

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Wisner Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 9th Street Wisner, NE 68791	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006. 11(E) Based on observation, record review, and interview; the facility failed to ensure the facility dishwasher was reaching temperatures to ensure adequate sanitation of dishes to prevent the potential for food borne illness. This had the potential to affect all facility residents. The facility census was 33. Findings are: Review of the undated facility policy General Sanitation of the Kitchen revealed the staff maintained the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule. Cleaning and sanitation tasks for the kitchen were recorded. Review of the undated facility policy Cleaning Dishes/Dish Machine revealed the dishes, and cookware would be washed and sanitized after each meal including checking the dish machine gauges throughout the cycle to assure proper temperatures. There was no indication as to what water temperatures were needed to ensure proper sanitation of the dishes. Review of the undated facility policy Dish Machine Temperature Log revealed the dishwashing staff would monitor and record dish machine temperatures to ensure proper sanitation of dishes. The Dietary Manager (DM) trained dishwashing staff to monitor dish machine temperature throughout the dishwashing process. In addition, the DM would spot check the dish machine log to assure proper temperatures. Review of an e-mail dated 6/6/26 at 4:00 PM revealed the solution specialist confirmed dishwasher temps for chemical sanitation systems was 120 degrees minimum in accordance with the food code. Review of the facility temp logs for June 2026 and July 2026 revealed temperatures were being checked and recorded 2-3 times daily and were not reaching 120 degrees consistently. In the month of June 2026 wash temperatures were recorded 85 times and only reached 120 degrees 18 times and the rinse temperatures only reached the required 120 degrees 68 times. The log indicated the dishwasher temperature range was 110 to 120 degrees (incorrect). Review of the facility temperature log for July 2026 revealed the wash and rinse temperatures were checked for the dishwasher 17 times and the wash temperature only reached the required 120 degrees 5 times and the rinse temperature only reached the required 120 degrees 9 times. During an interview on 6/7/26 at 3:10 PM the Certified Dietary Manager (CDM) confirmed being unsure what temperature the wash and rinse cycles were to be at and further confirmed, when the facility reached out to the Solution Specialist (personnel that checked the function of the facility dishwasher equipment and sanitation) for further clarification, it was confirmed wash and rinse temperatures needed to reach 120 degrees. In addition, the CDM had not ensured the staff responsible for dishwasher were educated on what temperatures the dish wash/rinse cycles needed to reach to ensure proper sanitation and the listed range of temperatures on the current dishwasher log of 110-120 degrees was incorrect.		

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E)Based on record review and interview; the facility failed to have informed consent and/or comprehensive informed consent for the use of psychotropic medications (any medications that affect behavior, mood, thoughts, or perception) in advance of administration that included the current dose and/or alternate treatment plan options for Residents 2, 14, 15, 31, and 32. The sample size was 5 and the facility census was 33. Findings are: A. Review of the facility policy Use of Psychotropic Medication(s) with a reviewed date of 8/25/25 revealed it was the policy of the facility to ensure residents only received psychotropic medications when other nonpharmacological interventions were clinically contraindicated. These medications were to be used only to treat the residents' medical symptoms and not used for discipline or staff convenience. The following compliance guidelines were identified: -psychotropic drugs include antipsychotics, antidepressants, hypnotics and antianxiety medications. -psychotropic medications are to be used only when a practitioner determined the medication(s) was appropriate to treat specific, diagnosed and documented conditions and the medication was beneficial to the resident as evidenced by monitoring and documentation of the resident's response to the medication(s). -the indications for initiating, maintaining, or discontinuation of medication(s), as well as the use of non-pharmacological approaches, was to be determined by evaluating the residents' physical, behavioral, mental and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks and the preferences and goals for treatment. -prior to initiation or increasing a psychotropic medication. The resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. -the facility was to document that the resident or the resident representative was informed in advance of the risks and benefits of the proposed care, and the treatment alternatives. -the facility was to document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deemed to use (written consent, narrative not etc.). B. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 6/18/26 revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, anemia, high blood pressure, osteoporosis, dementia, and depression. The following was assessed regarding the resident: -severe cognitive impairment. -staff assessment of the resident's mood revealed the resident had little interest or pleasure in doing things, was tired and/or had little energy, and the resident had trouble with concentrating. -behaviors which included resistance with cares, physical and verbal behaviors directed toward others and other behavioral symptoms not directed at others (hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, vocal/verbal symptoms such as screaming, or making disruptive sounds) -received antipsychotic and antianxiety medications. Review of a Psychotropic Medication Therapy Informed Consent Form dated 4/16/25 at 10:30 AM revealed the resident had an order for Ativan (medication used to treat anxiety) for diagnosis of anxiety. Further review revealed no evidence to indicate how often and at what dosage the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of a Psychotropic Medication Therapy Informed Consent Form dated 3/5/26 at 12:30 AM revealed the resident had an order for Seroquel (antipsychotic medication) for behavioral disorders associated with dementia. Further review revealed no evidence to indicate how often or at what dosage the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of the Resident 2's Medication Administration Record (MAR) dated 7/2026 revealed the resident continued to receive the following medications: -Seroquel 25 milligrams (mg) to be given three times a day for behavioral disorders with dementia. -Ativan 2 mg/milliliters (ml) 0.25 ml every 12 hours as needed for anxiety. During an interview with the Director of Nursing (DON) on 7/8/26 at 1:45 PM the DON confirmed the consents did not include documentation of non-pharmacological interventions attempted prior to initiation of medications and/or treatment alternatives, a list of symptoms the resident was displaying, and the potential effects or adverse effects of the medications. In addition, the consents did not address the dosage and/or how often the medications were to be administered. C. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 15's MDS dated [DATE] revealed the resident was cognitively intact; was independent with dressing, toileting, hygiene and bed mobility; diagnoses included Depression, Hypertension and Diabetes; the resident had behaviors that included rejection of care; the resident sometimes would socially isolate themselves; and the resident received antidepressant medications. Review of the facility form Monthly Pharmacy Regimen Review with the Consulting Pharmacist notes revealed in September of 2025 Resident 15 was started on Sertraline (an antidepressant medication) 25mg every day. Review of the facility facsimile (fax) regarding Resident 15 dated 3/24/26 revealed the residents Sertraline was increased to 50mg every day due to the resident refusing to leave the resident room and becoming fixated on several issues such as swelling, bowels and itching. Review of Resident 15's MAR for July 2026 revealed the resident received Sertraline 50mg every day with a start date of 3/24/26. Review of the Psychotropic Medication Therapy Informed Consent Form dated 10/30/25 at 9:00 AM revealed the resident had an order for Sertraline for the diagnosis of Depression. There was no evidence to indicate how often or what dose the resident was to receive, or that the facility had provided the resident or the resident representative with education as to the symptoms for which the resident was to receive the medication for, or the potential side effects and/or nonpharmacological interventions that had been or would be attempted. Interview on 7/7/26 at 3:15 PM with the MDS Coordinator and the DON confirmed consents did not include documentation of nonpharmacological interventions, alternative treatment options, the potential side effects of the medications or the dosage of the medication and how often the resident was to receive it. Further interview on 7/8/26 at 10:50 AM interview with the MDS Coordinator confirmed the facility did not obtain the consent prior to the administration of the medication and did not obtain a new consent when the medication was increased. D. Review of Resident 14's MDS dated [DATE] revealed the resident was admitted on [DATE] with a diagnosis of non-Alzheimer dementia, anxiety and depression. The following was assessed regarding the resident: -moderate cognitive impairment. -staff assessment of the resident's mood revealed the resident felt down and depressed. -behaviors which included hallucinations (belief that something was there but it was not), physical and verbal behaviors and rejection of cares. -received antidepressant medications. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Psychotropic Medication Therapy Informed Consent Form dated 5/14/26 at 2:00 PM revealed the resident had an order for Trazadone (medication used for depression), Divalproex Sodium (medication used to stabilize mood) and Duloxetine (medication used for depression) for diagnosis of major depressive disorder. Further review revealed no evidence to indicate how often and at what dosage the resident was to receive the medication, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of Resident 14's MAR dated 7/2026 revealed the resident continued to receive the following medications: -Trazadone 75mg at bedtime for insomnia. -Divalproex Sodium 250mg two times daily for major depressive disorder. -Duloxetine 30MG daily for major depressive disorder. E. Review of Resident 31's MDS dated [DATE] revealed the resident was admitted on [DATE] with a diagnosis of non-traumatic brain dysfunction, Alzheimer disease and anxiety. The following was assessed regarding the resident: -severe cognitive impairment. -inattention and disorganized thinking were continuously present. -staff assessment of the resident's mood revealed the resident had little interest or pleasure, felt tired or had little energy, had trouble concentrating and moved or spoke slowly. -behaviors which included delusions (a false belief that persists to be real), physical and verbal behaviors not directed at others and rejection of cares. -received antipsychotic, antianxiety and antidepressant medications. Review of a Psychotropic Medication Therapy Informed Consent Form dated 7/24/25 at 9:15 AM revealed the resident had an order for Olanzapine (antipsychotic medication) for a diagnosis of behavioral disorder associated with dementia, Sertraline (medication used to treat depression) for a diagnosis of generalized anxiety disorder, Lorazepam and Buspar (medications used to treat anxiety) for a diagnosis of anxiety disorder. Further review revealed no evidence to indicate how often and at what dosage the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of Resident 31's MAR dated 7/2026 revealed the resident continued to receive the following medications: (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Olanzapine 5mg daily for Alzheimer dementia with behavioral disturbance. -Sertraline 25mg daily for major depressive disorder. -Buspar 5mg two times daily for anxiety. -Lorazepam 0.5mg two times daily as needed for 6 months for anxiety. F. Review of Resident 32's MDS dated [DATE] revealed the resident was admitted [DATE]. Resident had a diagnosis of Alzheimer's disease. The following was assessed regarding the resident: -severe cognitive impairment. -inattention and disorganized thinking fluctuated. -staff assessment of the resident's mood revealed the resident had little interest or pleasure, felt tired or had little energy and had trouble concentrating. -behaviors which included delusions, physical and verbal behaviors. -received antipsychotic and antidepressant medications. Review of a Psychotropic Medication Therapy Informed Consent Form dated 8/7/25 at 9:00 AM revealed the resident had an order for Duloxetine (medication used for depression) for mood disorder and Olanzapine (antipsychotic medication) for diagnosis of major depressive disorder. Further review revealed no evidence to indicate how often and at what dosage the resident was to receive the medication, or that the facility had provided the representative with education as to the symptoms the resident was displaying, the potential effects or adverse effects and/or nonpharmacological interventions attempted. Review of Resident 32's MAR dated 7/2026 revealed the resident continued to receive the following medications: -Duloxetine 60mg daily for mood disorder. -Olanzapine 7.5mg at bedtime for agitation. During an interview with Registered Nurse (RN)-N on 7/7/26 at 3:30 PM confirmed the consents did not include the dosage or how often the medications were to be administered, documentation of non-pharmacological interventions attempted prior to initiation of medications and/or treatment alternatives, a list of symptoms the resident was displaying, and the potential effects or adverse effects of the medications.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview; the facility failed to report a hot liquid spill with injury as potential abuse/neglect for Resident 32. The sample size was 1 and the facility census was 33.Findings are:A.Review of the facility policy Abuse, Neglect, or Misappropriation of Property with a review date of 1/2026 revealed the facility supported a zero-tolerance policy for any type of crime committed against a resident, resident abuse, willful resident neglect, misappropriation of resident property, or exploitation. In addition, the policy contained the following: -An injury would be classified as an injury of unknown source when both of the following conditions were met: a. The source of the injury was not observed by any persons, or the source of the injury could not be explained by the resident. b. The injury was suspicious because of the extent of the injury. the location of the injury or number of injuries observed at one particular point in time.-Suspicion and/or knowledge of abuse would be immediately reported to a charge nurse or department supervisor. -The facility Administrator or Director of Nursing investigated through interviews (staff, residents, family, visitors and/or others), and record review.-Adult Protective Services (APS) was notified and within 5 working days from the alleged or potential abuse the facility submitted a complete report to Health Facility Investigations at the State Agency. B.Review of Resident 32's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 4/2/26 revealed the resident had a diagnosis of alzheimer disease, severe cognitive impairment and required partial assist with eating. Review of Resident 32's High Risk for Hot Spills assessment dated [DATE] revealed that resident was at risk for hot spills. Review of Resident 32's nursing documentation revealed that on 1/13/26 at 6:56 AM the physician was notified regarding resident's blisters and requested if any new orders to please specify. Review of facility fax dated 1/13/26 at 3:00 AM revealed the resident had several fluid filled blisters on both the right and left inner thighs. Review of facility reported investigations completed 3/4/25 to 7/7/26 revealed no evidence that the facility completed an investigation for Resident 32's hot liquid spill that was the cause of fluid filled blisters to right and left inner thigh. An interview with the Director of Nursing on 7/8/26 at 10:00 AM confirmed that Resident 32 did have a hot liquid spill that caused fluid filled areas to the right and left inner thighs. The facility did not report Resident 32's hot liquid spill to APS and should have.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview; the facility failed to investigate a hot liquid spill with injury for Resident 32 and to send the results of the investigation to as required to the State Agency. The sample size was 1 and the facility census was 33.Findings are:A.Review of the facility policy Abuse, Neglect, or Misappropriation of Property with a review date of 1/2026 revealed the facility supported a zero-tolerance policy for any type of crime committed against a resident, resident abuse, willful resident neglect, misappropriation of resident property, or exploitation. In addition, the policy contained the following: -An injury would be classified as an injury of unknown source when both of the following conditions were met: a. The source of the injury was not observed by any persons, or the source of the injury could not be explained by the resident. b. The injury was suspicious because of the extent of the injury. the location of the injury or number of injuries observed at one particular point in time.-Suspicion and/or knowledge of abuse would be immediately reported to a charge nurse or department supervisor. -The facility Administrator or Director of Nursing investigated through interviews (staff, residents, family, visitors and/or others), and record review.-Adult Protective Services (APS) was notified and within 5 working days from the alleged or potential abuse the facility submitted a complete report to Health Facility Investigations at the State Agency. B.Review of Resident 32's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 4/2/26 revealed the resident had a diagnosis of alzheimer disease, severe cognitive impairment and required partial assist with eating. Review of Resident 32's High Risk for Hot Spills assessment dated [DATE] revealed that the resident was at risk for hot spills. Approaches included a vinyl clothing protector; meal card was marked to alert staff that the resident was at risk for hot spills and hot liquid cups filled half full. Review of Resident 32's High Risk for Hot Spills assessment dated [DATE] revealed that the resident was at risk for hot spills. Approaches included a vinyl clothing protector; meal card was marked to alert staff that the resident was at risk for hot spills and hot liquid cups filled half full. No new approaches after hot liquid spill on 1/13/26. Review of Resident 32's nursing documentation revealed that on 1/13/26 at 6:56 AM the physician was notified regarding resident's blisters and requested if any new orders to please specify. Review of facility fax dated 1/13/26 at 3:00 AM revealed the resident had several fluid filled blisters on both the right and left inner thighs. Review of facility reported investigations completed 3/4/25 to 7/7/26 revealed no evidence that the facility completed an investigation for Resident 32's hot liquid spill that was the cause of fluid filled blisters to right and left inner thigh. An interview with the Director of Nursing on 7/8/26 at 10:00 AM confirmed that Resident 32 did have a hot liquid spill that caused fluid filled areas to the right and left inner thighs. The facility did not investigate or report Resident 32's hot liquid spill to APS.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(i)3 Based on observations, record review and interviews; the facility failed to provide assistance with toileting and incontinence cares for 1 (Resident 7) of 1 sampled resident who required assistance with all activities of daily living. The facility census was 33. Findings are: A. Review of Resident 7's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 6/8/26 revealed the resident was admitted [DATE] with diagnoses of anemia, coronary artery disease, Non-Alzheimer's dementia, Parkinson's disease, depression and post-traumatic- stress-disorder. The assessment identified the resident's cognition was severely impaired, the resident required substantial to maximal staff assistance with eating/drinking and was fully dependent on staff to assist with toileting hygiene, dressing, personal hygiene, and transfers. In addition, the resident was frequently incontinent of bowel and bladder. Review of Resident 7's current Care Plan (undated) revealed the resident had a self-care deficit related to advanced dementia and Parkinson's disease. In addition, the resident had a diagnosis of overactive bladder and benign prostatic hyperplasia (BPH-enlarged prostate) The resident was incontinent of bowel and bladder and utilized an incontinent product for dignity. The care plan identified an intervention to assist the resident with toileting in the morning, before and after each meal, at bedtime and as needed. Review of a Bowel and Bladder Assessment documented in the Progress Notes and dated 6/18/26 at 10:44 AM revealed the resident was frequently incontinent of bowel and bladder due to later stages of dementia, pervious stroke and Parkinson's disease. The resident required assist with toileting hygiene. Observations of Resident 7 on 7/7/26 revealed the following:-7:04 AM the resident was awake and alert and was seated in the tilt-n-space wheelchair (chair which provides alternatives in positioning with tilting or reclining of chair) next to the Bird Aviary.-7:30 AM the resident remained in the wheelchair next to the bird aviary.-7:58 AM the resident was assisted into the dining room and was positioned at a dining table.-8:28 AM the resident was served breakfast.-9:03 AM the resident remained in the dining room.-9:25 AM the resident remained in the wheelchair but was now positioned next to the bird aviary. -10:00 AM the resident remained next to the bird aviary and would shift weight from side to side in the chair and attempted to lean forward when staff/another resident walked by. A feces odor was observed from the area around the resident.-10:45 AM Nurse Aide (NA)-I and NA-L assisted the resident to the resident's room per the wheelchair. The resident continued to have a feces odor and the resident's slacks had a brown stain to the groin area. The resident was secured in the sit-to-stand lift (mechanical lift that allows for transfers from a seated position to a standing position) and was stood. While the resident was standing, NA-I and NA-L lowered the resident's slacks and disposable urinary incontinence brief and found both were heavily soiled with urine and feces. Interview with NA-I and NA-L on 7/7/26 at 11:38 AM revealed the resident had not been toileted or checked for incontinence since the resident was assisted out of bed at 6:30 AM (3 hours and 45 minutes prior). Staff reported the resident was normally provided toileting and/or incontinence cares first thing in the morning, before and immediately after meals and before going to bed at night. During an interview on 7/8/26 at 11:51 AM, the Director of Nursing (DON) confirmed the resident should be toileted every 2 hours to prevent potential attempts to self-transfer and to decrease the resident's risk for falls.		

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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 12-006.09Based on record review and interview; the facility failed to have documented evidence of any education provided to Resident 15 related to ongoing refusal of insulin and to keep the physician updated regarding this refusal. The sample size was 5 and the facility census was 33.Findings are:Review of the facility policy Medication Administration with a review date of 12/16/24 revealed the facility administered medications using authorized healthcare personnel. Medication orders included the name of the medication, right amount/dose, right route, right time, and right documentation and right response. If a dose of regularly scheduled medication was withheld, refused or sent along for an outing, the person providing the medication documented accordingly.Review of Resident 15's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 4/9/26 revealed the resident was cognitively intact; was independent with dressing, toileting, hygiene and bed mobility; diagnoses included Depression, Hypertension and Diabetes; and the resident received hypoglycemic (medications used to manage blood sugar) medication and insulin.Review of Resident 15's Care Plan, last revised 7/2/26 revealed the resident was independent with grooming, dressing, toileting, and ambulation; nurses were to administer medications, observe for effectiveness, and side effects, document administration on the Medication Administration Record (MAR) and explain procedures; and the resident was at risk for fluctuating blood sugars related to the Diabetes diagnosis, the resident received had orders for long and short-acting insulin. There was no documentation on the Care Plan about the resident refusing insulin or interventions for when the resident refused insulin.Review of Resident 15's MAR's for June 22nd-July 7th 2026 revealed the resident had orders for Humalog (short-acting insulin) scheduled with meals at 8:00 AM, 12:00 PM and 6:00 PM and Lantus (long-acting insulin) scheduled at 7:00 AM. The resident received 14 out of 15 doses of the Lantus insulin and received 12 out of 44 doses of Humalog insulin.Review of the Progress Notes for Resident 15 revealed the following entries:-on 6/22/26 at 7:27 AM the resident declined to receive the Humalog insulin due to blood sugar result of 73,-on 6/23/26 at 8:05 AM the Humalog was held due to blood sugar of 70; and at 1:47 PM the resident refused their Humalog insulin, there was no reason documented,-on 6/24/26 at 9:29 AM and 5:05 PM the resident refused their Humalog insulin doses, there was no reason documented,-on 6/25/26 at 9:42 AM The resident refused their Humalog insulin, there was no reason documented,-on 6/26/26 at 7:32 AM the Humalog was held due to a blood sugar of 73; at 2:33 PM the resident refused their Humalog insulin due to low blood sugar at 7:30 AM; and at 5:53 PM the resident refused the Humalog insulin, there was no reason documented,-on 6/27/26 at 9:12 AM and at 5:50 PM the resident refused their Humalog insulin doses, there were no reasons documented,-on 6/28/26 at 9:07 AM the resident refused their Humalog insulin, there was no reason documented,-on 6/29/26 at 7:47 AM the resident's insulin was held for a blood sugar of 71, and at 2:13 PM the resident refused their Humalog insulin due to having low blood sugar at 9:07 AM,-on 6/30/26 at 10:30 AM the resident refused their Humalog insulin; and at 12:32 PM the resident refused their Humalog insulin stating that their blood sugars run low all the time, the resident doesn't need insulin;-on 7/1/26 at 7:18 AM and at 4:58 PM the resident refused their Humalog insulin, there were no reasons documented,-on 7/2/26 at 8:03 AM, 12:27 PM, and 6:07 PM the resident refused their Humalog insulin doses, there were no reasons documented,-on 7/3/26 at 9:07 AM and at 5:23 PM the resident refused their Humalog doses, there were no reasons documented,-on 7/4/26 at 7:33 AM, 11:57 AM, and 4:57 PM the resident refused their Humalog doses, there were no reasons documented,-on 7/5/26 at 7:29 AM the resident refused the Humalog due to blood sugar reading of 97, and refused at 11:48 AM with no reason documented,-on 7/6/26 at 7:35 AM, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Wisner Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 9th Street Wisner, NE 68791	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:27 AM, and 5:17 PM the resident refused their Humalog insulin doses with no reasons documented, and-on 7/7/26 at 6:50 AM and 11:50 AM the resident refused their Humalog insulin doses with no reasons documented. Further review of the Progress Notes revealed there was no evidence that the resident was provided education and their response related to refusing the Humalog insulin and there was no evidence the residents Physician had been updated when the residents Humalog insulin was held or when the resident refused their Humalog insulin. Interview with the MDS Coordinator on 7/8/26 at 10:55 AM revealed the facility did not have a policy for administering insulin or when to notify the Physician when a resident refuses. Further interview confirmed the facility did not have documentation that the resident was educated about refusing insulin. Interview on 7/8/26 at 11:45 AM with the Administrator and the Director of Nursing confirmed the Physician had not been updated on the resident refusing their insulin routinely and further interview confirmed the facility did not have evidence that the resident was educated about refusing their insulin.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l)(i)Based on observations, record review and interview; the facility failed to implement fall prevention interventions for Resident 7 who had been assessed at high risk for falls. The sample size was 3 and the facility census was 33.Findings are:A. Review of the Resident Fall Policy and Procedure dated 3/30/24 revealed it was the policy of the facility to document all falls and to develop/ implement immediate interventions in an attempt to prevent a re-occurrence. B. Review of Resident 7 's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 6/18/26 revealed the resident was admitted [DATE] with diagnoses of anemia, coronary artery disease, diabetes, Non-Alzheimer's dementia, Parkinson's, depression, and post-traumatic-stress-disorder. The following was assessed regarding the resident:-severe cognitive impairment.-required substantial to maximal assistance with bed mobility, transfers, dressing, toilet use and personal hygiene.-frequently incontinent of bowel and bladder.-a chair alarm was used on a daily basis. Review of the resident's undated, current care plan revealed the resident was at risk for falls related to diagnosis of Parkinson's disease and diabetic neuropathy to bilateral feet. Fall prevention interventions included the following:-use fall risk screen to identify risk factors.-11/13/25 ensure pull alarm (alarm with a pull string that attaches magnetically to the alarm with a garment clip to the resident. When the resident attempts to rise out of the chair or bed the pull string magnet is pulled away from the alarm which causes the alarm to sound, alerting the care giver) was in place and function each shift to the recliner.-11/19/25 video monitor placed in the resident's room to monitor the resident for self-transfer attempts.-11/24/25 Dicem (a non-slip, rubber-like plastic material used to stabilize surfaces) to the seat of the wheelchair at all times.-assist the resident with toileting in the morning, before and after each meal, at bedtime and as needed to minimize attempts to self-transfer. -keep the resident in the lobby recliner before/after meals for increased supervision. Review of Incident Reports for Resident 7 revealed the following:-11/11/25 at 6:00 PM the resident was found on the floor in the commons area. A new intervention was identified for use of a pull alarm to the resident's wheelchair.-11/13/25 at 3:15 PM the resident was found on the floor of the resident's room. The resident had been seated in a recliner prior to the fall. A new intervention was developed for a pull alarm to the resident's recliner at all times.-11/21/25 at 5:15 PM the resident was on the floor in the dining room. The resident had been seated in a wheelchair prior to falling. A new intervention was identified to place a dicem non-stick pad to the seat of the resident's wheelchair. Review of a Fall Risk assessment dated [DATE] at 10:38 AM revealed the resident remained at high risk for falls.During observations of Resident 7 on 7/7/26 the following was identified:-7:04 AM the resident was awake and alert and was seated in the tilt-n-space wheelchair (chair which provides alternatives in positioning with tilting or reclining of chair) next to the Bird Aviary.-7:30 AM the resident remained in the wheelchair next to the bird aviary.-7:58 AM the resident was assisted into the dining room and was positioned at a dining table.-8:28 AM the resident was served breakfast.-9:03 AM the resident remained in the dining room.-9:25 AM the resident remained in the wheelchair but was now positioned next to the bird aviary.-10:00 AM the resident remained next to the bird aviary and would shift weight from side to side in the chair and attempted to lean forward when staff/another resident walked by. A feces odor was observed from the area around the resident.-10:45 AM Nurse Aide (NA)-I and NA-L assisted the resident to the resident's room per the wheelchair. The resident continued to have a feces odor and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Wisner Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 9th Street Wisner, NE 68791	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's slacks had a brown stain to the groin area. The resident was secured in the sit-to-stand lift (mechanical lift that allows for transfers from a seated position to a standing position) and was stood. While the resident was standing, NA-I and NA-L lowered the resident's slacks and disposable urinary incontinence brief and found both were heavily soiled with urine and feces. Further observation of the resident's wheelchair revealed no evidence a non-slip dicem pad had been placed on the seat of the resident's wheelchair to prevent the resident from sliding out of the chair. -11:19 AM to 12:15 PM the resident was seated in a recliner next to the Nurse's Station. The pull alarm was positioned on a table next to the resident, however the staff failed to place the alarm on the resident and/or on the recliner before walking away from the resident. -1:32 PM to 3:30 PM the resident was seated in the recliner in the front commons area across from the Nurse's Station. No pull alarm was observed to the resident or to the recliner. During an interview on 7/8/26 at 11:51 AM, the Director of Nursing (DON) confirmed the resident has been assessed at high risk for falls and had 3 falls over the last 7 months. The DON further confirmed the resident was to have a pull alarm to the recliner at all times, a dicem non-skid pad to the seat of the wheelchair, was to be toileted according to schedule to prevent self-transfer attempts and was to have been placed in the recliner immediately after meals until the right before the next meal to maintain visual supervision of the resident.		