face Sheet revealed that Resident 8 was admitted on [DATE] with diagnoses that included urinary tract infection [UTI], chronic kidney disease, and bladder neck obstruction. Record review of Resident 8's significant change Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 10/21/25 revealed that Resident 8 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 11 which indicated that Resident 8 was cognitively intact. The MDS identified that Resident 8 had a foley catheter with a diagnosis of obstructive uropathy.Record review of Resident 8's Electronic Medical Record [EMR] revealed that Resident 8 was hospitalized from [DATE] to 10/10/25 with UTI and bladder stones. Resident 8 was given Rocephin [an antibiotic] in the emergency room and the antibiotic was changed to Ertapenem [an antibiotic] while in hospital. Record review of Resident 8's EMR revealed that Resident 8 was admitted to Hospice Care on 10/15/25 on Bactrim DS [an antibiotic] 800milligrams [mg] -160mg twice a day for 7 days. Record review of Resident 8's Physician Orders dated 10/28/25 revealed an order from Hospice for Macrobid [an antibiotic] daily for UTI prevention.Record review of Resident 8's CCP dated 11/4/25 revealed no information related to the use of prophylactic antibiotic use for Resident 8. Interview on 12/04/2025 at 7:22 AM interview with Director of Nursing [DON] confirmed no CCP had been developed for the use of the prophylactic antibiotic for Resident 8. The DON confirmed that a CCP should have been developed for the use of antibiotics for Resident 8. B. Record review of Resident 14's Face Sheet revealed that Resident 14 was admitted on [DATE] with diagnoses that included unspecified atrial fibrillation and cerebral infarction [stroke].Record review of Resident 14's admission MDS dated [DATE] revealed that Resident 14 had a BIMS score of 15 which indicated that Resident 14 was cognitively intact. The MDS identified that Resident 14 used anticoagulant medications daily. Record review of Resident 14's Physician Orders dated 10/21/25 revealed an order for Apixaban Oral Tablet 5 mg, give 1 tablet by mouth two times a day related to unspecified atrial fibrillation. Resident 8's physician orders also revealed an order to monitor s/s [signs and symptoms] of bleeding; including black tarry stools, bleeding gums, bruising/nosebleed related to anticoagulant use every shift. Record review of Resident 14's CCP dated 11/3/25 revealed no information related to the use of anticoagulant medications or the risk for bleeding for Resident 14. Interview on 12/04/2025 at 7:22 AM with the DON confirmed no CCP had been developed for the use of anticoagulant medication or the risk for bleeding for Resident 14. The DON confirmed that a CCP should have been developed for the risk for bleeding and anticoagulant use for Resident 14.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. The facility failed to administer tube feeding as ordered by the physician for 1 (Resident 7) of 1 sampled residents. The facility staff identified a census of 86.Record review of facility policy entitled Enteral Nutrition Therapy (Continuous) dated reviewed 9/5/2025 revealed: - The facility will provide continuous enteral nutrition therapy in accordance with physician orders and professional standards of practice.Record review of Resident 7's admission Record revealed the facility admitted the resident on 7/24/2025. Further review of the admission record identified Resident 7 had diagnoses which included encephalopathy (brain dysfunction often caused by an underlying condition such as infections, toxins, liver or kidney failure, or nutritional deficiency) and severe protein-calorie malnutrition.Record review of Resident 7's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 11/13/2025 revealed the facility staff assessed the following about Resident 7: -the resident held food in cheek or residual food was left in the residents mouth after meals; -the resident had complaints of difficulty swallowing; -the resident had a feeding tube present on admission; -the resident had a mechanically altered diet; -the resident received 51 percent (%) or more of total calories through tube feeding, and; -the resident received 501 milliliters (mL) or more average fluid intake through the tube.Record review of Resident 7's Medication Administration Record (MAR) dated December 2025 revealed an enteral feed order for Osmolite (brand of tube feeding) 1.5 via G-tube at 55 mL per (/) hour (hr) for (x) 18 hours via pump for a total amount of 990 mL. Tube feed on from 4:00 PM to 10:00 AM dated 11/7/2025.Record review of Resident 7's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed the following interventions related to tube feeding: -G-tube water flushes; monitor weight; monitor meal intake; regular easy to chew diet dated revised 11/19/2025. -Tube feed per MD. Osmolite 1.5 dated 11/12/2025.Observation on 12/1/2025 at 9:29 AM revealed Resident 7's Osmolite 1.5 was hanging on the pole but not running. The tube feeding was not labeled with the date and time the tube feeding was first hung.Observation on 12/2/2025 at 7:25 AM revealed Osmolite 1.5 was hanging and the tube feeding pump was in alarm. The tube feeding pump displayed infusion complete.Observation on 12/3/2025 at 10:00 AM revealed Licensed Practical Nurse (LPN)-N entered Resident 7's room to disconnect the tube feeding. After hand hygiene, LPN-N donned (applied) gown and gloves. LPN-N explained to Resident 7 that it was time to disconnect the tube feeding. LPN-N shut the tube feeding pump off, disconnected the tube feeding from Resident 7, and flushed the G-tube with 60 mL's of water for line maintenance. LPN-N performed g-tube cares and applied a split-sponge dressing. The tube feeding container was not labeled with time and date of when the tube feeding was hung.Observation on 12/3/2025 at 10:47 AM revealed LPN-N returned to Resident 7's room to check the total amount of tube feeding administered. The tube feeding pump displayed 645 mL of tube feeding had been administered.An interview on 12/3/2025 at 10:47 AM with LPN-N confirmed the tube feeding was not dated or timed for when it was hung and should have been. LPN-N further confirmed the tube feeding amount administered read 645 mLs and that the resident did not receive the total amount of tube feeding nutrition as ordered by the provider.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, interview, and record review, the facility failed to obtain valid positive airway pressure (PAP) device (a machine used to treat sleep apnea) orders for 2 (Residents 6 and 63) of 3 sampled residents and oxygen orders for 1 (Resident 63) of 3 sampled residents. The facility census was 86. Findings are:A record review of the facility's BIPAP (bilevel positive airway pressure) / CPAP (continuous positive airway pressure) Administration Policy with a reviewed date of 09/24/2025 revealed the facility would ensure each resident received respiratory care and services in accordance with professional standards of practice. When a PAP was ordered, the mode, pressure setting, size and type of mask, liters of oxygen if ordered, and frequency of use must be included in the written order. A.A record review of Resident 6's Clinical Census dated 12/02/2025 revealed the resident was admitted [DATE]. A record review of Resident 6's Medical Diagnosis dated 12/04/2025 revealed the resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, and Obstructive Sleep Apnea. A record review of Resident 6's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 10/31/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15 which indicated the resident was cognitively aware (able to think and comprehend). The resident required substantial/maximal assistance with oral and personal hygiene (cleaning), bathing, and lower body dressing and was dependent on staff for toileting, upper body dressing, and footwear. The resident was on a non-invasive ventilator. A record review of Resident 6's Care Plan with an admission date of 07/21/2025 revealed an intervention of CPAP per order. A record review of Resident 6's Clinical Physician Orders dated 12/02/2025 revealed the resident had an order for CPAP/BIPAP on resident while sleeping/napping and off while awake and Oxygen with CPAP/BIPAP: Pressure setting okay for home settings APPY WHEN SLEEPING/NAPPING AND AT HS (bedtime) 9hours of sleep. A record review of Resident 6's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated November and December 2025 revealed the resident wore the PAP everyday. An observation on 12/01/2025 at 1:36 PM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST on a tray table on the left side of the bed. An observation on 12/02/2025 at 1:27 PM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST that was on the floor on the left side of the bed. An observation on 12/03/2025 at 7:27 AM revealed Resident 6 had a ResMed Airsense 10 BiLevel ST that was on a tray table on the left side of the bed. An observation on 12/03/2025 at 2:06 PM with the charge nurse, Licensed Practical Nurse (LPN)-H revealed Resident 6 had a ResMed Airsense 10 BiLevel ST that was on a tray table on the left side of the bed. In an interview on 12/01/2025 at 1:36 PM, Resident 6 confirmed the resident wore the PAP machine every night but did not know what the settings were. In an interview on 12/04/2025 at 7:03 AM, the Director of Nursing (DON) confirmed the facility did not have a written order for Resident 6's PAP and the order in the electronic medical record did not contain the mode or pressure settings. In an interview on 12/04/2025 at 6:48 AM, LPN-J confirmed Resident 6's physician's order for the PAP did not contain the required elements to make it a valid order. The physician's order did not contain the mode, pressure settings, or route of administration. B.A record review of the facility's Oxygen Administration (Infection Control, Safety, & Storage) policy with a revised date of 09/30/2025 revealed oxygen orders should include the specific liter flow. A record review of Resident 63's Clinical Census dated 12/03/2025 revealed the resident was admitted [DATE]. A record review of Resident 63's Medical Diagnosis dated 12/03/2025 revealed the resident had diagnoses of Morbid Obesity (extremely overweight), Heart Failure, Hypoxemia (low oxygen in the blood), Guillain-Barre Syndrome (nerve disorder), Obstructive Sleep Apnea, and Need For Assistance With Personal Care. A record review of Resident 63's MDS dated [DATE] revealed the resident had a BIMS of 15 which indicated the resident was cognitively aware. The resident was independent with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating and personal and oral hygiene, required partial/moderate assistance with bathing and upper body dressing, required substantial/maximal assistance with lower body dressing, and was dependent on staff for toileting and footwear. The resident was on a non-invasive ventilator. A record review of Resident 63's Care Plan with an admission date of 08/20/2024 revealed the resident had a CPAP and the resident was on oxygen. There was an intervention of Oxygen Settings: Administer oxygen per orders. A record review of Resident 63s Clinical Physician Orders dated 12/03/2025 revealed the resident had an order for Oxygen with CPAP/BIPAP: Pressure setting okay for previous home settings and CPAP/BIPAP on while sleeping/napping and off while awake. The Clinical Physician Orders did not reveal an order for oxygen without the PAP or a setting. An observation on 12/03/2025 at 1:36 PM revealed Resident 63 was lying in bed with an oxygen nasal cannula on and the oxygen concentrator (a machine that makes oxygen) was set a 1 liter per minute (l/m). The resident had a ResMed Airsense 11 Average Volume-Assured Pressure Support (AVAPS) PAP device on the overbed table. The observation did not reveal there was oxygen tubing or a bleed-in adapter to bleed in the oxygen to the PAP. An observation on 12/03/2025 at 1:55 PM with LPN-I revealed Resident 63 was lying in bed with an oxygen nasal cannula on and the oxygen concentrator (a machine that makes oxygen) was set a 1 liter per minute (l/m). The resident had a ResMed Airsense AVAPS PAP device on the overbed table. The observation did not reveal there was oxygen tubing or a bleed-in adapter to bleed in the oxygen to the PAP. In an interview on 12/03/2025 at 1:36 PM, Resident 63 confirmed the resident used oxygen all the time, the resident used the PAP device every night when the nurse remembered to help the resident put it on, and the resident did not think (gender) used oxygen at night with the PAP device. In an interview on 12/03/2025 at 1:55 PM, LPN-I confirmed Resident 63 had a PAP device and the resident was wearing oxygen and the concentrator was set at 1 l/m. LPN-I confirmed the resident's PAP order did not contain a mode, pressure settings, and oxygen settings and should have. LPN-I confirmed there was not an order for the resident's oxygen when the resident was not on the PAP. In an interview on 12/04/2025 at 7:03 AM, the Assistant Director of Nursing (ADON) confirmed the facility did not have a written order for Resident 63's oxygen and the order she got from the resident's provider the evening of 12/03/2025 was for 2-4 liters per minute. The ADON confirmed the residents PAP order did not have the mode or pressure settings and should have had and the ADON fixed it the evening of 12/03/2025.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to evaluate for and identify situational triggers for post-traumatic stress disorder (PTSD) for 1 (Resident 9) of 1 sampled resident. The facility staff identified a census of 86.The findings are:Record review of facility policy entitled Trauma Informed Care dated reviewed 9/2/2025 revealed: - 1. Screening and assessment - The facility will use a multi-pronged approach to identifying a residents with PTSD or history of trauma. This approach would include assessing the residents for indicators of trauma upon admission/readmission and with change in condition. This assessment will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event. - a. The facility will utilize the Trauma-Informed Care Assessment in PCC to assess the resident's experience of seventeen possible negative life events. - b. If the residents responds to any of the seventeen possible negative life events with an answer other than Doesn't Apply the facility will proceed to the next section of the Trauma-Informed Care UDA to determine symptom severity and help identify possible interventions. - c. The completed Trauma-Informed Care UDA is reviewed by the IDT to determine appropriate person-centered interventions to eliminate or mitigate triggers that may lead to re-traumatization. - 2. Implementing resident-driven care and services - The facility should collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, and any other health care professionals (such as psychologists, mental health professionals) to develop and implement an individualized plan of care with interventions. - In situations where trauma survivor is reluctant to share his or her history, the facility should still attempt to identify triggers which may retraumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. - Trigger-specific interventions should identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident. - 5. The facility should identify triggers which may retraumatize residents with a history of trauma. For many trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. While most triggers are highly individualized, some common triggers may include: - a. Experiencing a lack of privacy or confinement in a crowded or small space; - b. exposure to loud noises, or bright/flashing lights; - c. Certain sights, such as objects that are associated with those that used to abuse; and/or - d. sounds, smells and even physical touch.Record review of Resident 9's admission Record revealed the facility admitted the resident on 4/26/2024. Further review of the admission record identified Resident 9 had diagnoses which included schizoaffective disorder (relating to, characterized by, or exhibiting symptoms of both schizophrenia and a mood disorder [such as major depression or bipolar disorder]), major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies), generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities that occurs more days than not, for at least 6 months), obsessive-compulsive disorder, and post-traumatic stress disorder (PTSD, a psychological reaction occurring after experiencing a highly stressing event (such as wartime combat, physical violence, or a natural disaster) that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event).Record review of Resident 9's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. According to the MDS manual, a score of 15 indicated the resident was cognitively intact. Further review of the MDS identified the resident had (continued on next page)

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	12/08/2025

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.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PTSD.Record review of Resident 9's SOC/NRSG: Trauma Informed Care - V 2 ([NAME]) dated 5/6/2024 revealed the evaluation was marked as not applicable.Record review of Resident 9's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed no interventions related to Resident 9's past traumatic experience(s).During an interview with the Social Services Assistant (SSA) on 12/4/2025 at 10:10 AM, the SSA confirmed Resident 9 had a diagnosis of PTSD. The SSA further confirmed there was no history of trauma on the [NAME] and should have been and confirmed no interventions were listed on Resident 9's CCP.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(i) Based on observation, interview, and record review, the facility failed to provide secured storage for medications stored in the residents' rooms for 2 (Residents 6 and 43) of 2 sampled residents. The facility census was 86. Findings are:A record review of the facility's Self-Administration of Medications policy with a last revised date of 06/01/2024 revealed the care plan would reflect that the resident could self-administer medications. The staff would document in the resident's care plan if the resident or the facility staff were responsible for storage of the resident's medications. The facility should provide a secured compartment for the storage of the resident's medications. The storage compartment would be stored in the resident's room and locked when not in use. A.A record review of Resident 6's Clinical Census dated 12/02/2025 revealed the resident was admitted [DATE]. A record review of Resident 6's Medical Diagnosis dated 12/04/2025 revealed the resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD) but did not reveal a diagnosis of Allergic Rhinitis (inflammation of the nasal lining). A record review of Resident 6's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 10/31/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15 which indicated the resident was cognitively aware (able to think and comprehend). The resident required substantial/maximal assistance with oral and personal hygiene (cleaning), bathing, and lower body dressing and was dependent on staff for toileting, upper body dressing, and footwear. A record review of Resident 6's Care Plan with an admission date of 07/21/2025 revealed an intervention to administer medications as ordered but did not reveal the resident had a focus area or interventions for the self-administration of medications. A record review of Resident 6's Clinical Physician Orders dated 12/02/2025 revealed the resident had an order for Fluticasone Propionate (medication used to treat nasal inflammation) nasal spray for Allergic Rhinitis and for Nystatin Powder (treats skin infections) but did not reveal an order for a Dulera inhaler (a medication that is inhaled to treat Asthma). An observation on 12/03/2025 at 7:27 AM revealed there was a plastic basket on the dresser in the southwest corner of Resident 6's room that contained 3 bottles of Fluticasone Propionate nasal spray, 1 bottle of Nystatin Powder, and 1 Dulera inhaler with a spacer that was visible from the hall and the resident was not in the room. The medications were not in a locked storage compartment. An observation on 12/03/2025 at 9:53 AM revealed there was a plastic basket on the dresser in the southwest corner of Resident 6's room that contained 3 bottles of Fluticasone Propionate nasal spray, 1 bottle Nystatin Powder, and 1 Dulera inhaler with a spacer that was visible from the hall and the resident was not in the room. The medications were not in a locked storage compartment. An observation on 12/03/2025 at 2:06 PM with the charge nurse, Licensed Practical Nurse (LPN)-H revealed there was a plastic basket on the dresser in the southwest corner of Resident 6's room that contained 3 bottles of Fluticasone Propionate nasal spray, 1 bottle Nystatin Powder, and 1 Dulera inhaler with a spacer that was visible from the hall and the resident was not in the room. The medications were not in a locked storage compartment. In an interview on 12/03/2025 at 2:06 PM, the charge nurse, LPN-H confirmed Resident 6's room had 3 bottles of Fluticasone Propionate nasal spray, 1 bottle Nystatin Powder, and 1 Dulera inhaler in the resident's room, the medications were not secured and should have been, and the resident did not have an assessment or physician order to self-administer any medications. LPN-H removed the medications from the resident's room. B.A record review of Resident 43's Clinical Census dated 12/03/2025 revealed the resident was admitted [DATE]. A record review of Resident 43's Medical Diagnosis dated 09/11/2025 revealed the resident had diagnoses of Attention and Concentration Deficit Following Other Cerebrovascular Disease (stroke), Need For Assistance With (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Personal Care, Muscle Weakness, Other Lack of Coordination, and Dry Eye Syndrome of Bilateral Lacrimal Glands (not enough watery tears). A record review of Resident 43's MDS dated [DATE] revealed the resident had a BIMS of 15 which indicated the resident was cognitively aware. The resident was independent with eating and personal and oral hygiene, required substantial/maximal assistance with bathing and upper body dressing, and was dependent on staff for toileting, lower body dressing, and footwear. A record review of Resident 43's Care Plan with an admission date of 01/23/2025 revealed the resident had an intervention to administer medications as ordered but did not reveal the resident had a focus area or interventions for the self-administration of medications. A record review of Resident 43's Clinical Physician Orders dated 12/02/2025 revealed the resident had an order for Systane Balance Ophthalmic Solution (lubricant eye drop), Xalatan Ophthalmic Solution (a medication used to treat glaucoma), and Artificial Tears Ophthalmic Solution but did not reveal an order for Ketorolac Moxifloxacin (an eye medication used to treat inflammation and infections following surgery), Ketorolac Tromethamine (a potent eye medication to treat inflammation and pain for up to 5 days following eye surgery), or Prednisolone (a steroid eye drop to treat eye inflammation). An observation on 12/01/2025 at 9:01 AM revealed Resident 43 had medications in pill bottles on the bedside table that included 2 bottles of Prednisolone, 2 bottles Refresh Liquagel, 1 bottle Ketorolac Moxifloxacin, 1 bottle Ketorolac Tromethamine all in pill bottles labeled with directions and the resident's name. An observation on 12/03/2025 at 11:32 AM revealed Resident 43 had medications in pill bottles on the bedside table that included 2 bottles of Prednisolone, 2 bottles Refresh Liquagel, 1 bottle Ketorolac Moxifloxacin, 1 bottle Ketorolac Tromethamine all in pill bottles labeled with directions and the resident's name. An observation on 12/03/2025 at 2:06 PM with the charge nurse, LPN-H revealed Resident 43 had medications in pill bottles on the bedside table that included 2 bottles of Prednisolone, 2 bottles Refresh Liquagel, 1 bottle Ketorolac Moxifloxacin, 1 bottle Ketorolac Tromethamine all in pill bottles labeled with directions and the resident's name. In an interview on 12/03/2025 at 2:06 PM, the charge nurse, LPN-H revealed Resident 43 had medications in pill bottles on the bedside table that included 2 bottles of Prednisolone, 2 bottles Refresh Liquagel, 1 bottle Ketorolac Moxifloxacin, 1 bottle Ketorolac Tromethamine all in pill bottles labeled with directions and the resident's name and should not have had.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to complete admission paperwork for 1 (Resident 95) of 1 sampled resident. The facility staff identified a census of 86.The findings are:Based on record review and interview, the facility failed to complete admission paperwork for 1 (Resident 95) of 1 sampled resident. The facility staff identified a census of 86.The findings are:Record review of a facility policy entitled admission Policy dated reviewed 8/28/2025 revealed: - Resident Orientation - 1. Prior to, or upon admission, the resident is orientated, but not limited to: - a. Privacy Practices - b. Antidiscrimination policy - c. Grievance policy - d. Resident Rights. - e. A nursing facility that is a composite distinct part as defined in section 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations - f. Resident Trust Fund. - g. Financial Agreement. - h. Smoking policies and procedures. - i. Resident Care policies. - j. Physician Services. - k. Advanced Directives - l. Others as necessary or appropriate. - 2. Should the resident be medically incapable of understanding his/her rights, the legal guardian/representative for the resident will be required to undergo the orientation process. - 4. Resident/legal guardian/resident representative will receive a resident a copy [sic] of the admissions agreement prior to or upon admission. They will sign upon receiving a copy and this will be filed in the resident's chart. Record review of Resident 95's admission Record revealed the facility admitted the resident on 1/21/2025. Further review of the admission record identified Resident 95 had diagnoses which included osteomyelitis (an infection and inflammation of the bone, usually caused by bacteria which can cause pain, swelling, and redness), intracranial injury with loss of consciousness (traumatic brain injury), quadriplegia (one affected with partial or complete paralysis of both the arms and legs especially as a result of spinal cord injury or disease in the region of the neck), and depression.Record review of Resident 95's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 1/24/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11. According to the MDS manual, a score of 11 indicated the resident had moderate cognitive impairment.Record review of Resident 95's Power of Attorney for Health Care (Surrogate) dated 1/14/2025 revealed Resident 95 had identified an individual as agent for health care if Resident 95 was unable to make health care decisions.Record review of Resident 95's electronic health record (EHR) which included progress notes and scanned documents revealed there was no admission paperwork completed including privacy practices, antidiscrimination policy, grievance policy, resident rights, resident trust fund, financial agreement, smoking policies and procedures, resident care policies.An interview on 12/8/2025 at 8:55 AM and 9:20 AM with the Admissions Director (AD) revealed admission paperwork had not been completed at the time Resident 95 was admitted by the facility and should have been. The AD further confirmed that the resident's medical record was incomplete in the absence of the admission documents.