STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Kenesaw	100 West Elm Avenue Kenesaw, NE 68956

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Licensure Reference Number 175 NAC 12-006.05(S)Based on record review, observation, and interview the facility failed to promote resident dignity by ensuring that resident body parts were not exposed to public view for 1 resident (Resident 7) and not knocking and announcing entry to residents' room for 1 resident (Resident 5). The facility census was 66.Findings are:Record review of a document titled Residents' Rights of a Long-Term Care Facility and not dated the resident has the right to confidentiality and privacy during treatment and care and to be treated with consideration, respect, and dignity.A.Record review of a document titled admission Record revealed the facility admitted Resident 7 on 08/13/2021 with diagnosis of Type 2 Diabetes (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia {high blood sugar} resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production), and Spinal Stenosis (a narrowing of spaces in the spine causing pressure on the spinal cord and nerves).The 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) dated 02/12/2026 revealed Resident 7 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15 indicating the resident was cognitively intact. The MDS was coded to reflect the resident required substantial or maximal assistance with upper body dressing and utilized a wheelchair for mobility throughout the facility.In an observation completed on 02/17/2025 from 12:30 PM through 12:45 PM Resident 7 was observed to be sitting in the main dining area of the facility. The resident was observed to be sitting in their wheelchair in a sideways position so that the right side of the residents' body was closest to the edge of the table and left side of the body was away from the table. The resident's gray sweatshirt was observed to be pulled up exposing the resident's abdomen to public view. This observation occurred at mealtime and there were other residents sitting at their tables facing this resident and eating their meals. Staff were present in the dining area and walking around serving meals and passing drinks to residents. At 12:45 PM Resident 7 indicated to a staff member that they wanted to return to their room. The staff member removed the resident from the table and pushed the resident in their wheelchair down the hallway to their room. The staff member did not attempt to pull down the residents' shirt or other intervention to cover the resident's abdomen exposed body part.In an interview conducted on 02/17/2026 at 12:45 PM with Nurse Aide G (NA-G), NA-G confirmed that residents body parts should not be exposed to public view and this was a dignity issue for the resident. In an interview conducted on 02/17/2026 at 12:50 PM with Resident 7, Resident 7 confirmed that their abdomen was exposed in the dining room and while they were being assisted in their wheelchair down the hall to their room. The resident confirmed that they cannot pull their shirt down to cover their abdomen and need assistance with ensuring that their shirt is pulled down and their abdomen is not exposed.In an interview conducted on 02/17/2026 at 4:45 (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM with the facility Director of Nursing (DON), the DON confirmed that residents body parts should not be exposed for public view and this was a dignity issue for the resident. B.Record review of a facility document titled Basic Nursing Skills the Beginning 4 are dated 1995 from the Nebraska Health Care Association Basic Nursing Assistant Training Manual revealed the first of the beginning 4 is to knock prior to entering the room and request permission to enter the room.Record review of a admission Record revealed that the facility admitted Resident 5 on 09/22/2025 with diagnosis of schizoaffective disorder (a chronic mental health condition combining symptoms of hallucinations, delusions, disorganized speech with major mood disorder such as depression or mania) and morbid obesity (a chronic disease defined by a body mass index of 40 or higher typically representing 100 pounds or greater over ideal weight).The 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) dated 12/04/2025 revealed Resident 5 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15, indicating the resident was cognitively intact. The MDS was coded to reflect the required set up or clean up assistance with eating, partial to moderate assistance with bed mobility, and substantial or maximal assistance with transfers and toilet use.In an observation completed on 02/17/2026 at 11:30 AM Medication Aide A (MA-A) was entering Resident 7 room to administer their medications. The residents' door to their room was cracked open and the MA just pushed the door open and entered the room. Other staff were in the room providing personal care for the residents' roommate and the roommates' legs and lower half of their body was exposed when opening the door and entering the room. While the MA was assisting the resident with their medications a laundry staff member opened the door to the room and entered the room to place linen items in the resident's closet. The resident's roommate continued to receive cares and lower half of their body was exposed when the laundry staff member opened the door.In an interview completed on 02/17/2026 at 12:15 PM with Resident 5, Resident 5 states not sure if staff always knock prior to entering their room stated will wake up sometimes and staff will be in the room and will tell what they are there doing but does not recall them always knocking.In an interview completed on 02/17/2026 at 11:36 AM with MA-A, MA-A confirmed that they should always knock and announce themselves when entering a resident's room. The MA confirmed that they did not do this when entering Resident 5's room to administer their medications.In an interview completed on 02/17/2026 at 4:45 PM with the facility DON, the DON confirmed that staff should knock on the resident's door prior to entering the residents room.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(H)Based on record reviews and interviews, the facility failed to ensure that a resident was free from physical abuse for 1 resident (Resident 3). The facility census was 66. Findings are: A record review of a facility policy titled, Vulnerable Adult updated on 12/30/2025 revealed its purpose as a facility is to support a zero tolerance for resident abuse, neglect, mistreatment, and/or misappropriation of resident property.The policy identifies a vulnerable adult as every adult residing in the facility.The policy identifies neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.Resident to resident altercations; including physical, mental, or verbal abuse are reportable to the state agency. The facility should have systems in place to identify residents whose personal history render them at risk for abusing other residents.Adverse Event: An adverse event is an untoward, undesirable and usually unanticipated event that causes death or serious injury. Prevention: Employees will identify, intervene and correct situations in which abuse, neglect, mistreatment and/or misappropriation of resident property may occur. This includes assessment of the resident's environment, adequate staffing to meet resident needs and supervision of staff to identify inappropriate behaviors.Residents will be continually assessed, care planned and monitored in order to identify needs and behaviors which might lead to conflict or neglect.The facility will evaluate the individual's susceptibility of abuse and also evaluate the individual's risk of abusing other vulnerable adults. The plan will also include the measures to be taken to protect that individual from abuse and to minimize the risk of abuse to other vulnerable adults. A record review of Resident 3's progress notes dated 11/01/2025 revealed Resident 3 was observed wandering in and out of other resident rooms. Another resident alerted staff that Resident 3 would not leave their room resulting in Resident 3 being pushed out of their room, landing on the floor face down sustaining a hematoma above the left eye. A record review of Resident 3's Care Plan dated 2/9/2026 revealed interventions to place Resident 3 on 15-minute checks starting on 11/1/2025 ending on 11/3/2025. Additional interventions dated 11/3/2025 revealed to provide calming environment through playing resident's music, hand massage and 1:1 time. A record review of Resident 3's progress notes dated 11/09/2025 through 12/15/2025 revealed:11/9/2025: Resident 3 wandering into other resident rooms, redirected and going back into other resident rooms.12/7/2025: Resident 3 wandering into other resident rooms, touching residents on the chest and head.12/9/2025: Resident 3 wandering into other resident rooms, being invasive. Interventions used, snacks, toileting, 1:1, music therapy, PRN psychotropic medication.12/12/2025: Resident 3 wandering into other resident rooms, Resident 3 agitated and physically aggressive towards staff. A record review of Resident 3's progress notes dated 12/16/2025 revealed Resident 3 was found by staff after being instructed to check on residents screaming for help in a room on 400 hall. The staff member removed Resident 3 from another resident's room revealing the resident residing in the room stating, Resident 3 hit and choked them while sitting in their wheelchair. The resident was directed by staff to and an activity area with no visible injuries. A record review of Resident 3's Care Plan dated 2/9/2026 revealing interventions to the assault on 12/16/2025 to place Resident 3 on checks, 32x's a shift for 72 hours discontinue when resident was placed on 1:1 checks. A record review of Resident 3's progress notes dated 12/18/2025 revealed Resident 3 was in the activity room watching a movie when Resident 3 walked over and hit another resident on the top of the head. Staff member moved Resident 3 to check on the resident assaulted, when Resident 3 pursued another resident, hitting them in the face. Resident 3 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was assigned a 1:1 staff member. A record review of Resident 3's Care Plan dated 2/9/2026 revealed interventions for the assault on 12/18/2025 revealed the facility attempted to refer Resident 3 to another facility. Resident 3 then placed on 1:1 checks until discharge to a Mental Health inpatient facility. A record review of Resident 3's census list revealed Resident 3 went to the hospital from [DATE] and returned on 12/29/2025. An interview with Facility Administrator (FA) on 2/17/2026 at 3:45 PM revealed not recalling about specific interventions or incidents regarding Resident 3, needing to confer with the Minimum Data Set Coordinator (MDSC; a person who completes a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems). An interview with MDSC on 2/17/2026 at 4:10 PM revealed that Resident 3 wandered throughout the facility and at times 1:1 did occur, but not always. Temporary interventions listed for incidents occurring with Resident 3, revealed redirection, music, food, medications, closing some resident room doors, referrals to other facilities and inpatient psychiatric, however no long-term interventions were initiated. MDSC revealed, Resident 3 needed continuous 1:1 and the facility's inability to provide that type of care was evident only after Resident 3 was admitted to the facility. MDSC further revealed long-term interventions such as continuous 1:1's were not implemented for keeping Resident 3 and others safe from the related adverse behaviors.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)Licensure Reference Number 175 NAC 12-006.09(I)(i)(1)Licensure Reference Number 175 NAC 12-006.09(I)(i)(3)Based on observation, record review, and interview the facility failed to ensure that residents were protected from injury for 1 of 5 residents (Resident 1); failed to ensure that interventions to prevent falls were implemented for 1 of 5 residents (Resident 2); and failed to develop fall prevention interventions related to causal factors for 1 of 5 residents (Resident 6). The facility census was 66.Findings are:A. Interview on 2/17/26 at 3:37 PM with the facility Minimum Data Set Coordinator (MDSC) (a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) revealed that the facility does not currently have a policy and procedure for fall prevention and falls. The MDSC confirmed that the facility follows professional standards, Centers for Medicare and Medicaid Services regulations, and state regulations for fall prevention and falls. Record review of the facility policy titled Comprehensive Care Plans dated 12/3/25 revealed that it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs. The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will describe the resident specific interventions that reflect the resident's needs and preferences. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 1 dated 2/5/26 revealed that Resident 1 admitted into the facility on 1/18/22. The MDS revealed that Resident 1 had 1 fall with major injury since the previous MDS assessment dated [DATE]. Record review of the current care plan for Resident 1 dated 2/17/26 revealed that Resident 1 is a high risk for falls related to confusion, lack of safety awareness, history of falls with injuries, and dementia revised on 7/15/25. Fall prevention interventions included: -Anticipate and meet the resident's needs- dated 6/23/25. - Take the resident to the nurse's station and the nurse will sit with the resident for safety during busy times of nurse aides where they cannot watch as closely- dated 11/6/24. - Reiterate with staff to be in visualization and within distance to intervene when Resident 1 is attempting to self-transfer- dated 11/6/24. - The resident is to sit at the assisted table for all meals for close observation- dated 4/14/25. - Resident is to sit in the commons area when not in bed and not be left unattended while in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair- dated 11/6/24. - Resident's chair is to be reclined unless staff is sitting with the resident- dated 4/14/25. Observation on 2/17/26 at 9:55 AM in the facility west dining room revealed that Resident 1 was seated in a Broda wheelchair (a specialized, highly adjustable medical wheelchair providing the ability to tilt and recline patients for safety, advanced comfort, and support). The wheelchair was tilted back 45 degrees per visual measurement. Resident 1 had their knees bent and legs pulled up towards the resident's chest. No staff were next to or in close proximity to monitor Resident 1 while they were in their reclined wheelchair in the west dining room. Record review of the facility Incidents By Incident Type report dated 2/17/26 revealed that Resident 1 had a witnessed fall on 2/5/26 at 1:00 PM. Record review of the progress note for Resident 1 dated 2/5/26 at 3:10 PM revealed that a change in condition notification was initiated. Record review of the Change in Condition assessment for Resident 1 dated 2/5/26 at 3:10 PM revealed that this nurse (author of the progress note) was called to the dining room due to the resident falling out of their chair. The fall was witnessed by a nurse aide and a nurse. They stated that the resident leaned forward in the wheelchair and tumbled forward landing on their head. When this nurse arrived, Resident 1 was on their side next to the wheelchair. Resident 1 had blood in their hair and a 3 centimeter laceration on the front of the head. Resident 1 was sent to the hospital for a Computerized Tomography (CT) scan (a computerized x-ray imaging procedure) of the head and neck. Record review of the progress note for Resident 1 dated 2/5/26 at 11:50 PM revealed that the nurse called the hospital emergency room for an update on Resident 1. The hospital house supervisor revealed that Resident 1 was transferred to another hospital and admitted into the Intensive Care Unit for a subdural hematoma (a dangerous, often life-threatening condition where blood collects between the skull and the surface of the brain that is typically caused by a head injury). Record review of the progress note for Resident 1 dated 2/9/26 at 12:59 PM revealed that Resident 1 re-admitted into the facility from the hospital. Observation on 2/17/26 at 11:37 AM in the resident room revealed that Nurse Aide-C (NA-C) used a brush to comb the hair of Resident 1. A dark red/black scar approximately 2.5 centimeters in length was on the upper forehead just above the hairline. NA-C stated that Resident 1 had staples there that are now removed. NA-C transferred Resident 1 from the resident room into the west dining room. Interview on 2/17/26 at 1:05 PM with Nurse Aide-B (NA-B) revealed that NA-B had observed Resident 1 fall in the dining room on 2/5/26. NA-B revealed that the wheelchair was not tilted back and the resident fell forward from the chair and cut their head. NA-B confirmed that the wheelchair of Resident 1 is to be tilted back. Interview on 2/17/26 at 3:37 PM with the facility Minimum Data Set Coordinator (MDSC) confirmed that a fall intervention to have Resident 1's wheelchair tilted back to prevent falls was in place prior to Resident 1's fall on 2/5/26. The MDSC confirmed that staff failed to follow the intervention and that Resident 1 fell in the dining room and suffered an injury requiring hospitalization. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	B. Record review of the facility policy titled Risk Management dated 9/27/24 revealed that all accidents/incidents involving residents will be reported, investigated, and reviewed to ensure residents receive the highest quality of care. The nurse identifying an incident will be responsible for completing the incident report in the Risk Management module of the electronic health record. Incidents include witnessed or unwitnessed falls. Triggered assessments will be completed. Interview on 2/17/26 at 3:37 PM with the facility Minimum Data Set Coordinator (MDSC) (a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning) revealed that the facility does not currently have a policy and procedure for resident lifts and transfers or for fall prevention and falls. The MDSC confirmed that the facility follows professional standards, Centers for Medicare and Medicaid Services regulations, and state regulations for resident transfers and fall prevention and falls. The MDSC confirmed that when a resident has a fall the facility always does the incident report in the risk management module of the electronic health record. The MDSC confirmed that a fall risk assessment, post fall data collection, and change of condition assessment are always completed for a resident fall to gather data to assist with updating fall prevention interventions. Record review of the facility policy titled Comprehensive Care Plans dated 12/3/25 revealed that it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs. The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will describe the resident specific interventions that reflect the resident's needs and preferences. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 2 dated 2/2/26 revealed that Resident 2 admitted into the facility on 1/28/26. The MDS revealed that Resident 2 was dependent on staff for chair to bed transfers, toilet transfers, and tub/shower transfers. Resident 2 had a diagnosis of hemiplegia or hemiparesis (one-sided body weakness that can affect the arm, leg, or face). Resident 2 had a major orthopedic surgery prior to admission into the facility. Record review of the admission Record dated 2/17/26 for Resident 2 revealed a diagnosis of acquired absence of the left leg below the knee (a below the knee amputation of the left lower leg). Record review of the current care plan for Resident 2 dated 2/17/26 revealed that Resident 2 had a self-care performance deficit related to weakness and below the knee amputation of the left leg. Interventions included that Resident 2 was totally dependent on 2 staff for transferring dated 2/5/26. Resident 2 requires Mechanical Hoyer Lift (a mechanical total body lift- a mechanical assistive device used to transfer a resident with difficulty standing up on their own) with 2 staff assistance for transfers dated 2/5/26. Observation on 2/17/26 at 12:58 PM in the room of Resident 2 revealed a laminated sign on the wall above the bed Resident is a FULL Hoyer lift 2A (assist) for all transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility Incidents By Incident Type report dated 2/17/26 revealed that Resident 2 had a witnessed fall on 2/5/26 at 11:45 AM. Record review of the progress note for Resident 2 dated 2/5/26 at 4:06 PM revealed that it was a fall note. All nursing staff were provided written education that Resident 2 is a 2 staff assist with the Hoyer lift for all transfers. Record review of the hospital emergency room report dated 2/5/26 for Resident 2 revealed that Resident 2 presented to the emergency room for a fall. Resident 2 was being transferred at the facility when they reportedly dropped the resident and the resident got stuck between the shower chair and the wall injuring their right chest. The report revealed that no rib fracture or pneumothorax (an abnormal collection of air in the space between the lung and the chest wall often caused by trauma to the chest) were seen on imaging (X-ray). Record review of the progress note for Resident 2 dated 2/5/26 at 6:10 PM revealed that a nurse from the hospital called and stated that Resident 2 will be discharged from the emergency room and returned to the facility. The hospital nurse revealed that Resident 2 is complaining of right rib pain and has a lidocaine patch (a topical medicated patch for pain relief) to the right rib area. Resident 2 arrived back at the facility at 7:25 PM per ambulance. Interview on 2/17/26 at 1:08 PM with Registered Nurse-E (RN-E) revealed that Resident 2 is currently in the hospital for a procedure to debride the infected left stump (the remaining area on the leg where the lower leg was removed from). RN-E confirmed that RN-E was the charge nurse on 2/5/26 when Resident 2 fell. RN-E confirmed that Resident 2 fell during transfer by 2 nurse aides without the use of a lift. RN-E revealed that it was a teachable moment on the transfer status of the resident to the staff. Interview on 2/17/26 at 1:55 PM with Nurse Aide-B (NA-B) confirmed that NA-B was transferring Resident 2 with another nurse aide on 2/5/26. NA-B confirmed that they were not using the Hoyer lift to transfer Resident 2 as required. NA-B confirmed that they were doing a pivot transfer (an assisted movement technique where the resident stands and bears weight on at least one leg and pivots (spins) their body to sit on the new surface) with Resident 2. (Resident 2 was not being transferred per the care plan intervention of 2 person assist Mechanical Hoyer Lift). NA-B revealed that Resident 2 stated that they were getting weak and fell to the floor during the pivot transfer. Interview on 2/17/26 at 3:37 PM with the facility MDSC confirmed that staff failed to follow the care planned transfer status for Resident 2 resulting in a fall on 2/5/26. The MDSC confirmed that staff were re-educated that Resident 2 is a 2 staff assist with the Hoyer lift for all transfers after the fall on 2/5/26. Record review of the Inservice Record dated 2/5/26 revealed that Resident 2 is a 2 assist Hoyer lift for all transfers. Resident 2 is not safe to pivot transfer. The Inservice Record was signed by 22 facility staff. Interview on 2/17/26 at 3:59 PM with Licensed Practical Nurse-D (LPN-D) revealed that an incident report is always completed for a resident fall. LPN-D revealed that the nurse is expected to complete the change of condition assessment, fall risk assessment, and post fall data collection for all resident falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 2/17/26 at 4:05 PM with the Facility Administrator (FA) revealed that the resident transfer status is communicated to staff through the pocket care plan, the Kardex (a concise, and frequently updated nursing worksheet that provides a quick-reference overview of a resident's essential information and daily care needs), and the resident care plan. The FA confirmed that staff are expected to follow the care plan for the resident transfer status. The FA confirmed that a fall is any incident when a resident comes to rest on a lower surface. Record review of the medical record for Resident 2 revealed that it contained no fall risk assessment or post fall data collection for Resident 2's fall on 2/5/26. Interview on 2/17/26 at 4:18 PM with the FA confirmed that Resident 2 had a fall on 2/5/26 that was not reported to the state agency as there was no injury to the resident. The FA confirmed that the Risk Management incident report, change of condition assessment, fall risk assessment, and post fall data collection should be completed for the fall. This surveyor requested that the FA provide copies of the fall risk assessment and post fall data collection for Resident 2's fall on 2/5/26. Interview on 2/17/26 at 4:23 PM with the Regional Clinical Specialist (RCS) confirmed that the facility did not complete the fall risk assessment and post fall data collection for Resident 2's fall on 2/5/26 as required. The RCS confirmed that the assessments should have been completed as post fall interventions. C. Record review of a facility policy titled Risk Management and dated 09/27/2024 revealed all accidents and incidents involving residents will be reported and investigated. The Director of Nursing, MDS Coordinator, and Executive Director will review Monday through Friday ensuring that interventions are appropriate and care planned. Residents having 2 or more falls in a 30 day period will be reviewed for trends and need for further interventions. Record review of a facility policy titled Comprehensive Care Plans and dated 12/03/2025 revealed the residents comprehensive care plan will be person centered for each resident. The care plan will be reviewed and revised to ensure that services will be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. Record review of an admission Record revealed the facility admitted Resident 6 on 02/10/2026 with diagnosis of cerebral infarction (a stroke when the blood is cut off from part of the brain) affecting the L (left) side of the body and seizure disorder (a chronic neurological condition characterized by recurrent unprovoked seizures caused by sudden abnormal electrical activity in the brain). Review of Resident 6's comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 02/15/2026 revealed Resident 6 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15 indicating the resident was cognitively intact. The MDS was coded to reflect the resident utilized a wheelchair or walker for mobility and had functional limitations of range of motion to one side of the body upper and lower extremity. The resident required supervision or touching assistance with eating, partial to moderate assistance with bed mobility, toilet use and transfers. The resident was occasionally incontinent of bladder and continent of bowel. The MDS was coded to reflect that the resident had no falls in the last 6 months prior to admission and had suffered from falls without injury since admission to (continued on next page)

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	285166	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Kenesaw	100 West Elm Avenue Kenesaw, NE 68956

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the facility. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/11/2026 stated to review information on past falls and attempt to determine cause of falls and possible root causes. Record review of a facility supplied document titled Incident by Incident Type and dated 02/17/2026 revealed documentation that Resident 6 had 2 witnessed falls on 02/15/2026, 1 unwitnessed fall on 02/15/2026, 1 unwitnessed fall on 02/11/2026, and 1 unwitnessed fall on 02/10/2026. Record review of a facility supplied document titled Post Fall Data Collection and dated 02/10/2026 at 5:35 PM revealed documentation that the Resident 6 was found on the floor of their room. In the section labeled potential root cause of fall the other specify box was checked and in the description of the cause of the fall it was documented that the resident was unable to use their call light do to lack of function of hands and a new/different call light was obtained for the resident. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/10/2026 was listed for a pressure call light that was placed due to the resident not being compliant with call light use. Record review of a facility supplied document titled Post Fall Data Collection and dated 02/11/2026 at 5:47 AM revealed that the resident (Resident 6) was found on the floor of their room. Documentation reflected that the resident had socked feet and stated that they had needed to go to the bathroom and attempted to self-transfer. In the potential root cause of fall, footwear was documented with description for the resident was attempting to self-transfer and was reminded to call for assistance, and no skid socks were place as well as lighting adjustments so the resident could see better. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/11/2026 revealed an intervention of side rails being placed on the bed to prevent falls was listed. There was no intervention to correlate with the documented root cause of the fall on the care plan of skid socks or to change lighting so the resident could see better. There was no intervention placed addressing the residents need to toilet being the reason they attempted to self-transfer and fell. Record review of a facility supplied document titled Post Fall Data Collection and dated 02/15/2026 at 4:30 AM revealed that the resident was found on the floor of their room. Documentation reflected that the resident had socked feet and was self-ambulating. The potential root cause of the fall was documented as toileting status and described as the resident was self-ambulating and had turned on the call light but did not wait for staff to assist the resident to go to the bathroom and the resident did not have no skid socks on. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/15/2026 revealed an intervention of a bed alarm being placed when the resident was in bed due to the resident being non complaint with fall precautions and self-transferring. There was not intervention to correlate with the documented root cause of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the fall on the care plan of skid socks or addressing the residents need to toilet being the reason the resident self-transferred and fell. Record review of a facility supplied document titled Post Fall Data Collection and dated 02/15/2026 at 7:50 AM revealed that the resident had a fall to the floor in their room. Documentation reflected that the resident had socked feet and was attempting to self-transfer and ambulate. The potential root cause of the fall was documented as the residents medical or physical condition and the resident attempting to transfer and ambulate without assistance. Interventions were documented to review and adjust toileting schedule and to re-arranging the residents' room to improve ease of movement. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/15/2026 revealed an intervention of nonskid strips were placed on the exit side of the bed and bathroom to prevent falls. There was no interventions to correlate with review and adjustment of the resident's toilet schedule and that the room was rearranged to improve ease of movement. Record review of a facility supplied document titled Post Fall Data Collection and dated 02/15/2026 at 11:50 AM revealed the resident had a fall to the floor in the commons area the resident was self-transferring with their shoes on. There was no potential root cause of fall identified, or documentation of interventions placed. Record review of Resident 6's Care Plan on 02/17/2026 revealed a focus of the resident being at high risk for falls with a goal stated of the resident will not sustain serious injury through the review date dated 02/11/2026. An intervention dated 02/15/2026 revealed an intervention of anti-roll backs were placed on the residents' wheelchair to prevent falls. In an interview conducted on 02/17/2026 at 2:30 PM with Resident 6, the resident was lying awake in their bed with a pressure alarm visible underneath the hip area of the resident's bed. The resident had the white control box in their right hand. The resident states has gotten into some trouble and had some falls denied getting hurt from falls. Resident stated that when they try to get out of their bed without help the alarm will sound (holds up the white box). The resident stated that they think it is supposed to remind the resident to call for help (resident points to their call light). During conversation resident begins to scoot self on the pressure alarm to the edge of the bed. Once at the edge of the bed the resident reaches out with their right hand and grasps their wheelchair that is sitting approximately 4 feet from the edge of the bed where the resident is sitting with both foot pedals in place and in the down position. The resident is able to grasp the side of the wheelchair and turn the seat and foot pedals towards themselves. The resident uses their right leg wrapped under their left leg and their right hand to adjust their foot position placing feet on the no skid strips that are placed on the floor beside the residents bed. The resident grasps the wheelchair and pulls themselves into a standing position and rotates lowering to the seat of the wheelchair the places their socked feet onto the wheelchair pedals. The bed alarm begins sounding once the resident is in a standing position. A staff member enters the room and asks the resident what they need and observes the resident sitting in their wheelchair and the alarm sounding. The staff shut off the alarm and ask the resident why they did not turn on the call light and wait for help. The resident stated I thought that is what that (points to the bed alarm) is for so you know I need help. In an interview completed on 02/17/2026 at 3:51 PM with the MDS Coordinator (MDSC), the MDSC stated that the facility does not have a policy or procedure in regard to falls. The MDSC stated that the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	incidents are reviewed and interventions are placed not sure if always necessary by documentation of root cause of the incident. Reviewed Resident 6's falls with the MDSC, the MDSC confirmed that the facility had not evaluated the resident's toileting schedule or habits and toileting was identified as a root cause of 2 of the residents falls. In an interview completed on 02/17/2026 at 4:45 with the facility Director of Nursing (DON), the DON confirmed that root cause of each fall should be determined and interventions to prevent further incidents/falls should be placed using the root cause. The DON confirmed that the interventions placed for Resident 6 were not by using the root cause of the incident/fall.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interviews, the facility failed to ensure a medication error rate of 5% or less with an actual observed medication error rate of 90%. This had the potential to affect all the residents residing and receiving medications administered by the facility. The facility census was 66.Findings are:Record review of a facility policy titled Medication Administration and dated 12/03/2025 revealed medication is administered by licensed nurses or other staff who are legally authorized to do so in the state and as ordered by the physician and in accordance with professional standards of practice. With compliance guidelines listed as to ensure that the six rights of medication administration are followed including the right dose, right time, and right documentation and to sign out the medication as administered after observing the resident consume the medication.Record review of a document titled Nursing Rights of Medication Administration and dated 01/2025 by the National Library of Medicine stated the five rights of medication administration are the right patient (ensuring the medication is being administered to the recipient it is prescribed for), the right drug (ensuring the medication being administered is identical to what is being prescribed), the right route (ensuring the medication is administered in the correct way as prescribed), the right time (ensuring the medication is administered at the correct time intervals ensuring therapeutic dosing), and the right dose (ensuring the medication is administered at the prescribed dose).In an observation completed on 02/17/2026 from 11:05 AM through 11:35 AM of Medication Aide A (MA-A) administering medication to Resident 5 the following was observed:-MA-A opened the computer screen to Resident 5's medication administration page. Resident 5's medication listed were all observed to be highlighted in red. All of the medication listed had an administration time listed to be administered between 0630AM - 1100AM.-MA-A removed the cardboard bubble pack packaged medications from the medication cart and placed them on top of the medication cart. The MA compared the label on the bubble pack to the computer and then removed the medication from the bubble pack placing it into a clear plastic medication cup. The MA then signed out (clicked on the Y button) in the computer for each medication after placing it in the medication cup. The MA did not wait until the resident had consumed the medication to sign out the medication in the electronic medication administration record.-MA-A informed Resident 5 that they had their nasal spray medication for the resident. The MA placed the tip of the white bottle labeled Azelastine 0.1% into the residents left nostril and depressed the applicator twice and then into the resident's right nostril and depressed the applicator twice.-MA-A poured a white granular powder from a white bottle labeled Polyethylene Glycol 3350 into a 30 milliliter (ml) clear plastic cup approximately 1/2 full. The MA stated the dosage for the medication was to administer 17 grams. The MA confirmed that grams were not a measurement on the 30ml plastic cup and would need to ask the nurse how to measure the dosage appropriately. The MA then placed the clear plastic cup with the white granular substance in it into the trash can located on the side of the medication cart. The MA did not dispose of the medication/white granular medication per facility policy or professional guidelines.Record review of Resident 5's Medication Administration Record (MAR) for the month of February 2026 revealed Resident 5 had orders for the following medications to be administered in the AM (0630 AM-1100 AM): Calcium Citrrate (a mineral supplement medication) 950 milligrams(mg), Cholecalciferol (a vitamin supplement medication) 25 micrograms(Mcg), Cyanocobalamin (a vitamin supplement medication) 1000 Mcg, Docusate Sodium (a laxative medication) 100 mg, Escitalopram (an antidepressant medication) 10 mg, Escitalopram 20 mg, Ferrous Sulfate (a mineral supplement medication) 325 mg, Folic Acid (a vitamin supplement medication) 1 mg, Polyethylene Glycol (a laxative medication) 350 17 grams, Omeprazole (a stomach acid reduction medication) 40 mg, Trelegy Ellipta (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inhalation (an inhaled medication to improve breathing), Vraylar (an antipsychotic medication) 1.5 mg capsule, Azelastine (an inhaled allergy relief medication) 0.1% nasal spray with direction for 1 spray to each nostril, Calcitrol (a vitamin supplement medication) 0.25 Mcg capsule, Geri-Lanta (a laxative medication), Oxcarbazepine (an antispasmodic medication) 150 mg, Pregabalin (a nerve pain medication) 100 mg, Topiramate (an antispasmodic medication) 50 mg, UTI-Stat (a liquid supplement medication) 30 milliliters, and Midodrine (a blood pressure medication) 5 mg.In an interview completed on 02/17/2027 at 11:36 AM with MA-A, MA-A confirmed that all of Resident 5's medications were administered late and late administering of medications was a medication error. MA-A confirmed that Resident 5's Azelastine 0.1% ordered dose was for 1 spray each nostril and they administered 2 sprays to each nostril. The MA confirmed that this was a medication error. The MA confirmed that they signed out each medication prior to the medication being consumed by the resident and they should not have. The MA stated that the white granular powder was a medication and should have been destroyed and not placed in the trash can.In an interview completed on 02/17/2026 at 12:25 PM with Resident 5, Resident 5 confirmed that all their morning medications were administered late. The resident confirmed that they are to receive only 1 spray in each nostril and the MA gave them 2 sprays in each nostril.In an interview completed on 02/17/2026 at 12:30 PM with Licensed Practical Nurse D (LPN-D) LPN-D confirmed that all of Resident 5's medications were administered late and that they would notify the provider of the late medication administration.In an interview completed on 02/17/2026 at 12:40 AM with the facility Director of Nursing (DON), the DON confirmed that Resident 5's medications were administered late, and the late administration of medications were medication errors. The DON confirmed that the facility utilized medication destroyer for medication destruction and the MA should have destroyed the medication using this method and not placed the medication in the trash can. The DON confirmed that MA-A administered the wrong dose of the nasal spray to Resident 5 and this was a medication error and that the MA-A should not have signed out the medications as administered until after the resident consumed the medications. The DON confirmed that the MA-A did not administer Resident 5's medications using the 5 rights of medication administration.