

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER Adept Nursing & Rehab of Gretna		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Highway 6 Gretna, NE 68028	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2). Based on interview and record review the facility failed to obtain orders for treatment of a pressure ulcer for 1(Resident 51) of 2 residents sampled. The facility census was 40. The findings are:Record review of the facility policy dated 08-2025 titled Wound Treatment Management revealed the policy was to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with the current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders. Record review of Resident 51's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-could not make themselves understood.-required partial assistance with bed mobility, eating and hygiene.-required substantial assistance with upper body dressing and transfers.-required total assistance with toileting and lower body dressing. Record review of Resident 51's Admission/readmission Assessment ([NAME]) dated 01-09-2026 revealed a pressure ulcer had been identified to the sacral area (the area just above the tailbone) measuring 2.0 by 1.0 centimeters (cm). Record review of Resident 51's Order Summary (OS) printed on 03-02-2026 revealed no order for the treatment of the pressure ulcer to the sacrum. An interview conducted with Registered Nurse (RN) F on 03-05-2026 at 10:35 AM revealed Resident 51 had a pressure ulcer to the sacral area and confirmed the physician was not notified and an order was not obtained and should have been.</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>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 3 errors out of 25 opportunities for error resulting in a medication error rate of 12%. The facility census was 40. The findings are:Record review of the facility's undated policy titled Medication Errors revealed it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors.Medication error means the observed or identified preparation or administration of medications or biologicals which were not in accordance with the prescriber's order; manufacturer's specifications regarding preparation and administration of medication or biological; or accepted professional standards and principles which apply to professionals providing services. The facility shall ensure medications will be administered as follows:-according to physician's orders-per manufacturer's specifications regarding preparation and administration of the drug or biological-in accordance with the accepted standards and principles which apply to professionals providing services. The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. A.Record review of Resident 35's Physician's Orders (PO) revealed an order for torsemide 80 milligrams (mg), give by mouth in the morning for edema (swelling). An observation conducted on 03-04-2026 at 7:10 AM of Medication Aide (MA) D administering medications to Resident 35 revealed a medication torsemide 80 mg was unavailable for administration. An interview conducted on 03-04-2026 at 7:15 AM with MA D revealed MA D would inform the charge nurse of the need to obtain the torsemide from the facility's medication bank. An interview conducted on 03-04-2026 at 8:30 AM with Licensed Practical Nurse (LPN) E revealed Torsemide 80 mg was not available in the facility's medication bank and the pharmacy had been notified. An interview conducted on 03-04-2026 at 2:00 PM with LPN E confirmed the Torsemide for Resident 35 had not arrived from the pharmacy and Resident 35 had missed a dose and a missed dose is a medication error. B.Record review of Resident 24's PO revealed an order for sucralfate (a medication used to treat stomach ulcers) 1 gram (GM) by mouth before meals and at bedtime. An observation conducted on 03-04-2026 at 12:45 AM of MA C administering medications to Resident 24 revealed the sulcrafate 1 GM was administered after Resident 24 had already eaten lunch. An interview conducted on 03-04-2026 at 12:50 PM with MA C confirmed the medication was given after the meal and should have been administered before. C.Record review of Resident 33's PO revealed an order for finasteride 5 mg by mouth one time a day for urinary retention. The finasteride was scheduled to be given at 8:00 PM. An observation conducted on 03-04-2026 at 1:00 PM of MA C administering medications to Resident 33 revealed MA C administered finasteride 5mg. An interview conducted with the Director of Nursing (DON) on 03-05-2026 at 8:30 AM confirmed the finasteride 5mg should have been administered at 8:00 PM for Resident 33 and confirmed missed doses and medications given at the wrong time were medication errors.</p>		