STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285137	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and interview, the facility failed to ensure that the posted nurse staffing information contained the required information related to the total number of actual hours worked per discipline. This had the potential to affect all residents that resided in the facility. The facility staff identified a census of 98.Record reviews of 30 days of past posted nurse staffing between 8/10/25 and 9/10/25 revealed the daily posted nurse staffing did not contain the total number of actual hours worked for the different types of staff.An interview on 9/15/25 at 1:02 PM with the facility Administrator confirmed the nurse staff posting information did not contain the total number of actual hours worked per discipline and that the hours had not been calculated or documented on the posted nurse staffing and should have been.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 behavior monitoring was completed for 1 (Resident 28) who received a psychotropic medications (drugs that alter mental processes, emotions, and behavior), failed to monitor for side effects for 1 (Resident 54) who received Depakote (a drug used to treat bipolar disorder, seizures, and prevent migraines) and Lexapro (a drug used to treat depression and anxiety), failed to ensure a sleep diary or test was completed for 1 (Resident 28) who received Zolpidem Tartrate (Ambien, a drug used to treat sleep disorders), failed to ensure as needed (PRN) antipsychotic medications (drugs used to treat mental health conditions) had a stop date of 14 days after first issuance for 1 (Resident 30), and failed to perform baseline and ongoing Abnormal Involuntary Movement Scale (AIMS) testing for the use of antipsychotics for 1 (Resident 71) for a total of 5 sampled residents. The facility census was 98. Findings are:A. A record review of the facility's Psychotropic Medication Use policy with a last revision date of 09/15/2024 revealed that psychotropic medications are drugs that affect mood, perception, or behavior, and include antipsychotic, antianxiety, antidepressant, mood stabilizers, and hypnotic (medications used to treat sleep disorders) medications. All medications used to treat behaviors should be monitored for efficacy (ability to produce desired result), risks, benefits, and adverse consequences (side effects). A record review of Resident 28's Clinical Census dated 09/11/2025 revealed the resident was admitted on [DATE] and had a medical record number of 8149. A record review of Resident 28's Medical Diagnosis dated 09/11/2025 did not reveal the resident had diagnoses of Anxiety, Depression, or a sleep disorder. A record review of Resident 28's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 06/30/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 14 which indicated the resident was cognitively aware. The resident needed setup or clean-up assistance for eating, oral hygiene (cleaning) and upper body dressing, needed partial/moderate assistance for bathing, and dependent of staff for toileting, lower body dressing, and personal hygiene. The resident was on antianxiety medications, antidepressant medications, and hypnotics. The resident did have depression symptoms but did not have behaviors in the lookback period. A record review of Resident 28's Care Plan with an admission date of 06/23/2025 revealed the resident had focus areas and interventions for the resident being on sedative/hypnotic therapy and antidepressant medications but did not reveal the staff should monitor for the target behaviors related to those medications. A record review of Resident 28's Order Summary Report dated 09/11/2025 revealed the resident had orders for 1 milligram (mg) tablet of Clonazepam (a seizure and antianxiety medication) two times a day (BID) for anxiety, one 30 mg capsule Duloxetine (an antidepressant medication) one time a day (Q-day) for depression, one 100 mg tablet of Trazadone (an antidepressant medication) at bedtime for depression, and Zolpidem Tartrate 5 mg tablet at bedtime for difficulty sleeping. The Order Summary Report included orders for side effect monitoring for the psychotropic medications but did not include (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders for the target behavior monitoring of those medications. A record review of Resident 28's Electronic Medical Record dated 06/23/2025 – 09/11/2025 did not reveal specific target behavior monitoring for the resident's ordered psychotropic medications. In an email dated 09/11/2025, the facility's Regional Nurse Consultant (RNC)-A confirmed the facility did not have behavior monitoring for Resident 28's psychotropic medications. B. A record review of the undated American Association of Psychiatric Pharmacist's Medication Fact Sheet revealed Valproate (Depakote) is a mood stabilizer medication that works in the brain and is approved for the treatment of mania (abnormally elevated or expansive mood) associated with Bipolar disorder. https://www.nami.org/NAMI/media/NAMI-Media/Research/Valproate.pdf A record review of Resident 54's Clinical Census dated 09/11/2025 revealed the resident was admitted [DATE] and the resident's medical number was 7701. A record review of Resident 54's Medical Diagnosis dated 09/11/2025 did not reveal the resident had diagnoses of Bipolar Disorder (a serious mental illness that causes unusual shifts in mood) or Depression. A record review of Resident 54's MDS dated [DATE] revealed the resident had a BIMS of 15 which indicated the resident was cognitively aware. The resident was independent of staff for eating and oral hygiene, needed partial/moderate assistance for upper body dressing, needed substantial/maximal assistance with bathing, lower body dressing, and personal hygiene. The resident was on antidepressant medications, and an anticonvulsant (medications to treat seizures). The resident did not have mood symptoms but did exhibit a rejection of care behavior in the lookback period. A record review of Resident 54's Care Plan with an admission date of 03/18/2024 revealed the resident had a focus areas and interventions for the resident's target behaviors but did not reveal the staff should monitor for the side effects for the medications to be administered as ordered. A record review of Resident 54's Order Summary Report dated 09/11/2025 revealed the resident had orders for one 125 mg tablet Depakote Q-day for Bipolar disorder and one 10 mg tablet Lexapro Q-day for depression. The Order Summary Report did not included orders for side effect monitoring for the medications. A record review of Resident 54's Electronic Medical Record dated 11/29/2023 – 09/11/2025 did not reveal side effect monitoring for the resident's ordered Depakote or Lexapro. In an email dated 09/11/2025, the facility's Regional Nurse Consultant (RNC)-A confirmed the facility did not have any psychotropic side effect monitoring for Resident 54. C. A record review of the facility's Psychotropic Medication Use policy with a last revision date of 09/15/2024 revealed that psychotropic medications are drugs that affect mood, perception, or (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior, and include antipsychotic, antianxiety, antidepressant, mood stabilizers, and hypnotic (medications used to treat sleep disorders) medications. All medications used to treat behaviors must have a clinical indication and should be monitored for efficacy (ability to produce desired result), risks, benefits, and adverse consequences (side effects). The facility staff should monitor the resident's behavior using a behavior monitoring chart. A record review of Resident 28's Care Plan with an admission date of 06/23/2025 revealed the resident had a focus area of the resident is on a sedative/hypnotic therapy. An intervention was to evaluate other factors potentially causing insomnia (trouble falling and staying asleep) and attempt to modify and control the external factors before initiating hypnotic therapy. A record review of Resident 28's Order Summary Report dated 09/11/2025 revealed the resident had orders for Zolpidem Tartrate 5 mg tablet at bedtime for difficulty sleeping. A record review of Resident 28's Electronic Medical Record dated 06/23/2025 – 09/11/2025 did not reveal a sleep test or sleep diary had been completed to monitor the effectiveness of the Zolpidem Tartrate. In an email dated 09/11/2025, the facility's Regional Nurse Consultant (RNC)-A confirmed the facility did not have a sleep test or 3-day sleep for Resident 28's Zolpidem Tartrate. D.Record review of the facility's policy titled Psychotropic Medication Use dated 09-15-2024 revealed PRN orders for antipsychotic medications shall be limited to 14 days and cannot be renewed unless the attending physician or prescriber evaluates the resident for the appropriateness of that medication. The required evaluation of a resident before writing a new PRN order for antipsychotic entails the prescribing practitioner directly examining the resident and assessing the resident's current condition and progress to determine if the PRN antipsychotic medication is still needed. Record review of Resident 30's MDS 08-08-2025 revealed the facility staff assessed the following about the resident: -BIMS was scored as a 10. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment. -required limited assistance with bed mobility. -required extensive assistance with bathing -required total assistance with transfers, toileting, and wheelchair mobility. -was taking antipsychotic, antianxiety, and antidepressant medications. Record review of Resident 30's Medication Administration Record (MAR) for September 2025 revealed an order dated 08-05-2025 for Seroquel (an antipsychotic medication) 25 mg give one tablet by mouth every 6 hours PRN (as needed) for anxiety and aggression and an order dated 08-06-2025 for Haloperidol (an antipsychotic medication) 1 mg tablet give 2 tablets by mouth every 6 hours PRN agitation if not responsive for Seroquel. An interview with Regional Nurse Consultant (RNC) A conducted on 09-10-2025 at 10:45 AM confirmed (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the orders for PRN Seroquel and Haloperidol was not stopped after 14 days and should have been. E. Record review of the facility policy titled Tardive Dyskinesia (a chronic involuntary movement disorder that can develop as a side effect of antipsychotic medications) Assessment (AIMS) dated 08-29-2025 revealed each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used without adequate monitoring or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. Upon initiation of a medication with known extrapyramidal symptoms side effects the facility will complete a baseline AIMS (Abnormal Involuntary Movement Assessment) and then every 3 months and as needed thereafter for as long as the medication is being used. Record review of Resident 71's MDS dated [DATE] revealed the facility staff assessed the following about the resident: -BIMS was scored as a 3. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment. - required set up assistance with dressing, toileting and hygiene. -was independent with dressing, toileting and ambulation. - was taking an antipsychotic medication. Record review of Resident 71's Order Summary Report dated 09-09-2025 revealed an order for Risperidone (an antipsychotic medication) dated 06-10-2025 was to be given 0.125 mg in the morning every other day, and an order for Risperidone dated 06-10-2025 give 0.25 mg in the morning every other day. Record review of Resident 71's Electronic Medical Record revealed an in progress AIMS test dated 01-27-2025 that had not been completed and a incomplete initial AIMS test dated 10-02-2025. An interview was conducted with the RNC A on 09-10-2025 at 2:15 PM that confirms the AIMS tests were not completed for Resident 71 and should have been.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(G) Based on interview and record review, the facility failed to complete a discharge plan for 1 (Resident 102) of 2 sampled residents. The facility census was 98. Findings are:A record review of Resident 102's Progress Notes dated 09/11/2025 revealed the resident was discharged to home on [DATE]. A record review of Resident 102's Notice Of Resident Transfer Or Discharge dated 08/18/2025 revealed the resident discharged to home and the box was marked that the resident's health had improved sufficiently and no longer needed the services provided by the facility. A record review of Resident 102's Discharge Summary Information dated 08/18/2025 revealed the resident was discharged to home. The reason for discharge was patient request. The resident was educated on the discharge process and was not expected to return. A record review of Resident 102's Care Plan with an admission date of 08/08/2025 did not reveal a Focus area or interventions for the discharge plan. A record review of Resident 102's Baseline Care Plan dated 08/08/2025 revealed the box for Discharge Plan was not checked. In an interview on 09/10/2025 at 11:50 AM, the facility's Regional Nurse Consultant (RNC)-A confirmed there was not a discharge plan done for Resident 102 and it should have been done.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Licensure Reference Number 175 NAC 12-006.06(A) Based on interview and record review, the facility failed to provide a bed hold policy to 3 (Residents 7, 100, and 111) of 3 sampled residents on hospital transfer and failed to notify the State Long term Care (LTC) Ombudsman (an official appointed to investigate individuals complaints) of a facility-initiated transfer on 3 (Residents 7, 100, and 111) of 3 sampled residents. The facility census was 98. Findings are: A record review of facility's Bed-Hold Policy with a reviewed date of 09/05/2024 revealed the facility was obligated to provide two notices related to bed-holds. The first notice is given on admission well in advance of any transfer, i.e., information provided in the admission packet. Reissuance of the first notice would be required if the bed-hold policy under the State Plan or the facility's policy were to change. The second notice must be provided to the resident, and if applicable the resident's representative, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. A record review of facility's Ombudsman Program policy revised 10/06/2022 revealed Notice to the Office of the State LTC Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. In the case of emergency transfers the notice is sent as soon as practicable. The medical record must contain evidence that the notice was sent to the Ombudsman. A. A record review of Resident 100's Progress Notes dated 09/09/2025 revealed the resident was transferred to the emergency room (ER) for tachycardia (rapid heart rate) and low oxygen saturations (oxygen in blood) on 08/20/2025. A record review of the facility's Nursing Home to Hospital Transfer Form dated 08/20/2025 revealed Resident 100 was sent to the hospital for altered mental status. It did not reveal a bed-hold was given to the resident or the resident's representative. A record review of Resident 100's Electronic Medical Record (EMR) dated 08/06/2025 – 09/09/2025 did not reveal a bed-hold had been completed and given to the resident and/or the resident's representative at the time of or following the emergent transfer to the hospital. The EMR did not reveal the State LTC Ombudsman had been notified of the resident's hospital transfer on 08/20/2025. In an interview on 09/09/2025 at 12:23 PM, the facility's Regional Nurse Consultant (RNC)-A confirmed the facility did not complete a bed-hold for Resident 100's 8/20/2025 transfer to the hospital. In a telephone interview on 09/10/2025 at 11:10 AM, Resident 100's representative confirmed the facility did not give the resident's representative a bed-hold notice for the hospital transfer on 08/20/2025. In an interview on 09/10/2025 at 11:25 AM, RNC-A confirmed a bed hold was not given to the resident (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or the resident's representative for Resident 100's 08/20/2025 transfer to the ER and should have been. In an interview on 09/10/2025 at 12:05 PM, RNC-A confirmed that the facility did not notify the State LTC Ombudsman of Resident 100's 08/20/2025 transfer to the hospital and should have. B. A record review of Resident 111's Progress Notes dated 09/10/2025 revealed the resident was transferred to the ER for a psychiatric evaluation on 07/28/2025 following an attempt at self-harm. A record review of the facility's undated SBAR (Situation-Background-Assessment-Recommendation) Communication Form and the facility's eINTERACT Change in Condition Evaluation dated 07/28/2025 revealed Resident 111 was sent to the hospital for behavior symptoms on 07/28/2025 but did not reveal a bed-hold was given to the resident or the resident's representative. A record review of Resident 111's Electronic Medical Record (EMR) dated 06/06/2025 – 09/10/2025 did not reveal a bed-hold had been completed and given to the resident and/or the resident's representative at the time of or following the emergent transfer to the hospital. The EMR did not reveal the State LTC Ombudsman had been notified of the resident's hospital transfer on 08/20/2025. In an interview on 09/10/2025 at 12:38 PM, RNC-A confirmed that the facility did not notify the State LTC Ombudsman of Resident 100's 07/28/2025 transfer to the hospital and should have. In an interview on 09/10/2025 at 12:13 PM, RNC-A confirmed a bed hold was not given to the resident or the resident's representative for Resident 111's 07/28/2025 transfer to the ER and should have been. D. A review of Resident 7's census section of the electronic medical record revealed the following: -Resident 7 was on paid hospital leave from 91/25-9/5/25 -Resident 7 was on paid hospital leave from 7/14/25-7/18/25 -Resident 7 was on paid hospital leave from 6/10/25-6/11/25 A review of Resident 7's electronic medical record including progress notes did not reveal Resident 7 was provided information on facility bed hold policy or ombudsman was notified of hospital admission. In an interview on 9/10/25 at 12 PM, Registered Nurse Consultant A confirmed that bed hold information was not provided to the resident or family and ombudsman notification was not completed.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on observation, interview and record review the facility failed to accurately code the Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) for 1 (Resident 13) of 1 residents sampled. The facility census was 98. The findings are:Record review of Resident 13's MDS dated [DATE] 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 15 indicates a person is cognitively intact.-required limited assistance with upper body dressing.-required extensive assistance with bed mobility and lower body dressing.-required total assistance with toileting, bathing, and transfers-oral and dental status including edentulous and loosely fitting dentures were not present. An observation on 09-08-2025 at 10:36 AM revealed Resident 13 was edentulous. During the observation a interview conducted with Resident 13 with Resident 13 reporting the dentures were to big. An interview conducted on 09-15-2025 at 10:15 AM with the Regional Director of Clinical Reimbursement confirmed the MDS was coded incorrectly for Resident 13's oral status.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(F)(iii)Based on record review and interview, the facility failed to revise the comprehensive care plan related to fluid restriction for 1 (Resident 1) of 22 residents sampled. The facility staff identified a census of 98.The findings are:Record review of a facility policy entitled Comprehensive Care Plans and Revisions dated reviewed 9/11/2024 revealed: -The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. -Procedure: -1. The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care. -2. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include: -a. Additional interventions on existing problems, -b. Updating goal or problem statements -c. Adding a short-term problem, goal, and interventions to address a time limited condition.Record review of Resident 1's Clinical Census revealed the facility admitted the resident on 2/24/23.Record review of Resident 1's Medical Diagnoses revealed the resident had diagnoses which included end-stage renal disease and heart failure.Record review of Resident 1's Minimum Data Set, dated [DATE] (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) revealed the resident had 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 received hemodialysis (the process of removing blood from an artery, purifying it by dialysis, adding vital substances, and returning it to a vein).Record review of Resident 1'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) printed 9/10/2025 identified an intervention for sips of fluid only in between meals dated 3/6/2023.Record review of Resident 1's electronic health record (EHR) including physician's orders, progress notes, and scanned documents did not reveal an order for fluid restriction.An interview on 9/15/2025 with the Regional Director of Clinical Reimbursement (RDCR) confirmed Resident 1's fluid restriction ended in May of 2025. The RDCR further confirmed the care plan was not revised related to fluid restriction after completion of the 8/27/2025 MDS and should have been.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview the facility failed to complete neurological evaluations after an unwitnessed fall for 1 (Resident 71) of 3 residents sampled. The facility census was 98. The findings are: Record review of the facility policy titled Neurological Checks dated 08-29-2025 revealed a neurological check list shall be initiated when indicated by the resident assessment such as a head injury, post fall or neurological decompensation. Record review of Resident 71's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 08-22-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored as a 3. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment. - required set up assistance with dressing, toileting and hygiene.-was independent with dressing, toileting and ambulation.- was taking an antipsychotic medication.-had 2 or more falls in the last 3 months. Record review of the facility's incident log printed on 09-08-2025 revealed on 06-16-2025 Resident 71 had an unwitnessed fall. Record review of Resident 71's Electronic Medical Record revealed a neurological check assessment with entries completed for the initial check, the next three 15 minute checks, the next four 30 minute checks, the next four 2 hour checks and the next four 4 hour checks. The remaining four 8 hour checks and the last check 24 hours after the last 8 hour check were blank. An interview with the Director of Nursing on 09-15-2025 at 8:40 AM confirmed the neurological checks were not completed for the unwitnessed fall on 06-16-2025 and should have been.

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	285137	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Omaha	6032 Ville DE Sante Drive Omaha, NE 68104

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, interview, and record review, the facility failed to implement interventions to prevent the potential for accidents on 2 (Residents 9 and 111) of 7 sampled residents. The facility census was 98. Findings are:A. A record review of the facility's “Transportation Coordination and Services” policy with a reviewed date of 05/15/2025 revealed the facility would ensure safety and infection control procedures were followed in accordance with state and federal guidance. A record review of the facility's “Suicide Precautions” policy with a reviewed date of 09/06/2024 revealed that residents who made attempts should be transferred to an acute setting for evaluation and reported in accordance with state regulation. Provide one to one supervision (1:1)(one staff with the resident at all times) until resident was transferred to an acute inpatient setting (hospital). A record review of Resident 111's “Clinical Census” dated 09/10/2025 revealed the resident was admitted [DATE] and the resident's Point Click Care number was 7563. A record review of Resident 111's “Medical Diagnosis” dated 09/11/2025 revealed the resident had diagnoses of Schizoaffective Disorder (a mental health condition that combines symptoms of schizophrenia and mood disorders), Alcohol Abuse, Traumatic Subdural Hemorrhage Without Loss of Consciousness (bleeding between the brain and the inner layer of the [NAME]), and Other Speech And Language Deficits Following Cerebrovascular Disease (speech or language impairment after a stroke or other brain event). A record review of Resident 111's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 07/03/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 10 which indicated the resident was moderately cognitively impaired. The resident was independent for activities of daily living except the resident needed supervision or touching assistance with bathing. The resident was independent with all areas of mobility. The resident was on antipsychotic medications (medications used to treat psychotic disorders), antianxiety medications, and antidepressant medications. The resident did have inattention, disorganized thinking but did not have mood symptoms or behaviors in the lookback period. A record review of Resident 111's “Care Plan” with an admission date of 06/26/2025 revealed the resident had a focus area of at risk for behavior problem related to schizoaffective disorder and interventions of administer medications as ordered with a date initiated of 11/10/2023, anticipate and meet the residents needs with a date initiated of 11/10/2023, explain all procedures to the resident before starting and allow the resident time to adjust to changes with a date initiated of 11/10/2023. A record review of Resident 111's “Progress Note” dated 07/28/2025 at 2:30 PM by Registered Nurse (RN)-C revealed during a bingo activity Resident 111 placed an orange bingo cap in the resident's mouth with an attempt to swallow it. The nurse spotted it and it was removed. The resident “appeared tearful, was rocking back and forth and was emotionally distressed.” (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was provided safety by providing a 1:1. A record review of Resident 111's “Progress Note” dated 07/28/25 at 14:55 PM by RN-C revealed a non-emergency medical transportation company would transport the resident to the hospital emergency room (ER) for evaluation. A record review of Resident 111's “Progress Note” dated 07/28/25 at 15:04 PM by RN-C revealed report was called to a nurse at the hospital ER and notified of the reasoning the resident would be seen in the ER. A record review of Resident 111's “Progress Note” dated 07/28/25 at 16:30 PM by Licensed Practical Nurse (LPN)-D revealed the hospital ER nurse called the facility to voice frustration that the resident was sent to the ER unaccompanied (no companion or escort). In a telephone interview on 09/10/2025 at 8:22 AM, RN-C confirmed RN-C was the nurse that took care of Resident 111 on 07/28/2025. RN - C reported Resident 111 was in the dining room playing bingo. The Activities Director (AD) came and got RN-C and reported Resident 111 was trying to make Resident 111 gag. RN-C took the resident to the resident's room and RN-C seen an orange cap about the size of a medicine bottle cap in the resident's mouth and removed it. RN-C went and got the Director of Nursing (DON). The DON instructed RN-C the resident needed 1:1 supervision so RN-C went and got the Bath Aide to do the 1:1. RN-C confirmed RN-C spoke to the resident and the resident confirmed the resident was trying to harm self. RN-C confirmed an attempt was made to transfer the resident with the facility van driver, but they were bust, so RN-C contacted the driver from the non-emergency transportation company to transport the resident to the ER and called the hospital ER to give report. RN-C confirmed RN-C told the driver to keep an eye on the resident, but confirmed RN-C did not make Driver-E aware that the resident had attempted self-harm. RN-C's reported their shift was ending, so RN-C gave report to Licensed Practical Nurse (LPN)-D and left for the day. RN-C confirmed when RN-C left, the resident was still at the facility and the Bath Aide was still doing 1:1 with Resident 111. RN-C confirmed it was RN-C's decision to call the non-emergency transport company's driver and not to call 911 since the cap was out and the Bath Aide was doing 1:1. In an interview on 09/10/2025 at 9:20 AM, Driver-E confirmed Driver-E recalled the transport to the ER of Resident 111 on 07/28/2025, but did not recall being given any special instructions or being given a packet to take to the ER. In an interview on 09/10/2025 at 3:04 PM, LPN-D confirmed Resident 111 had already left the facility when LPN-D started the shift on 07/28/2025. LPN-D recalled getting report from RN-C but did not know who transported the resident. LPN-D confirmed the Bath Aide did not go to the ER with the resident, but the resident was gone when LPN-D got there. In an interview on 09/10/2025 at 1:30 PM, the facility's RNC-A confirmed facility staff did not go with Resident 111 to the hospital ER on [DATE]. B. Record review of Resident 9's “Clinical Census” revealed the facility admitted the resident on 1/26/24. Record review of Resident 9's “Medical Diagnosis” printed 9/9/2025 revealed the resident had diagnoses which included muscle weakness, need for assistance with personal care, convulsions, and abnormal posture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 9's MDS dated [DATE] revealed Resident 9 had a BIMS score of 13. According to the MDS manual, a score of 13 indicated the resident was cognitively intact. Further review of the MDS identified Resident 9 required supervision while eating and was dependent upon staff for all other activities of daily living including transfers and mobility. Record review of Resident 9's “Progress Notes” printed 9/9/2025 revealed: -7/8/2025: “Bath aide called nurse to show purple bruise to left front shoulder. Resident not sure how she got this, denies pain to area. Message left with family to return call to facility. NP [nurse practitioner], DON notified.” Record review of a facility provided document “Skin Related Injury” dated 7/8/2025 involving Resident 9 revealed after facility investigation, the determined cause of the bruise to the shoulder was related to wheelchair positioning. Further review of the document showed a note dated 7/9/2025 “therapy applied a wedge in between knees to assist with positioning.” Record review of Resident 9's CCP revealed interventions to place an abductor wedge between the knees and make sure wedge is in place between resident and armrest on right side while in wheelchair dated revised 5/8/2025. An observation on 9/11/2025 at 10:34 AM revealed a standard foam cushion in the seat of Resident 9's wheelchair. Nurse Aide (NA)-B utilized a gait belt, performed a stand pivot transfer with Resident 9, and seated Resident 9 in the wheelchair. No wedge was placed between the resident and the armrest of the wheelchair, nor was an abductor wedge placed between Resident 9's knees. An observation on 9/15/2025 at 11:45 AM revealed Resident 9 seated in the wheelchair in the main dining room. A standard foam cushion was in the seat of the wheelchair. No further positioning devices were present. An interview on 9/11/2025 at 10:34 AM with NA-B revealed [gender] works with Resident 9 approximately half of NA-B's scheduled shifts. NA-B further revealed that [gender] was never made aware that Resident 9 required positioning devices to prevent the potential for further injury. NA-B reported that [gender] has never seen cushions or wedges in use with Resident 9. An interview on 9/15/2025 at 11:50 PM with the Director of Nursing confirmed the resident did not have any wedge or abductor wedge in use for Resident 9. An interview on 9/15/2025 at 12:20 PM with the Director of Rehabilitation (DOR) confirmed Resident 9 should have an abductor wedge between the knees. The DOR reported that the wedge between the resident and the right side of the wheelchair was no longer an active intervention. Record review of a facility policy entitled “Incident and Reportable Event Management” dated reviewed 9/25/24 revealed: -The Five “I's” to Event Management: -Intervention -1. The licensed nurse should implement an appropriate immediate intervention, based on the conclusions of the initial investigation. -2. The licensed nurse should update the resident care plan and communicate the intervention to the staff caring for the resident. -3. The IDT will, as part of their review, determine if the initial intervention is sufficient or if a modification is needed. Any changes from the initial intervention will be documented on the resident's care plan and communicated to the staff caring for the resident.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility staff failed to monitor lab values related to thyroid medication for 1 (Resident 30) of 5 residents sampled and failed to hold blood pressure medication when the blood pressure was outside of parameters for 1 (Resident 71) of 5 residents sampled. The facility census was 98. The findings are:A. Record review of the facility policy titled Unnecessary Medication dated 08-30-2022 revealed the facility will ensure only medications required to treat the resident's assessed condition are being used, reducing the need for and maximizing the effectiveness of medications. The facility's medication management process will support and promote the monitoring of medications for efficacy and adverse consequences. Record review of Resident 30's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 08-08-2025 revealed the facility staff assessed the following about the resident:-BIMS was scored as a 10. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-required limited assistance with bed mobility.-required extensive assistance with bathing-required total assistance with transfers, toileting, and wheelchair mobility. -was taking antipsychotic, antianxiety, and antidepressant medications. Record review of Resident 30's Pharmacy Consultation Report (PCR) dated 02-18-2025 through 02-20-2025 revealed Resident 30 receives a thyroid replacement medication and a Thyroid Stimulating Hormone (TSH) concentration was not located in the medical record for the last year and an order for a TSH concentration on the next convenient lab day and at least annually was requested. The physician's response dated 03-06-2025 was to have a TSH concentration drawn on the next laboratory day and every 6 months thereafter. Record review of Resident 30's PCR dated 04-22-2025 through 04-23-2025 revealed Resident 30 receives a thyroid replacement medication and an order for a TSH concentration on the next convenient lab day and at least annually was requested. The physician's response dated 05-05-2025 was to have a TSH concentration drawn on the next laboratory day. Record review of Resident 30's Electronic Medical Record revealed no TSH laboratory results from 03-06-2025 to 09-10-2025. An interview conducted on 09-10-2025 at 3:28 PM with the Regional Nurse Consultant (RNC) confirms the TSH concentration had not been done and should have been. B. Record review of Resident 71's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-BIMS was scored as a 3. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment. - required set up assistance with dressing, toileting and hygiene.-was independent with dressing, toileting and ambulation.- was taking an antipsychotic medication. Record review of Order Summary Report dated 09-09-2025 revealed an order dated 12-30-2024 for hydralazine 25 milligram (mg) give a half a tablet every 8 hours for Hypertension (HTN: high blood pressure) and to hold the medication if the systolic blood pressure (SBP: the top number of a blood pressure reading) was below 110. Record review of Resident 71's Medication Administration Record (MAR) for August 2025 revealed the following for hydralazine 25m g give a half tab every 8 hours and hold if SBP less than 110. -08-11-2025 at 8:00 AM blood pressure was 102/60 and documented as administered. -08-15-2025 at 8:00 AM blood pressure was 103/66 and documented as administered. -08-23-2025 at 8:00 AM blood pressure was 102/50 and documented as administered. -08-24-2025 at 8:00 AM blood pressure was 103/78 and documented as administered. -08-29-2025 at 8:00 AM blood pressure was 98/68 and documented as administered. -08-29-2025 at 2:00 PM blood pressure was 98/68 and documented as administered. -08-21-2025 at 10:00 PM blood pressure was 94/56 and documented as administered. Record review of Resident 71's MAR for September 2025 revealed the following for hydralazine 25mg give a half tablet every 8 hours for HTN, hold if SBP less than 110.-09-05-2025 at 10:00 PM blood pressure was 109/64 and documented as administered. -09-08-2025 at 8:00 AM blood pressure was 102/64 and documented as administered. An interview conducted on 09-15-2025 at 8:40 AM with the Director of Nursing (DON) confirmed the medication hydralazine was not held on the dates identified and should have been.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, interview and record review the facility failed to ensure a medication error rate of 5% or less as evidenced by 2 medication administration errors out of 25 opportunities for error, resulting in an error rate of 8%. The facility census was 98. The findings are:Record review of the facility policy titled Medication Administered through an Enteral Tube (feeding tube) dated 11-15-2024 revealed medications are administered by authorized and qualified facility staff, as prescribed, in accordance with standard nursing principles and practices. Insert medication syringe into the appropriate port and pour each medication through the syringe. Medications should be prepared and given separately. Do not mix medications together in a medication syringe. Record review of Resdient 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-required total assistance with eating, hygiene, bathing, dressing, toileting, transfers and bed mobility.-had a feeding tube (a tube inserted into the gastrointestinal tract to deliver nutrition, fluids and medications). An observation on 09-15-2025 at 1:37 PM was conducted of Licensed Practical Nurse (LPN) F administering medication to Resident 3 revealed hydralazine 75 milligram (mg) tablet and baclofen 5 mg tablet were to be administered. LPN F removed the tablets from the medication cards and placed both medications in a clear pouch and inserted the pouch into the pill crusher and crushed the medications together. After the medications were crushed the medications were poured out of the clear pouch and into a clear medicine cup. Then LPN F along with LPN G went to Resident 3's room to administer the medication. LPN F poured approximately 3 teaspoons of water into the cup with medications and stirred it with a plastic spoon until the medication had dissolved. Resident 3's tube feeding was placed on hold by LPN F and a feeding syringe was inserted into the resident feeding port and after checking placement, LPN F flushed the feeding tube with water and then administered both medications dissolved in water through the feeding tube followed by a water flush. LPN G was present during the observation and was training LPN F. An interview with LPN G on 09-15-2025 at 1:45 PM reveals Resident 3's physician had given an order for medications to be crushed and administered together through the feeding tube. An interview with the Director of Nursing on 09-15-2025 confirmed Resident 3 did not have an order for medications to be crushed and administered together through the feeding tube and confirmed medications should not have been crushed and administered together for Resident 3.