STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285148	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Shepherd Lutheran Home	2242 Wright Street Blair, NE 68008

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Licensure Reference Number 175 NAC 12-006(F)(i)(5)Based on interview and record review the facility failed to notify the provider of weight change greater than 5 pounds on 1 (Resident 7) of 2 sampled residents. The facility census was 62.Findings are:A. Record Review of the facility's undated policy Following Physician Order revealed the following: PURPOSETo ensure all physician/practitioner orders are accurately received, transcribed, communicated, implemented, monitored, and followed in accordance with professional standards of practice, resident needs, and applicable federal and state regulations.POLICYThe facility shall ensure physician/practitioner orders are implemented as written unless clarified, modified, discontinued, refused by the resident, unavailable, clinically contraindicated, or otherwise unable to be completed. Any inability to follow an order shall be identified, documented, communicated, and addressed timely.Orders include but are not limited to: Medication orders Treatment orders Laboratory and diagnostic orders Therapy orders Dietary orders Activity orders Safety interventions Consultations/referrals Monitoring parameters Isolation/precaution orders Behavioral health interventions Durable medical equipment orders4. Orders Unable to Be CompletedIf an order cannot be implemented as written, staff shall: Assess resident status and immediate risk. Determine cause, including but not limited to: Medication unavailable Equipment unavailable Resident refusal Clinical contraindication Missed dose/treatment Delivery delay Pharmacy issue External appointment delay Notify the physician/practitioner. Obtain additional orders as necessary. Document: Reason order was not completed Notifications made Practitioner response Resident outcome Corrective actions taken Follow alternative interventions ordered by practitioner. B. Record Review of Resident 7's Order Report Summary dated 5/20/2026 revealed the resident has an order to obtain daily weights and notify Resident 7's Primary Care Practitioner (PCP) if weight gain was greater than 5pounds. Record Review of Resident 7's April 2026 and May 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed the following:Weights were not obtained on 4/9/2026, 4/15/2026, 4/16/2026, 4/22/2026, 4/23/2026, 4/25/2026, 4/29/2026, 4/30/2026, 5/1/2026, 5/6/2026 and 5/14/2026. Record Review of Resident 7's Electronic Health Record (EHR) revealed there was no provider notification regarding weight increase on 4/7/2026 with a weight gain of 7 pounds, 4/24/2026 with a weight gain of 7.2 pounds, 4/28/2026 with a weight gain of 5.4 pounds and on 5/10/2026 with a weight gain 8.2 pounds. In an interview on 5/26/2026 at 7:04 AM Infection Preventionist (IP) confirmed that weights were not obtained on 4/9/2026, 4/15/2026, 4/16/2026, 4/22/2026, 4/23/2026, 4/25/2026, 4/29/2026, 4/30/2026, 5/1/2026, 5/6/2026 and 5/14/2026 and should have been. The IP confirmed that there was no notification to the provider seen in the residents EHR regarding the 5 pound or greater weight gain.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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) Based on interview and record review, the facility failed to add oxygen interventions to 1 (Resident 22) of 2 sampled resident's Comprehensive Care Plan (a detailed roadmap outlining a resident's medical, physical, and daily living needs). The facility census was 62. Findings are:A record review of the facility's undated Comprehensive Care Plans policy revealed that the care plan would include the services to be furnished to the resident. A record review of Resident 22's Clinical Census dated 05/26/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 22's Medical Diagnosis dated 05/26/2026 reveled the resident had diagnoses of Cerebral Infarction (stroke) and Morbid (Severe) Obesity. A record review of Resident 22's Minimum Data Set (MDS, a comprehensive assessment used to develop a resident's care plan) dated 05/15/2026 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 (able to understand). The resident required setup or clean-up assistance with eating and oral hygiene (cleaning), partial/moderate assistance with upper body dressing and personal hygiene, and required substantial/maximal assistance with lower body dressing, toileting hygiene, bathing, and footwear. The resident required partial/moderate assistance with bed mobility and transfers. The resident was on oxygen. A record review of Resident 22's Clinical Physician Orders dated 05/26/2026 revealed the resident had an order for oxygen at 1-2 liters per minute (l/m) via nasal cannula (a tubing inserted in a resident's nose to deliver oxygen). Notify primary care provider (PCP) if saturations less than 90 percent (%). A record review of Resident 22's Care Plan Report with an admission date of 11/10/2025 did not reveal a focus area or interventions for the resident's oxygen. An observation on 05/18/2026 at 10:12 AM revealed Resident 22 was not in the resident's room, the oxygen concentrator (machine used to purify oxygen) was on, and the nasal cannula was lying on the bed sheet. An observation on 05/20/2026 at 7:01 AM revealed Resident 22 was not in the resident's room, the oxygen concentrator was on, and the nasal cannula was lying on the bed sheet. An observation on 05/20/2026 at 10:45 AM with the Director of Nursing (DON) revealed Resident 22 was not in the resident's room, the oxygen concentrator was on, and the nasal cannula was lying on the bed sheet. In an interview on 05/20/2026 at 7:04 AM, Resident 22 confirmed the resident wore oxygen, but only at night. In an interview on 05/20/2026 at 10:45 AM, the DON confirmed Resident 22 was on oxygen at night. In an interview on 05/26/2026 at 8:52 AM, the DON confirmed Resident 22's oxygen was not on the care plan 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)Based on observation, record review and interview, the facility failed to follow practitioner orders to obtain a urinalysis for 1 (Resident 41) of 3 residents sampled, failed to follow physician orders to notify provider of oxygen saturation less than 90% for 1 of (Resident 22) of 2 residents sampled, and failed to obtain daily weights and notify the provider of a 5 pound or greater weight gain for 1 (Resident 7) of 2 residents sampled. The facility identified a census of 62.Findings are: Findings are: A. Review of an undated facility policy titled 'Following Physician Order' revealed the following: 'PURPOSE To ensure all physician/practitioner orders are accurately received, transcribed, communicated, implemented, monitored, and followed in accordance with professional standards of practice, resident needs, and applicable federal and state regulations. POLICY The facility shall ensure physician/practitioner orders are implemented as written unless clarified, modified, discontinued, refused by the resident, unavailable, clinically contraindicated, or otherwise unable to be completed. Any inability to follow an order shall be identified, documented, communicated, and addressed timely. Orders include but are not limited to: Medication orders Treatment orders Laboratory and diagnostic orders Therapy orders Dietary orders Activity orders Safety interventions Consultations/referrals Monitoring parameters (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Isolation/precaution orders Behavioral health interventions Durable medical equipment orders Procedure 1. Receiving Orders 2. Order review and verification 3. Implementation of Orders Orders shall be initiated promptly according to: Order timing Resident condition Clinical urgency Staff shall ensure implementation of: Medication administration Treatments Monitoring parameters Laboratory services Referrals/consults Care plan updates Required assessments Equipment acquisition/setup Therapy services Care plans, Kardex, EHR tasks, treatment records, MAR/TAR, and other applicable systems shall be updated as required. 4. Orders Unable to Be Completed If an order cannot be implemented as written, staff shall: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess resident status and immediate risk. Determine cause, including but not limited to: Medication unavailable Equipment unavailable Resident refusal Clinical contraindication Missed dose/treatment Delivery delay Pharmacy issue External appointment delay Notify the physician/practitioner. Obtain additional orders as necessary. Document: Reason order was not completed Notifications made Practitioner response Resident outcome Corrective actions taken Follow alternative interventions ordered by practitioner. 5. Resident Refusal When residents refuse ordered services/interventions: Staff shall: Educate resident/responsible party regarding risks and benefits Reapproach as appropriate (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess contributing factors Notify practitioner when clinically indicated Documentation shall include: Intervention refused Resident statement/reason Education provided Reapproach attempts Notifications Outcome Ongoing refusals shall be reviewed by the interdisciplinary team. 6. Monitoring and Follow-Up Nursing staff shall monitor implementation and outcomes of orders including: Medication effectiveness Treatment response Laboratory results Adverse reactions Resident condition changes Completion of ordered services Significant findings shall be communicated to the practitioner timely. 7. Documentation Requirements Documentation shall include: Order receipt date/time Implementation date/time Notifications (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clarifications obtained Refusals Delays or omissions Practitioner communication Outcomes and follow-up actions Documentation shall be complete, accurate, and entered into the medical record timely. 8. Quality Assurance Monitoring The facility shall monitor compliance through: Medication audits Treatment audits Missed order reviews Pharmacy reports EMR audits QAPI review Incident trending Identified concerns shall be addressed through corrective action and performance improvement processes'. B. Record review Resident 41's Annual 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 4/2/26 revealed the facility admitted the resident on 5/9/25 and readmitted the resident after a hospitalization on 2/24/26. The facility staff assessed Resident 41's Brief Interview for Mental Status (BIM's, a cognitive screening tool used to determine cognitive function in long term care facilities) of 6/15 indicating severe cognitive impairment. In addition, Resident 41 admitted with the with diagnoses of vascular dementia, moderate, without behaviors, metabolic encephalopathy, acute and chronic respiratory failure with hypoxia, neurogenic bladder with suprapubic catheter (a catheter placed directly in the bladder through the abdomen) and hypertension. Further review indicated Resident 41 required set up or clean up assistance for eating, oral hygiene, and upper body dressing, supervision or touching assistance for toileting hygiene, personal hygiene and sit to stand transfers, and partial to moderate assistance for bath/shower self and lower body transfers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the May 2026 Treatment Administration Record revealed an order dated 5/23/26 at 3 PM for urinalysis screen/culture one time only related to neuromuscular dysfunction of bladder, unspecified. Record review of progress notes revealed the UA was not obtained until 5/25/26 at 12:56 PM Interview with the Director of Nursing (DON) on 5/26/26 at 2:30 PM confirmed the order for obtaining UA/Culture was not followed on 5/23/26 and should have been. C. A record review of the facility's undated Following Physician Order policy revealed that the facility would ensure physician/practitioner orders were implemented as ordered and documentation would include notifications and practitioner communication. A record review of Resident 22's Clinical Census dated 05/26/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 22's Medical Diagnosis dated 05/26/2026 reveled the resident had diagnoses of Cerebral Infarction (stroke) and Morbid (Severe) Obesity. A record review of Resident 22's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 05/15/2026 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 (able to understand). The resident required setup or clean-up assistance with eating and oral hygiene (cleaning), partial/moderate assistance with upper body dressing and personal hygiene, and required substantial/maximal assistance with lower body dressing, toileting hygiene, bathing, and footwear. The resident required partial/moderate assistance with bed mobility and transfers. The resident was on oxygen (o2). A record review of Resident 22's Care Plan Report with an admission date of 11/10/2025 did not reveal a focus area or interventions for the resident's oxygen. A record review of Resident 22's Clinical Physician Orders dated 05/26/2026 revealed the resident had an order for oxygen at 1-2 liters per minute (l/m) via nasal cannula (a tubing inserted in a resident's nose to deliver oxygen). Notify primary care provider (PCP) if saturations (sats) less than 90 percent (%). A record review of Resident 22's O2 Sats Summary dated 05/26/2026 revealed: - On 05/26/2026 the resident's sats were 84% - On 05/05/2026 the resident's sats were 88% - On 04/21/2026 the resident's sats were 88% - On 04/08/2026 the resident's sats were 88% - On 03/19/2026 the resident's sats were 77% (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 03/12/2026 the resident's sats were 87% - On 03/09/2026 the resident's sats were 89% - On 03/07/2026 the resident's sats were 82% - On 03/05/2026 the resident's sats were 86% - On 02/26/2026 the resident's sats were 84% - On 02/23/2026 the resident's sats were 88% - On 02/11/2026 the resident's sats were 88% - On 02/08/2026 the resident's sats were 84% - On 02/07/2026 the resident's sats were 78% - On 02/06/2026 the resident's sats were 88% - On 02/05/2026 the resident's sats were 88% - On 02/04/2026 the resident's sats were 89% A record review of Resident 22's Progress Notes dated 05/26/2026 did not reveal the resident's PCP had been notified of the above oxygen levels below 90%. A record review of Resident 22's Client Uploaded Files dated 05/26/2026 did not reveal the resident's PCP had been notified of the above oxygen levels below 90%. In an interview on 05/26/2026, the DON confirmed the facility did not have notifications to the PCP and it had not been done and should have been. D. Record Review of the facility's undated policy Following Physician Order revealed the following: PURPOSE To ensure all physician/practitioner orders are accurately received, transcribed, communicated, implemented, monitored, and followed in accordance with professional standards of practice, resident needs, and applicable federal and state regulations. POLICY The facility shall ensure physician/practitioner orders are implemented as written unless clarified, modified, discontinued, refused by the resident, unavailable, clinically contraindicated, or otherwise unable to be completed. Any inability to follow an order shall be identified, documented, communicated, and addressed timely. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orders include but are not limited to: Medication orders Treatment orders Laboratory and diagnostic orders Therapy orders Dietary orders Activity orders Safety interventions Consultations/referrals Monitoring parameters Isolation/precaution orders Behavioral health interventions Durable medical equipment orders 4. Orders Unable to Be Completed If an order cannot be implemented as written, staff shall: Assess resident status and immediate risk. Determine cause, including but not limited to: Medication unavailable Equipment unavailable Resident refusal Clinical contraindication Missed dose/treatment Delivery delay Pharmacy issue External appointment delay (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the physician/practitioner. Obtain additional orders as necessary. Document: Reason order was not completed Notifications made Practitioner response Resident outcome Corrective actions taken Follow alternative interventions ordered by practitioner. Record Review of Resident 7's Order Report Summary dated 5/20/2026 revealed Resident 7's practitioner had ordered daily weights be obtained and notify Primary Care Practitioner (PCP) if weight gain is greater than 5 pounds. Record Review of Resident 7's April 2026 and May 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed the following: Weights were not obtained on 4/9/2026, 4/15/2026, 4/16/2026, 4/22/2026, 4/23/2026, 4/25/2026, 4/29/2026, 4/30/2026, 5/1/2026, 5/6/2026 and 5/14/2026. Record Review of Resident 7's Electronic Health Record (EHR) revealed there was no provider notification regarding weight increase on 4/7/2026 with a weight gain of 7 pounds, 4/24/2026 with a weight gain of 7.2 pounds, 4/28/2026 with a weight gain of 5.4 pounds and on 5/10/2026 with a weight gain 8.2 pounds. In an interview on 5/26/2026 at 7:04 AM Infection Preventionist (IP) confirmed that weights were not obtained on 4/9/2026, 4/15/2026, 4/16/2026, 4/22/2026, 4/23/2026, 4/25/2026, 4/29/2026, 4/30/2026, 5/1/2026, 5/6/2026 and 5/14/2026 and should have been. The IP confirmed that there was no notification to the provider seen in the residents EHR regarding the 5 pound or greater weight gain.

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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 0689 Level of Harm - 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** License Reference Number 175 NAC 12-006.09(I)Based on observation, interview, and record review the facility failed to implement interventions to prevent potential accidents for 3 (Residents 37, 55, and 57) of 3 sample residents. The facility census was 62.Findings are: A. Record Review of the facility's undated policy Safe Resident Handling/transfers revealed the following: Policy: It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize the risks for injury and provide and promote a safe, secure and comfortable environment for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy Explanation: All residents required safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Compliance Guidelines: 1. The interdisciplinary team or designee will evaluate and assess each resident's individual mobility needs, taking into account other factors as well, such as weight and cognitive status. 2. The resident's mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observations or recommendations. 14. Resident lifting and transferring will be performed according to the resident's individual plan of care. Record review of the facility's undated policy Falls and Fall Risk, Managing revealed the following: Resident-Centered Approaches to Managing Falls and Fall Risk 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g. Dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. Record Review of the facility's undated policy Accidents and Supervision revealed the following: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents 3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment. The process includes: Communicating the interventions to all relevant staff Assigning responsibility Providing training as needed Documenting interventions (e.g., plans of action developed through the QAA Committee or care plans for the individual resident) Ensuring that the interventions are put into action Interventions are based on the results of the evaluation and analysis of information about hazards and risks and are consistent with relevant standards, including evidence-based practice Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully Facility-based interventions may include, but are not limited to: Educating staff Repairing the device/equipment Developing or revising policies and procedures Resident-directed approaches may include: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Implementing specific interventions as part of the plan of care Supervising staff and residents, etc. Facility records document the implementation of these interventions 1. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions. Modification is the process of adjusting interventions as needed to make them more effective in addressing hazards and risks. Monitoring and modification processes include: Ensuring that interventions are implemented correctly and consistently Evaluating the effectiveness of interventions Modifying or replacing interventions as needed Evaluating the effectiveness of new interventions 2. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: Defined by type and frequency Based on the individual resident's assessed needs and identified hazards in the resident environment. Record Review of Resident 57's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 3/23/2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE] -Brief Interview of Mental Status (BIMS) was scored as an 11. According to the MDS Manual a score of 8-12 indicates a person has moderate cognitive impairment. -was dependent on staff for lower body dressing, putting on/taking off footwear, chair to bed/bed to chair transfer, toilet transfer and tub/shower transfers. -had diagnosis of osteo arthritis (deuteriation of joints), pain in left hip, trochanteric bursitis in left and right hip (outer hip pain), age related osteoporosis without current pathological fracture (fragile bones). Record Review of Resident 57's Care Plan revealed the following: -Transfer: required 2 staff assist to move between surfaces and as necessary. -9/20/24- 2 assist with transfers on admission. Date Initiated: 09/24/2024 and revised on 04/11/2025. - 3/4/25-Therapy to eval for transfers and overall weakness. Date Initiated: 03/05/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- 4/10/25- Staff education of 2 staff members for all transfers. Date Initiated: 04/11/2025 and revised on 04/11/2025. - Care plan did not reveal the use of a sit to stand lift with transfers for Resident 57. Record Review of the Resident 57's Physical Therapy (PT) Evaluation and Plan of Treatment with a start of care date as 5/1/2026 revealed that the certification period is 5/1/2026-6/29/2026. Further review revealed that Resident 57 was referred to physical therapy due to a decline in functional mobility, strength and activities of daily living performance. Record Review of the facility's Describe the Incident report dated 5/6/2026 revealed the following: -On 5/2/2026 at 9:20 PM Resident 57 was lowered to the floor after attempts were made to transfer Resident 57 to the bed. According to the incident report dated 5/02/2026 Resident 57 was unable to bear weight and was assisted to the floor by a nursing assistant. - Resident 57 complained of ankle pain after doctor's appointment today and was transferred to [NAME] walk in clinic at the hospital. -Received a report from a Nurse Practitioner (NP) at 12:21 that Resident 57 had an acute right ankle pain with a obvious fracture noted. ACE wrap applied to affected extremity. -Received call from the hospital with report that radiologist noted a fracture to the top of Resident 57's foot. Record review of Resident 57's Visual/Bedside Kardex Report dated 5/26/2026 revealed the following: 'Safety' - 4/10/25- Staff education 2 staff members for all transfers. - walker and W/C for mobility. 'Transferring' - Transfers: requires 2 staff assist to move between surfaces and as necessary. -9/20/24- 2 staff assist with transfers on admission. - Resident 57's Kardex Report did not reveal the use of a sit to stand lift with transfers. In an interview on 5/26/2026 at 6:57 AM, Director of Nursing (DON) confirmed Resident 57's transfer status at the time of the fall was 2 assists. DON confirmed that residents' transfer status is always (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	on their Kardex. In an interview on 05/26/2026 at 9:40 AM DON confirmed that causative factor for Resident 57's fall was not completing the 2 assists transfer. In an interview on 05/26/2026 at 4:10 PM, DON confirmed Resident 57 was already on physical therapy at the time of the fall and the intervention after the fall was to have physical therapy evaluate Resident 57. B. A record review of the facility's undated Safe Resident Handling/Transfers revealed all residents require safe handling when transferred to prevent or minimize the risk of injury to the resident or staff. While manual lifting techniques may be utilized, depending on the resident's condition, the use of a mechanical lift is a safer alternative and should be used. The staff would inspect equipment prior to use and alert maintenance if the equipment was not functioning properly. Damaged, broken, or improperly functioning lift equipment would not be used and tagged out according to facility policy. A record review of the facility's Lifting Machine, Using a Mechanical policy dated 2017 revealed the staff should have made sure all necessary equipment (clings, hooks, chains, straps, and supports) were on hand and in good condition. A record review of Resident 37's Clinical Census dated 05/26/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 37's Medical Diagnosis dated 05/26/2026 reveled the resident had diagnoses of Cerebral Infarction (stroke), Alzheimer's Disease, Disorientation, Dementia (confusion), Muscle Weakness, Unspecified Abnormalities Of Gait (pattern of walking or moving) And Mobility, and Unsteadiness On Feet. A record review of Resident 37's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 04/16/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 2 which indicated the resident was severely cognitively impaired (unable to understand). The resident was dependent on staff for all activities of daily living (ADLs) except eating and for mobility and transfers. The resident had bilateral lower extremity (both legs and feet) limited range of motion. A record review of Resident 37's Care Plan Report with an admission date of 12/09/2024 revealed the resident required the assistance of two staff for transferring. The resident was on hospice, and the staff was to adjust the provision (supplying something or a specific measure taken) ADLs to compensate for the resident's changing abilities. An observation on 05/20/2026 at 7:26 AM revealed Nursing Assistant (NA)-L and NA-M entered Resident 37's room to assist the resident in transferring to the resident's wheelchair. NA-L positioned the sit-to-stand mechanical lift that was labeled number 4 in front of the resident, both NAs assisted the resident with dressing, applied the sit-to-stand lift sling around the resident and fastened the sling to the sit-to-stand lift. NA-M went to fasten the leg strap and confirmed the leg strap on the sit-to-stand lift was broke and the buckle was missing, so NA-M attempted to tie the strap. NA-M could not get the sit-to-stand lift leg strap tied, so NA-L and NA-M continued to use the sit-to-stand (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	lift to lift resident off the bed and transfer into the resident's wheelchair. NA-L then placed the sit-to-stand lift in the hallway and NA-M continued to assist the resident with ADLs. An observation on 05/20/2026 at 10:37 AM with the facility's Administrator revealed the leg strap on the number 4 sit-to-stand mechanical lift in the 600 hallway had a missing buckle and could not be fastened. In an interview on 05/20/2026 at 10:05 AM, NA-L confirmed NA-L and NA-M transferred Resident 37 with a sit-to-stand lift and the buckle on the leg strap was broken and they should not have used that lift. NA-L confirmed that when there was a defective piece of equipment, the staff was just to put an order in the facility's work order system (TELS). NA-L confirmed the staff had been using the defective lift for about one month and a workorder had been put in the system. In an interview on 05/20/2026 at 10:37 AM, the facility's Administrator confirmed the sit-to-stand mechanical lift in the 600 hallway's leg strap buckle was broken and could not be fastened. The Administrator confirmed NA-L and NA-M should not have used the defective number 4 sit-to-stand mechanical lift to transfer Resident 37 from the bed to the wheelchair. C. Record review of Resident 55's admission 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 4/29/26 identified the facility admitted the resident on 4/17/26 with a Brief Interview for Mental Status (BIM's, a cognitive screening tool used to determine cognitive function in long term care facilities) of 3/15 indicating severe cognitive impairment. Further review revealed Resident 55 required set up/clean up for eating, partial/moderate assist for oral hygiene, upper body dressing, personal hygiene, and sitting to standing transfers, dependent on staff for toilet hygiene, lower body dressing, and putting on and taking off footwear. Record review of Resident 55's Visual/Bedside Kardex Report revealed a section titled 'safety' with: -5/2/26 Assist resident out of bed between 6:30-7:30 AM -5/4/26 Fall mat placed on left side of bed -fall matt to be placed to left side of bed when resident in bed Observation of Resident 55 on 5/20/26 at 6:35 AM revealed Resident 55 alone in room, sitting up on the left side of the bed with the fall matt folded up against the wall between the dresser and the heating/air conditioner unit. Observation of Resident 55 on 5/21/26 at 7:13 AM revealed the resident sitting on the left side of the bed with the fall matt folded up against the wall between the dresser and the heating/air conditioner unit. In an interview with the Director of Nursing (DON) on 5/20/26 at 6:37 AM confirmed the fall matt was not on the floor next to the bed as is care planned when resident is in bed and should be.

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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 observation, record review and interview, the facility failed to ensure that the posted nurse staffing information contained the required information related to the facility census, the total number of hours worked per discipline per shift and the total number of hours worked for the each shift. This had the potential to affect all residents that resided in the facility. The facility census was 62. Findings are:Record review of an undated facility policy entitled Posting Direct Care Daily Staffing Numbers revealed the following information:Policy Explanation and Implementation:Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. 2. The information recorded on the form shall include the following:The name of the facility.The current date.The resident census at the beginning of the shift for which the information is posted.Twenty - four hour shift schedule operated by the facility.The shift for which the information is posted.Type RN, LPN, LVN or CAN (Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses or Certified Nurse Aides) and category (licensed and unlicensed) of nursing staff working during that shift for each category who are paid by the facility (including contract staff).The actual time worked during that shift for each category and type of nursing staff.Total number of licensed and un-licensed nursing staff working for the posted shift. Observation on 05/19/26 at 3:20 PM and 5/20/26 at 3:25 PM revealed the posted nursing staffing information for 05/18/26, 5/19/26 and 5/20/26 did not contain the facility census, a calculation of the number of hours worked per discipline per shift or the total number of hours worked per shift and daily. Record review of 30 days past posted nurse staffing documentation between 4/18/26 and 5/20/26 revealed the daily posted nurse staffing did not contain the facility census, a calculation of the total number of hours worked per discipline per shift and the total number of hours worked for each shift. Interview on 05/21/2026 at 8:34 AM with the facility Director of Nursing [DON] confirmed that the facility census was not included on the past 30 days of the posted nurse staffing information and no calculation of hours worked per discipline and no calculation of the total number of hours worked had been completed or documented on the posted nurse staffing information. The DON confirmed that those items should have been included in the posted nurse staffing information.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Licensure Reference Number 175 NAC 12.006.10(D)The facility failed to prevent significant medication errors for 2 Residents (2 and 6) of 13 Residents sampled. The facility identified a census of 62.Findings are: Findings are: A. Review of a facility policy titled Medication Administration-Medications not available with no date revealed the following Policy Statement The facility shall maintain systems to ensure medications are available for timely administration as ordered. When a medication is unavailable at the time of administration, nursing staff shall immediately initiate actions to obtain the medication, minimize interruption of therapy, ensure resident safety, and appropriately document actions taken. Medications shall not be omitted without assessment, intervention, provider notification when indicated, and appropriate follow-up. Purpose To establish procedures for managing medications that are unavailable at the time of the administration while ensuring resident safety, continuity of care, regulatory compliance, and timely communication. Procedure Identification of medication unavailability When a medication is not available during the scheduled medication administration pass, the nurse shall a. Verify the medication is not available in: -Resident medication cart -Medication stock room -Backup stock/ house stock (if applicable) -Emergency medication supply (E-Box/ eBox) -Alternate storage locations approved by facility policy b. Confirm the medication was not previously delivered or misplaced. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Verify current physician orders, medication schedule, and administration time. 2. Pharmacy Notification/Retrieval Process If the medication remains unavailable, nursing staff shall immediately contact the pharmacy to: -Determine delivery status -Request urgent delivery, courier, or stat delivery when appropriate -verify availability of replacement medication -obtain guidance regarding expected arrival time -confirm whether emergency dispensing processes are available Documentation shall include: -date and time of delivery -Pharmacy representative spoken with (if available) -expected delivery timeframe -actions taken 3. eBox/Emergency Medication use The nurse shall review and utilize the Emergency Medication Box (eBox/E-Box) when applicable and permitted by facility policy. If the ordered medication or approved equivalent is available within the eBox: -Medication may be obtained following facility procedures -Requires inventory, access, and documentation processes shall be completed -Administration shall be documented in the MAR and applicable logs The nurse shall ensure replacement medication is requested from pharmacy if eBox supply is utilized. 4. Provider Notification If the medication remains unavailable at the scheduled administration time and administration cannot occur as ordered: The attending physician/provider shall be notified. Provider notification shall include: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Medication unavailable -Missed or delayed dose timing -Resident condition /status -Pharmacy actions completed -eBox review/use status -Clinical risk associated with delay The nurse shall obtain and implement new orders as provided. Examples may include: -Hold order -Substitute medication -Schedule adjustment -Clinical monitoring parameters -Alternative route/order -Transfer for urgent evaluation (if indicated) All new orders shall be followed as directed. B. Review of undated facility policy titled Medication Error revealed the following: Policy It is the policy of this facility to provide protection 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. Definitions: Medication error means the observed or identified preparation of administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. 4. The facility will consider factors indicating errors in the medication administration, including, but (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to, the following: i. Incorrect dose, route of administration, dosage form, time of administration; ii. Medication omission; iii. incorrect medication. C. Record review of Resident 2's Order Summary report revealed an order dated 12/05/25 for Eliquis (an anticoagulant) 5mg take 1 tablet by mouth twice daily for Atrial Fibrillation (an abnormal heart rhythm). Observation of a medication pass on 5/20/2026 at 8:25 AM Registered Nurse (RN) J was asked about Resident 2's Eliquis 5mg tablet, RN J stated she did not have the medication available. RN went back into the Electronic Health Record (HER) and changed documentation to medication not available. In an interview with RN J, on 5/20/26 at 8:27 AM, it was confirmed she had documented the medication was given and then changed it to not available. Record review of Resident 2's MAR revealed the Eliquis 5mg was documented as not available and not given on 5/4/26 at 8 AM, 5/8/26 at 8 AM, 5/9/26 at 8 AM, 5/11/26 at 8 AM and at 8 PM, 5/12/26 at 8 AM and 8 PM, 5/13/26 at 8 AM, 5/14/26 8 AM, 5/18/26 8 AM, 5/20/26 8 AM In an interview was conducted with with the Director of Nursing on 5/20/26 at 2:26 PM. During the interview the DON confirmed medications not available would be considered a medication error. D. Record review of Resident 6's Order Summary Report dated 5/19/2026 revealed the following orders: -Lantus Solos (medication to lower blood sugar) inject 100/ML (milliliter) Inject 15 unit subcutaneously (below the skin) at bedtime related to type 2 diabetes mellitus (your body's inability to break down sugar) without complications started on 10/17/2025. -Levothyroxine (hormone replacement for energy, metabolism and growth) tablet 137MCG (microgram) take 1 tablet by mouth daily on empty stomach *take at least 30 minutes prior to meal related to hypothyroidism (under active thyroid gland) started on 4/28/2026. -Mirtazapine tablet 15MG (milligrams) take one tablet by mouth at bedtime for unspecified mood (affective) disorder started on 4/15/2025. -Olanzapine tablet 5MG take one tablet by mouth at bedtime for unspecified mood (affective) disorder (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started on 4/15/2025. Record Review of Resident 6's Medication Administration Record (MAR) dated 4/1/2026 - 4/30/2026 and 5/1/2026 - 5/31/2026 revealed the following: -Levothyroxine 125mcg was not administered on 4/17/2026, 4/23/2026, 4/25/2026, and was increased on 4/28/2026 to 137mcg but not administered as scheduled on 5/3/2026, 5/4/2026, 5/9/2026, 5/14/2026. No documentation of administration on 4/12/2026. -Lantus Solos injection was not administered on 4/16/2026, 4/18/2026, 4/22/2026, 4/23/2026, 5/3/2026, 5/13/2026. Refused on 4/21/2026, 4/30/2026 and 5/2/2026. -Mirtazapine tablet 15MG was not administered on 4/16/2026, 4/18/2026, 4/22/2026, 4/23/2026, 5/3/2026, 5/13/2026. -Olanzapine tablet 5MG was not administered on 4/16/2026, 4/18/2026, 4/22/2026, 4/23/2026, 5/3/2026 and 5/13/2026. In an Interview on 5/19/2026 at 1:31 PM, Director of Nursing (DON) confirmed nurses should be attempting to administer the medication three times before charting an omission (not given) and should be documenting that an attempt was made three times in the progress notes. In an Interview on 5/19/2026 at 1:31 PM, Infection Preventionist (IP) confirmed the medications listed were not administered on the dates listed. .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.11 Based on observation, interview, and record review the facility failed to ensure hand hygiene was completed between 2 (Residents 58 and 62) of 2 sampled residents during dining service and failed to perform hand hygiene when indicated during food prep. This had the potential to affect all residents but 1 resident in the facility. The facility census was 62. Findings are: A. RR of the facility's undated Handwashing Guidelines for Dietary Employees policy revealed the following: 6. Frequency of Handwashing: Dietary employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single service and [NAME] use articles and also in the following situations: a. Every time an employee enters the kitchen; at the beginning of the shift; after returning from break; after using the toilet. b. After hands have touched anything unsanitary i.e., garbage, soiled utensils/equipment, dirty dishes, etc. c. After hands have touched bare human body parts other than clean hands (such as face, nose, hair etc.). g. when switching between working with raw food and working with ready to eat food. h. Before donning gloves for working with food. An observation during meal preparation on 5/20/2026 between 8:44 AM and 10:25 AM revealed the Dietary Manager (DM) completed hand hygiene (HH) for 20 seconds (sec), applied gloves, grabbed a box of pork chops, cut open each individual wrapped pork chop and placed them on the baking sheet. The DM removed the soiled gloves and did not complete HH touching clean baking sheets. The DM lined the baking sheets with parchment paper without completing HH and applied gloves. The DM open each individually wrapped pork chop with a knife and place them on the baking sheet. The DM discarded the trash from the porkchops, removed the soiled gloves, and did not complete HH. The DM washed the counter with a sanitizer washcloth towel, took the washcloth to the dish area, did not complete HH, went to walk-in to grab potato salad and brought potato salad back to prep area and opened the containers of potato salad. The DM removed trash, removed the soiled gloves and did not complete HH. In an interview on 5/20/2026 at 9:43 AM DM confirmed that hand hygiene was not completed between glove changes and should have been. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. A record review of the facility's undated Handwashing/Hand Hygiene (sanitizing) policy with a revised date of October 2023 revealed hand hygiene should be completed before touching a resident and after touching a resident. An observation on 05/20/2026 at 8:06 AM revealed Nursing Assistant (NA)-M entered the dining room and assisted Resident 58 with setting up the resident's meal tray and applying a clothing protector while touching the resident's neck and clothing without performing hand hygiene. NA-M then approached Resident 62 and applied a clothing protector while touching the resident's neck and clothing before NA-M sat down beside Resident 62 to assist Resident 62 with eating. No hand hygiene was performed before or after contact with Resident 58, or before resident contact with Resident 62. In an interview on 05/21/2026 at 7:54 AM, the DON confirmed NA-M should have completed hand hygiene before and after resident contact in the dining room.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that the facility assessment included information related to staffing levels needed for specific shifts, a plan to maximize recruitment and retention of direct care staff and a contingency plan for events that do not require the activation of the facility emergency plan but have the potential to impact resident care. This had the potential to affect all residents that resided in the facility. The facility census was 62. Findings are:A record review of the facility's undated Facility Assessment policy revealed The facility would conduct and document a facility-wide assessment to determine what resources were necessary to care for the residents competently during both day-to-day operations (including nights and weekends) and emergencies. The assessment would address or include the resident population including, but not limited to number of residents and the facility's capacity, staff competencies and skill sets, physical environment, equipment and services, and cultural, ethnic, and religious factors and the facility resources, The care required by the resident and the facility resources. The facility would be used to Inform staffing decisions to ensure sufficient number of staff with appropriate competencies and skill sets, consider specific staffing needs per unit and each shift, develop and maintain plan to maximize recruitment and retention of staff, and a contingency plan for events that do not require activation of the facility's emergency plan.Record review of the Facility assessment dated [DATE] revealed no information related to specific staffing needs per unit and each shift, no total calculation of the hours worked per each shift, no plan for the development or retention of staff and no contingency plan related to events that could happen which don't active the emergency plan but still had the potential to affect residents. Interview on 05/21/2026 at 7:20 AM with the facility Administrator confirmed that the Facility Assessment did not contain specific information related to staffing needs per unit pershift and did not include a list of specific personnel in house to meet the resident needs. The Administrator confirmed that the plan did not cover specific staffing levels withnumbers of staff needed for each shift. The Administrator confirmed that the Facility Assessment did not include information about retention and recruitment of staff and did notinclude a contingency plan for events that did not require the activation of the facility emergency plan but could have the potential to impact resident care.