STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Crest Health Center	2824 North 66th Avenue Omaha, NE 68104

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(5). Based on interview and record review the facility failed to notify the resident representative of a change of condition for 1(Resident 1) of 2 residents sampled. The facility census was 151. The findings are:A.Record review of the facility policy titled Change in Condition dated 05-21-2023 revealed it is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The resident and/or their representatives will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Requirements for notification of resident, the resident representative and their physician:-an accident involving the resident, which results in injury and has the potential for requiring physician intervention. -a significant change in the resident's physical, mental, or psychosocial status.-a need to alter treatment significantly such as the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. B.Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-26-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had a diagnosis of Cerebral Vascular Accident (stroke) affecting the right side of the body.-Brief Interview of Mental Status (BIMS) was scored as a 5. According to the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment. -required total assistance with toileting, hygiene, dressing, bed mobility, transfers and bathing.-was frequently incontinent of bladder.-was always incontinent of bowel. -did not have a pressure ulcer. Record review of Resident 1's Tissue Analytics Document (TAD) dated 03-03-2026 revealed Resident 1 had developed a new wound on the right ankle and a new Deep Tissue Injury to the left heel. Record review of Resident 1's Progress Notes revealed no indication Resident 1's representative was informed of the new wounds on the right ankle or left heel. An interview conducted with Licensed Practical Nurse (LPN) C on 04-30-2026 at 3:41 PM confirmed Resident 1's representative was not updated of the new wounds to the right ankle and left heel and should

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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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Licensure Reference Number 175 NAC 1-005.04Based on record review and interview, the facility failed to resolve grievances and provide grievance resolution response for 1 (Resident 10) of 2 sampled residents. The facility staff identified a census of 151.Findings are:A. Record review of facility policy entitled Grievances dated reviewed/revised 08/25/2026 revealed: - 9. Upon receipt of a written grievance/complaint, Social Services and Department Managers will investigate the allegations and submit a written report of such findings to the administrator. The investigation and report will include, as each may apply: -a. The date and time of the alleged incident; -b. The circumstances surrounding the alleged incident; -c. The location of the alleged incident; -d. The names of any witnesses and their account of the alleged incident; -e. The resident's account of the alleged incident; -f. The employee's account of the alleged incident; -g. Accounts of any other individuals involved (i.e., employee's supervisor, etc.); and -h. Recommendations for corrective action. -9. The administrator will review the findings with the person investigating the complaint to determine what corrective actions, if any, need to be taken. -10. The resident or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems in a timely manner. A written summary of the report will also be provided to the resident if requested, and a copy will be filed in the Social Services office.B. Record review of Resident or Family Concern/Grievance Report Form (grievance form) received from Social Worker (SW)-A on 04/28/2026 at 10:46 AM revealed Resident 10's family member had submitted a grievance on 03/02/2026 regarding a staff member's attitude towards Resident 10 and the family member. The rest of the grievance form including the resolution and administrator review were incomplete.Record review of a grievance form received on 04/28/2026 at 2:18 PM from the Social Services Supervisor (SSS) detailed the grievance received by the facility on 03/02/2026 revealed the grievance of a staff member's attitude towards Resident 10 and their family member. The form was completed to include resolution and follow up with Resident 10 and their family member via a one-to-one discussion dated 03/10/2026.Interview on 04/28/2026 at 10:45 AM with the SSS revealed the facility was in receipt of a grievance regarding a concern with a staff member's attitude. SSS further revealed the grievance was written and was being processed.Interview on 04/28/2026 at 10:46 AM with SW-A revealed the grievance form was incomplete because SW-A was awaiting the permanent interventions from the Director of Nursing or Assistant Director of Nursing.Interview on 04/28/2026 at 10:59 AM with the Assistant Director of Nursing (ADON) revealed the ADON spoke with the staff member in question regarding the grievance. The staff member denied the allegation. The ADON reported the staff member was removed from Resident 10's care and education was provided.Interview on 04/28/2026 at 11:05 AM with the facility Administrator (ADM) revealed the ADM was unaware of the grievance until 04/28/2026 due to the ADM was not at the facility at the time of the grievance.Interview on 04/28/2026 at 3:33 PM with SSS revealed the facility provided grievance resolution on 03/10/2026 to Resident 10 and their family member.Phone interview 04/29/2026 at 10:47 AM with Resident 10's family member revealed the grievance filed was related to a staff member's attitude. Resident 10's family member further revealed that [gender] had not been notified of the resolution of the grievance filed.Interview on 04/29/2026 at 11:50 AM with the ADM revealed a reasonable time frame for grievance resolution was within 10-14 days, which included the form completion and review.During a follow up interview on 04/30/2026 at 11:45 AM, SW-A confirmed the grievance form was not complete when originally provided to surveyors on 04/28/2026 because the permanent grievance resolution was unknown. SW-A reported they informed Resident 10 and the family member of resolution the facility would normally implement in these types of grievances, not the permanent and grievance-specific resolution provided for Resident 10. SW-A further confirmed the grievance was not completed until 04/28/2026.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to report an allegation of physical abuse to law enforcement within the required timeframe for 1 (Resident 6) of 3 sampled residents. Facility staff identified a census of 151.Findings are:A. Record review of facility policy entitled Abuse Reporting dated revised 08/08/2024 revealed in accordance with the Elder Justice Act, the facility administrator or designee would immediately notify, but not later than two hours after the allegation is made if the events that cause the allegation involved result in serious bodily injury or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury the following persons or agencies of such an incident: the state licensing authority, the Ombudsman, the resident's representative; Adult Protective Services; law enforcement officials; the resident's attending physician; and the facility medical director. Further review of the abuse reporting policy identified if the allegations were true, the employee would be terminated from employment.B. Record review of Resident 6's Clinical Census showed the facility admitted the resident on 02/21/2019.Record review of Resident 6's Medical Diagnosis revealed Resident 6 had diagnoses of moderate vascular dementia with agitation (dementia of abrupt or gradual onset that is caused by cerebrovascular disease), generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities [e.g., work or school performance] that occurs more days than not, for at least 6 months), bipolar disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone), and major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies).Record review of Resident 6's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 03/18/2026 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 Resident 6 had rejected care in four to six days of the assessment period. There were no other behavioral symptoms checked, including physical behavioral symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually).Record review of an e-mail from the Social Services Supervisor (SSS) to facility management revealed on 03/17/2026 between breakfast and lunch, a Nurse Aide (NA) entered Resident 6's room, placed a lift sling (sling used for mechanical lift transfers) under Resident 6, and informed Resident 6 that [gender] would be taking a shower. Resident 6 reported they refused the bath. Resident 6 reported to facility staff the situation then escalated, resulting in both Resident 6 and the NA exchanging punches. Resident 6 was observed by facility staff to have bruises on both arms.Record review of a Potential Resident Abuse Report Form with date of incident listed as 03/17/2026 at around 10:30 AM revealed no evidence law enforcement was notified of the allegation.Record review of Skin Check dated 03/16/2026 revealed Resident 6 had no bruising at the time of assessment.Record review of Skin Check dated 03/18/2026 revealed bruising in the following areas: -radial aspect of the right hand (above the thumb) measuring 2 centimeters (cm) by (x) 2.5 cm; -back of the right hand over the fifth metacarpal joint measuring 1 cm x 1.5 cm; -Forearm: most distal (furthest) bruise from the elbow measured 2.5 cm x 2.5 cm; second most distal bruise from elbow measured 2 cm x 1 cm; and bruise closest to elbow measured 4 cm x 4 cm. -dorsal side (back side) of the left hand measured 6.5 cm x 4 cm; -left radial (thumb side) of wrist measured 6 cm x 5 cm; -left (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mid-forearm measured 1 cm x 1 cm; second most distal bruise measured 1 cm x 1.2 cm; third most distal bruise measure 0.5 cm x 0.5 cm; and antecubital fossa (the fold in the elbow) measured 7 cm x 2 cm.Record review of Resident 6's Electronic Health Record (EHR) including progress notes and scanned documents revealed no evidence law enforcement was notified of the allegation of physical abuse.Interview on 04/29/2026 at 11:50 AM with the facility Administrator (ADM) confirmed law enforcement was not notified of the allegation of physical abuse. The ADM revealed the facility does not report bruising to the Police Department.Interview on 04/29/2026 at 12:36 PM with the SSS confirmed the allegation of physical abuse was not reported to law enforcement and should have been.

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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** Based on record review and interview, the facility failed to update the 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) to reflect the current resuscitation status for 1 (Resident 10) of 15 sampled residents. The facility staff identified a census of 151.Findings are:A. Record review of facility policy entitled Comprehensive Care Plans dated reviewed/revised 09/02/2025 revealed the CCP would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set ((MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) assessment.B. Record review of Resident 10's MDS dated [DATE] revealed the facility admitted Resident 10 on 09/23/2024. Further review of the MDS revealed Resident 10 had a condition or chronic disease that may result in a life expectancy of less than six months, and Resident 10 was receiving hospice services.Record review of Resident 10's Do-Not-Resuscitate Order (DNR) dated 04/03/2026 revealed Resident 10's representative requested a DNR resuscitation status.Record review of Resident 10's Order Listing Report identified an order Do Not Resuscitate dated 04/22/2026.Record review of Resident 10's CCP printed 04/28/2026 at 9:18 AM revealed Resident 10 had a full code, do not resuscitate status dated 10/02/2024.Interview on 04/28/2026 at 3:33 PM with the Social Services Supervisor (SSS) revealed the facility had updated the care plan on 04/28/2026. The SSS further confirmed the code status should have been updated at the time of the code status change.

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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(H)(iii)(3). Based on observation, interview and record review the facility failed to implement physician's orders to prevent altered skin integrity for 1 (Resident 5) of 3 residents sampled. The facility census was 151. The findings are:A. Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-24-2026 revealed the facility staff assessed the following about the resident:-Had a diagnosis of End Stage Renal Disease (ESRD)-dialysis dependent, Type 2 Diabetes Mellitus, Atrial Fibrillation (A-Fib), Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure. -Brief Interview of Mental Status (BIMS) was scored as a12. According to the MDS Manual a score of 12 indicates moderate cognitive impairment.-required set up and clean up assistance with eating.-required total assistance with hygiene, toileting, bathing, dressing, bed mobility, and transfers.-was receiving dialysis services. Record review of Resident 5's Order Listing Report (OLR) printed on 04-28-2026 revealed an order for wound care for the buttocks and coccyx (tailbone) area as follows:-cleanse with foam soap and water and pat dry-apply preventative ointment up to 4 times a day and as needed for soiling-secure with a sacral mepilex dressing (according to the manufacturer Molnlycke Health Care, mepilex sacral dressing is a self-adherent, 5-layer, silicone foam dressing specifically shaped for the sacral area to treat and prevent pressure injuries). Record review of Resident 5's Nurse Administration Record (NAR) for April 2026 revealed no order for wound care to the buttocks and coccyx area. An observation conducted on 04-30-2026 at 10:40 AM during the provision of incontinence care for Resident 5 revealed pink skin discoloration to the sacral area and the absence of a mepilex dressing to the sacral and coccyx area.An interview conducted on 04-30-2026 at 2:30 PM with Licensed Practical Nurse (LPN) C confirmed Resident 5 was to receive wound care to the sacral and coccyx area, confirmed the treatment had not been provided and there must have been a glitch in the electronic medical record program because the order was not on the NAR to cue the staff to provide the treatment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) & 12-006.09(H)(iii)(2). Based on observation, interview and record review the facility failed to develop, implement and reevaluate interventions for the prevention of pressure ulcer development and to promote wound healing for 2 (Resident 1 and 7) of 3 residents sampled. The facility census was 151. The findings are:A. Record review of the facility policy titled Pressure Ulcer Prevention and Management dated 09-25-2025 revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale Score, on all residents upon admission/re-admission, weekly for 4 weeks, then quarterly or whenever the resident's condition changes significantly. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the Quality Assurance Committee Schedule, and as needed when actual or potential problems are identified. Interventions on the resident's plan of care will be modified as needed. Considerations for needed modifications include: -changes in resident's degree of risk for developing a pressure injury.-new onset or recurrent pressure injury development-lack of progression towards healing-resident non-compliance-changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights. Record review of the National Library of Medicine article titled Nursing Assessment of Pressure Injury Risk with the Braden Scale dated 11-21-2022 revealed the Braden Scale is an evidence-based nursing tool to assess a patient's risk of developing pressure ulcers based on a score:-a score of 0 to 9 indicates a very high risk of pressure ulcer development.-a score of 10 to 12 indicates a high risk of pressure ulcer development.-a score of 13 to 14 indicates a moderate risk of pressure ulcer development.-a score of 15 to 18 indicates a mild risk of pressure ulcer development.-a score of 19 to 23 indicates no risk of pressure ulcer development. B. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 01-26-2026 revealed the facility staff assessed the following about the resident:-admitted to the facility on [DATE].-had a diagnosis of Cerebral Vascular Accident (stroke) affecting the right side of the body.-Brief Interview of Mental Status (BIMS) was scored as a 5. According to the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment. -required total assistance with toileting, hygiene, dressing, bed mobility, transfers and bathing.-was frequently incontinent of bladder.-was always incontinent of bowel. -did not have a pressure ulcer. Record review of Resident 1's Electronic Health Record (EHR) under the assessments section revealed Resident 1's Braden Scale score on admission [DATE] was a 13 indicating moderate risk of pressure ulcer development. Record review of Resident 1's Baseline Care Plan (BCP) dated 01-20-2026 revealed Resident 1 was to have a pressure relieving cushion to the wheelchair. Record review of Resident 1's Electronic Health Record (EHR) under the assessments section revealed Resident 1's Braden Scale score on admission [DATE] was a 11 indicating high risk of pressure ulcer development. Record review of Resident 1's Comprehensive Care Plan (CCP) dated 01-22-2026 revealed Resident 1 was at high risk for skin breakdown due to immobility, right-sided hemiplegia (paralysis), decreased sensation and incontinence. The right heel and other bony prominences are particularly vulnerable to pressure injury. The goal was Resident 1's skin would remain intact. Interventions listed to achieve the goal were:-Braden skin risk evaluation completed on admission, every week for 4 weeks, quarterly and with any significant change.-Nurse Aids to observe skin with morning and bedtime cares and report any abnormalities.-consult the dietician for a nutritional (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment as needed. -document on a flow sheet: if skin is intact; mark Y. If skin is reddened or has open areas; mark N. Report any new openings to Registered Staff.-ensure special mattress is in place for pressure relief-maintain good skin hygiene. Moisturize dry skin as needed.-maintain the head of the bed at the lowest degree of elevation possible.-monitor labs and weights as ordered.-observe for alteration in skin integrity and report to practitioner. Skin will be inspected by licensed staff weekly per schedule.-provide adequate nutrition and hydration. Nutritional supplements and vitamins as ordered. Record review of Resident 1's Skin Check (SC) dated 01-28-2026 revealed Resident 1 had no pressure ulcers. Record review of Resident 1's SC dated 02-04-2026 revealed Resident 1 had blanchable redness to the right heel. Record review of Resident 1's Nurse Administration Record (NAR) for February 2026 revealed an order for Prevalon boots (according to the manufacturer [NAME]/Sage Products, the boots prevent and treat heel pressure ulcers by completely floating the heel off of mattress to relieve pressure) to be worn when in bed. Further review of the NAR for February 2026 revealed on February 6, 7, 8 and 9 there was a 9 in the box indicating to see the progress notes. Record review of Resident 1's Progress Notes (PN) dated 02-06-2026 revealed the Prevalon boots on when in bed were not available. Record review of Resident 1's PN dated 02-07-2026 revealed the Prevalon boots on when in bed were not available. Record review of Resident 1's PN dated 02-08-2026 revealed the Prevalon boots on when in bed were not available. Record review of Resident 1's PN dated 02-09-2026 revealed no pressure relieving boots were available, heels are floating on a pillow. Record review of Resident 1's TAD dated 02-10-2026 revealed an order to protect heels at all times with Prevalon boots, floating the heels and repositioning. Record review of Resident 1's SC dated 02-11-2026 revealed Resident 1 had a pressure ulcer to the right heel measuring 2.5 centimeters (cm) in length by 0.8 cm in width. Record review of Resident 1's Tissue Analytics Document (TAD) dated 02-17-2026 revealed Resident 1's pressure ulcer to the right heel measured 5.81 cm in length by 5.06 cm in width. The TAD also revealed an order to protect heels at all times with Prevalon boots, pillows, floating and repositioning. Record review of Resident 1's NAR for February 2026 revealed the order for Prevalon boots was not changed to reflect the practitioner's order for Prevalon boots at all times dated 02-10-2026. Record review of Resident 1's TAD dated 03-03-2026 revealed Resident 1's right heel pressure ulcer had gotten larger with a new dark area indicative of a Deep Tissue Injury (DTI) measuring 6.56 cm in length by 4.16 cm in width. The TAD also revealed a new wound to the right ankle measuring 0.72 cm in length by 0.71 cm in width with an etiology of possible skin tear vs. pressure ulcer vs. straps from Prevalon boots rubbing on skin and a DTI was identified to the left heel measuring 0.85 cm in length by 0.41 cm in width. The TAD also revealed instructions from the wound care practitioner to protect heels at all times including when Resident 1 is out of bed and do not let Resident 1's feet rest on foot pedals. Record review of Resident 1's NAR for March 2026 revealed on 03-06-2026 the facility had changed the order for Prevalon boots from wear while in bed, to wear at all times, 25 days after the initial practitioner order. Record review of Resident 1's Dietary Progress Notes (DPN) dated 03-07-2026 revealed a nutritional evaluation was conducted for wound healing, 27 days after the first pressure ulcer was identified. The DPN also revealed the Registered Dietician (RD) recommended a nutritional supplement of Ensure Plus give one carton twice a day. Record review of Resident 1's Medication Administration Record (MAR) for March 2026 revealed Ensure Plus give 1 carton twice a day was not administered to Resident 1 until 03-11-2026, 4 days after the RD recommendation. Record review of Resident 1's TAD dated 03-10-2026 revealed Resident 1's right heel pressure ulcer was 1.28 cm in length and 1.87 cm in width, the right ankle worsened measuring 3.91 cm in length by 1.14 cm in width, and the left heel DTI measured 1.36 cm in length by 0.54 cm in width. Record review of Resident 1's EHR revealed a TAD was not completed on 03-17-2026. Record review of Resident 1's TAD dated 03-24-2026 revealed Resident 1's right heel pressure ulcer was 1.83 cm in length and 0.88 cm in width, the right ankle worsened measuring 4.82 cm in length and 1.56 cm in width, and the left heel DTI measured 0.81 in length by 0.77 cm in width. Record review of Resident 1's PN dated 03-24-2026 revealed Resident 1 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was transferred to the hospital for evaluation of a change in condition. An interview conducted on 04-30-2026 at 1:45 PM with Registered Nurse (RN) D revealed Resident 1 was non-compliant with the Prevalon boots and could not recall if the Interdisciplinary Team (IDT) had re-evaluated Resident 1's interventions for pressure relief for the bilateral feet. The interview also revealed that Resident 1 was not on a turning schedule and the schedule should have been put into the tasks in the EHR to cue the staff to reposition Resident 1. An interview conducted on 04-30-2026 at 2:00 PM with LPN C confirmed the turning schedule for Resident 1 was not entered into the EHR to cue the staff to reposition Resident 1, confirmed the nutritional evaluation was not requested prior to 03-07-2026 and confirmed pressure relieving interventions for Resident 1's had not been re-evaluated and confirmed new interventions on Resident 1's care plan were dated 04-21-2026, 28 days after Resident 1 discharged . C. Record review of the Joerns DermaFloat LAL model air mattress dated 2015 revealed directions for setting up the air mattress to prevent bottoming out (providing greater than 1 inch of air between the resident's sacral area/buttocks and the lower safety mattress) as outlined:-begin by placing the head of the bed in the appropriate position based on the resident's clinical condition.-select the highest or most firm Comfort Adjust setting.-Hand Check: place a hand with 3 fingers (if the head of the bed is at 30 degrees or higher) and 4 fingers (if the head of the bed is lower than 30 degrees) stacked vertically beneath the cells of the mattress and above the safety mattress directly between the lowest point of the resident's sacral area/buttocks. The smallest finger should be resting on the safety mattress. -sequentially reduce the Comfort Adjust setting to the firmness level where the height of the 3 or 4 fingers can slide with minimal resistance between the resident's sacral area/buttocks and the lower safety mattress. This is the proper Comfort Adjust setting for the resident to assure proper inflation of the air cells and prevent bottoming out of the mattress.-document the resident's Comfort Adjust setting for future reference and re-evaluate with the Hand Check as the resident's condition warrants. D. Record review of Resident 7's MDS dated [DATE] 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 a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact. -required total assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transfers.-was always incontinent of bowel and bladder.-was at risk of developing a pressure ulcer.-had a stage 2 pressure ulcer. An observation conducted on 04-27-2026 at 1:30 PM revealed Resident 7 was lying in bed on a DermaFloat air mattress set at the firmest setting.An observation conducted on 04-28-2026 at 8:00 AM revealed Resident 7 was lying in bed on a DermaFloat air mattress set at the firmest setting.An observation conducted on 04-29-2026 at 4:50 AM revealed Resident 7 was lying in bed on a DermaFloat air mattress set at the firmest setting. An interview conducted with the Director of Nursing (DON) on 04-30-2026 at 3:30 PM confirmed the facility had not followed the DermaFloat air mattress manual for the set up of Resident 7's air mattress and could not confirm if the mattress was at the correct setting to prevent bottoming out as described in the manual.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Licensure Reference Number 175 NAC12-006.09 Based on observation, interview and record review the facility failed to coordinate the provision of medication administration with dialysis services and failed to adhere to physician ordered fluid restriction for 1 (Resident 5) of 1 residents sampled. The facility census was 151. The findings are:A.Record review of the facility policy titled Guideline for Care of the Dialysis Resident dated 02-20-2022 revealed the purpose of the policy was to ensure dialysis residents would be provided care and services in a manner that promotes the resident's quality of life, and to attain or maintain the resident's highest possible physical, mental, and psychosocial well-being. The attending physician orders all diets served to dialysis residents. Dialysis residents are given fluid based on the fluid restriction as ordered by the physician. The nursing and dietary staff will organize the division and distribution of fluid. Medications will be administered as ordered prior to departure and after arrival from the dialysis center. These hours will not interfere with the hours designated for the dialysis treatment. The licensed nurse will obtain specific orders regarding administration or holding of medications. B.Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-24-2026 revealed the facility staff assessed the following about the resident:-Had a diagnosis of End Stage Renal Disease (ESRD)-dialysis dependent, Type 2 Diabetes Mellitus, Atrial Fibrillation (A-Fib), Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure. -Brief Interview of Mental Status (BIMS) was scored as a12. According to the MDS Manual a score of 12 indicates moderate cognitive impairment.-required set up and clean up assistance with eating.-required total assistance with hygiene, toileting, bathing, dressing, bed mobility, and transfers.-was receiving dialysis services. Record review of Resident 5's After Visit Summary (AVS) dated 04-21-2026 revealed an order for a 1500 milliliter (ml) fluid restriction. Record review of Resident 5's Order Listing Report (OLR) printed on 04-28-2026 revealed an order for a Regular diet, thin consistency, no added salt, double protein at meals, avoid high potassium foods with a 1200 ml fluid restriction. Record review of Resident 5's Comprehensive Care Plan (CCP) revised 03-26-2026 revealed Resident 5 had a potential for altered nutrition and hydration and weight changes related to the therapeutic diet, fluid restriction, ESRD and dialysis treatments. The goal was Resident 5 would not have a significant weight change through the next review period and would not show signs or symptoms of dehydration through the review period. Interventions were:-confer with the dialysis Registered Dietician (RD) on an ongoing basis regarding diet, labs, weight and supplements.-diet as ordered: No added salt, Double protein, Low Potassium, regular texture, thin liquids and 1200 ml fluid restriction.-fluids offered within ordered daily fluid restriction of 1200 ml.-Monitor and record meal and fluid intake daily. -monitor for signs and symptoms of dehydration.-monitor weight and report any significant changes to the dietician.-no water pitcher in room. -resident attends dialysis 3 times a week. -supplements as ordered by the dialysis clinic. Record Review of Resident 5's Medication Administration Record (MAR) for April 2026 revealed an order for a fluid restriction 1200 ml per day give 240 ml with breakfast, 240 ml at lunch, 240 ml at dinner and 120 ml with each med pass. Record review of Resident 5's meal ticket revealed staff were to provide 240 ml fluid of choice. An observation conducted on 04-28-2026 at 10:00 AM revealed Resident 5 was in bed with the bedside table next to the bed and on the table was a 600 ml water pitcher that was full up to the 500 ml line on the pitcher. An observation conducted on 04-28-2026 at 12:15 PM revealed a lunch tray was delivered to Resident 5 containing a 240 ml carton of milk, a red plastic glass of juice and a white Styrofoam cup of ice and the 600 ml water pitcher was on the bedside table with the meal. An observation conducted on 04-29-3036 at 12:30 PM revealed Resident 5 had a lunch tray containing a 240 ml carton of milk, a red plastic cup of ice, and a white Styrofoam cup of juice. An interview conducted on 04-30-2026 with Registered Nurse (RN) E confirmed Resident 5 had a water pitcher in the room this morning and RN E had removed it because the Resident 5 was not to have a water pitcher in the room (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and confirmed Resident 5 was to have 240 ml of fluid with meals and had been offered more than 240 ml at the lunch meal. C. Record review of Resident 5's MAR for April 2026 revealed on 04-24-2026 a 3 indicating Resident 5 did not receive the medication due to being away from the facility without medications:-atorvastatin (a medication used to treat high cholesterol) 10 milligrams (mg) at 9 am.-Fluticasone nasal spray 1 spray both nares at 9 am.-linagliptin (a medication used to treat Type 2 Diabetes) 5mg 1 tablet at 9 am.-sennosides-docusate sodium 8.6-50 mg tablet at 9 am.-metoprolol tartrate (a medication that lowers the resting heart rate, reduces the hearts workload and lowers blood pressure) 25 mg tablet at 9 am.-mucinex extended release (a medication used for chest congestion) 600 mg at 9 am.-carboxymethycellulose sodium ophthalmic solution 0.5% (used for dry eyes) 1 drop in both eyes at 9 am.-ipratropium-albuteral inhalation solution (a medication used to open airways for COPD) 3 mg/ml 3ml inhaled at 9 am. An interview conducted with the Director of Nursing on 04-30-2026 at 3:00 PM confirmed the medications were omitted due to being out of the facility at dialysis and did not know the provision of medications should be scheduled around dialysis services.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04. Based on interview and record review the facility failed to ensure timely response to call lights as evidenced by call light response times, greater than 30 minutes for 3 (Residents 4, 5 and 7) of 15 sampled residents. The facility census was 151. The findings are:A. An interview conducted with Resident 4 on 04-29-2026 at 9:00 AM revealed Resident 4 had been left on the toilet for a very long time in mid-January of this year. The interview further revealed on 04-26-2026 Resident 4 was left on the toilet for a long time, but not as long as in January.Record review of Resident 4's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 1/15/2026 revealed the facility staff assessed Resident 4's Brief interview for Mental Status (BIMS) as a 13. According to the MDS [NAME] a score of 13 to 15 indicates a person is cognitively intact.Record review of Resident 4's Alarm Average Response Time Report (AARTR) for 01-10-2026 to 01-17-2026 revealed on January 13, 2026 Resident 4's call light was on for 167 minutes and 51 seconds. Record review of Resident 4's AARTR for 04-17-2026 to 04-30-2026 revealed on April 26, 2026 at 8:59 AM Resident 4's call light was on for 46 minutes and 32 seconds, and at 1:05 PM Resident 4's call light was on for 73 minutes and 34 seconds. B. Record review of Resident 5's MDS dated [DATE] the facility staff assessed Resident 5's BOMS as a 12. According to the MDS [NAME] a score of 8 to 12 indicates a persons cognition is moderately impaired.An interview conducted on 4-28-2026 at 8:00 AM with Resident 5's family member revealed Resident 5 has had to wait an hour to be laid down after dialysis. Record review of Resident 5's AARTR for 04-17-2026 to 04-30-2026 revealed on 04-26-2026 at 1:13 AM Resident 5's call light was on for 61 minutes and 38 seconds, and on 04-26-2026 at 6:26 AM Resident 5's call light was on for 76 minutes and 33 seconds. C. An interview conducted on 04-28-2026 at 10:00 AM with Resident 7 revealed Resident 7 had waited as long as 2 hours for someone to answer the call light. Record review of Resident 7's MDS dated [DATE] revealed the facility staff assessed the residents BIMS as a 15.Record review of Resident 7's AARTR for 04-17-2026 to 04-30-2026 revealed on 04-25-2026 at 2:44 PM Resident 7's call light was on for 65 minutes and 18 seconds and at 8:01 PM Resident 7's call light was on for 63 minutes.An interview conducted with the Director of Nursing (DON) on 04-30-2026 revealed the goal for call light response was 7 minutes and confirmed call light times over 30 minutes were not timely.

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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). Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 1 (Resident 5) of 1 residents sampled. The facility census was 151. The findings are:A.Record review of Medication Errors in Nursing Homes Fact Sheet from the Long-Term Care Community Coalition dated 01-2023 revealed a medication error means an observed or identified preparation or administration of medications which is not in accordance with the prescriber's order, the manufacturer's specifications, or accepted professional standards or principles. A significant medication error is an error which causes the resident discomfort or jeopardizes their health and safety. Common medication errors include taking medication dose late, omitted dose, dispensing the wrong medication, giving the medication through the wrong route, and a wrong or extra dose of medication.B.Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-24-2026 revealed the facility staff assessed the following about the resident:-Had a diagnosis of End Stage Renal Disease (ESRD)-dialysis dependent, Type 2 Diabetes Mellitus, Atrial Fibrillation (A-Fib), Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure. -Brief Interview of Mental Status (BIMS) was scored as a12. According to the MDS Manual a score of 12 indicates moderate cognitive impairment.-required set up and clean up assistance with eating.-required total assistance with hygiene, toileting, bathing, dressing, bed mobility, and transfers.-was receiving dialysis services. Record review of Resident 5's Comprehensive Care Plan (CCP) revised 04-13-2026 revealed Resident 5 needs dialysis related to ESRD and had dialysis appointments on Monday, Wednesday and Friday. Record review of Resident 5's Medication Administration Record (MAR) for April 2026 revealed on 04-24-2026 a 3 indicating Resident 5 did not receive the following medication due to being away from the facility without medications:-metoprolol tartrate (a medication that lowers the resting heart rate, reduces the hearts workload and lowers blood pressure) 25 milligram (mg) tablet at 9 AM. Record review of Resident 5's Progress Note dated 04-24-2026 revealed morning medications were not given due to being at dialysis that morning and the physician wrote an order to give metoprolol tartrate 25mg now due to Resident 5's heart rate was 116. An interview conducted with the Director of Nursing (DON) on 04-30-2026 at 3:00 PM confirmed Resident 5 did not receive the metoprolol and linagliptin on 04-24-2026 and a medication omission was an error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility staff failed to change gloves between residents during the provision of blood glucose monitoring, perform hand hygiene after doffing (removing) gloves, and handle glucose strips in a manner to prevent the potential for cross contamination for 2 (Residents 14 and 15) of 6 sampled residents; and the facility failed to use enhanced barrier precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition [e.g., residents with wounds or indwelling medical devices]) to prevent the potential for cross-contamination for 1 (Resident 5) of 2 sampled residents. Facility staff identified a census of 151.Findings are:Record review of facility policy entitled Glucometer Cleaning dated revised 03/02/2020 revealed it was the facility's policy to clean meters before and after each use. Each resident had their own glucometer to provide adequate control. The facility staff would make sure the meter was powered off and wet the glucometer with a sani-wipe until the meter was visibly wet for a full 2 minutes. Record review of facility policy entitled Using Gloves updated 02/21/2020 revealed: -1. Wash your hands following procedure before putting gloves on. -4. Dispose of the gloves by placing them into the trash. -5. Wash your hands thoroughly for a minimum of 20 seconds. Reminders for gloves: -6. Discard gloves after use, never wash or reuse disposable gloves. A. Record review of Resident 14's Nurse Administration Record (NAR) dated April 2026 identified Resident 14 required blood glucose monitoring at 8:00 AM for monitoring related to Type 2 Diabetes Mellitus (T2DM, a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). B. Record review of Resident 15's NAR dated April 2026 identified Resident 15 required blood glucose monitoring each morning for T2DM. Continuous observation on 04/30/2026 from 7:02 AM to 7:10 AM revealed Licensed Practical Nurse (LPN)-B exited room [ROOM NUMBER] wearing gloves on both hands and carrying insulin supplies and a glucometer. LPN-B placed the insulin supplies in the cart and discarded the previous glucometer test strip. Without doffing gloves, without the benefit of hand hygiene, and without cleaning the glucometer, LPN-B placed fingers into the cannister of test strips, placed a strip in the glucometer, and retrieved a lancet, alcohol pad, and cotton ball. LPN-B entered Resident 14's room, poked Resident 14's finger, and obtained a blood glucose sample. LPN-B exited the room, wrote on a piece of paper and discarded the used test strip and lancet. LPN-B did not remove gloves, perform hand hygiene, or clean the glucometer after use. With the previously used gloves, LPN-B retrieved a test strip from the cannister, retrieved an alcohol swab, cotton ball, and lancet, and entered Resident 15's room. LPN-B reported to Resident 15 that a new lancet needed to be obtained. LPN-B exited the room, doffed (removed) gloves, and without the benefit of hand hygiene, obtained a new lancet. LPN-B donned (applied) new gloves and performed the blood glucose check. LPN-B exited the room, disposed of supplies, doffed gloves, and wrote on a piece of paper. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/2026 at 7:17 AM with LPN-B confirmed the use of the same gloves between three different residents. LPN-B further confirmed the glucometer was not cleaned between uses and should have been, and hand hygiene was not performed when gloves were changed. Interview on 04/30/2026 at 12:23 PM with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) confirmed using the same gloves, not disinfecting the glucometer between uses, and the absence of hand hygiene presented the potential for cross-contamination. ADON/IP further confirmed gloves are single-use gloves and should be changed between residents. C. Record review of Resident 5's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 03-24-2026 revealed the facility staff assessed the following about the resident: -Had a diagnosis of End Stage Renal Disease (ESRD)-dialysis dependent, Type 2 Diabetes Mellitus, Atrial Fibrillation (A-Fib), Chronic Obstructive Pulmonary Disease (COPD) and Chronic Heart Failure. -Brief Interview of Mental Status (BIMS) was scored as a12. According to the MDS Manual a score of 12 indicates moderate cognitive impairment. -required set up and clean up assistance with eating. -required total assistance with hygiene, toileting, bathing, dressing, bed mobility, and transfers. -was receiving dialysis services. Record review of Resident 5's Comprehensive Care Plan (CCP) dated 05-13-2024 revealed Resident 5 was on Enhanced Barrier Precautions (EBP) due to having a dialysis catheter. The goal was Resident 5 would have reduced risk of infection and maintain the integrity of the dialysis catheter site through the review period. Interventions were for staff to use barrier precautions, such as disposable gowns when providing care. An observation conducted on 04-27-2026 at 1:30 PM revealed an EBP sign on the wall outside of Resident 5's room that stated, EBP everyone must: clean their hands, including before entering and when leaving the room. Further review of the sign revealed providers, and staff must also wear gloves and a gown for the following High-Contact Resident Care Activities: -dressing -bathing and showering -transferring -changing linens -providing hygiene -changing briefs or assisting with toileting -during wound care for any skin opening requiring a dressing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-during device or use, such as central lines, urinary catheters, feeding tubes and tracheostomy. An observation conducted on 04-30-2026 at 10:40 AM of Nursing Assistant (NA) F changing Resident 5's incontinence brief revealed no use of a gown during the brief change. An interview conducted on 04-30-2026 at 11:00 AM with NA F confirmed a gown should have been worn while changing Resident 5's brief and wasn't because I forgot.