STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285172	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilber Care Center	611 North Main Wilber, NE 68465

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 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. License reference number NAC 12-007.03(K)Based on observation, and interview, the facility failed to provide a safe walkway in the hallway for ambulatory residents. This affected 1 out of 2 sampled residents but had the potential to affect all ambulatory residents. The facility census was 30.Findings are: A.Record review on 05/19/2026 at 2:58 PM revealed Resident 32 had an admission date of 02/07/2025. Record review of Resident 32's 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 05/07/2026 revealed that Resident 32 had moderately impaired cognition and wandered daily. The MDS also revealed Resident 32 had vascular dementia, Alzheimer's Disease, and anxiety. Record review of Resident 32's care plan revealed that Resident 32 wandered without purpose. The facility had placed interventions on the care plan stating Resident 32 does wander and staff are to redirect Resident 32, and staff were to avoid over stimulation for Resident 32. Record review of Resident 32's Progress Notes revealed that on 05/01/2026 Resident 32 was wandering around the facility with a front wheeled walker. Record review of Resident 32's Progress Note dated 05/16/2026 revealed that Resident 32 had been confused all shift, had been pacing the hallways and was anxiously looking for their family. B.During an observation on 05/18/2026 at 10:03 AM Resident 8 was near the nurse's station beside a laundry cart that was parked in the hall. Resident 8 was attempting to walk down the hall. During an observation on 05/18/2026 10:35 AM Resident 8 was wandering up and down the 100 hall. During an observation on 05/19/2026 at 8:00 AM while Resident 32 was sitting in a recliner at the nurse's desk there were 6 large wheelchairs lining the inside of the hall. A sit-to-stand lift and a Hoyer lift were also on the inside of the wall. During an observation on 05/19/2026 at 1:41 PM Resident 32 was sitting in recliner by nurse's desk and there were 6 large wheelchairs lined up against the wall of the hallway. A sit to stand lift and a Hoyer lift were also lined up against the wall of the hallway. During an observation on 05/19/2026 at 3:34 PM there were 5 tilt and space wheelchairs, 1 sit to stand lift, 1 Hoyer lift, a tray table with an office wheeled chair pushed under the tray table, and on top of the tray table was a wireless keyboard that was lined up against the wall in the hallway. During an observation on 05/20/2026 at 6:34 AM there were 6 wheelchairs lined up against the wall, and a Hoyer lift. During an observation on 05/20/2026 at 8:33 AM there were 4 wheelchairs, 1 sit to stand lift, and 1 Hoyer lift out in the hallway lined up against the wall. During an observation on 05/20/2026 at11:33 AM there were 4 tilt and space wheelchairs, 1 sit to stand lift, and 1 Hoyer lift lined up against the wall in the hallway. During an observation on 05/20/2026 at 1:24 PM the beautician was ambulating next to Resident 32, who was utilizing a front wheeled walker to ambulate. The beautician was walking closest to the wall that had 6 wheelchairs lined up in a single file, 1 sit to stand and 1 Hoyer lift. When a staff member attempted to get past the beautician and Resident 32, the staff had to wait until they ambulated past the wheelchairs that were lined up against the wall. During an observation on 05/20/2026 at 2:45 PM Resident 8 was ambulating down hallway without assistance and had a shuffled gait. At that time there were 6 wheelchairs, 2 sit to stand lifts, and 1 Hoyer lift parked against the wall in the same hallway. In an interview on 05/20/2026 at 3:30 PM with the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) confirmed that all the unused wheelchairs and lifts should be out of the hallway as this was a safety concern for residents who ambulated. The DON further confirmed that the facility did not have a storage policy for lifts or wheelchairs that were not in use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number NAC 12-006.18(B) Based on observation, record review and interview, the facility failed to wear the required Personal Protective Equipment (PPE-personal protective equipment-special equipment, including gloves, gown, masks and eye protection, worn to prevent exposure to hazards such as infectious materials), place soiled linen in a linen bag, ensure supplies were placed on a clean surface and throw a soiled glove in the trash can all during wound care for Resident 1, and failed to perform peri-care in a manner to prevent cross-contamination, and complete hand hygiene when changing gloves and after assisting with cares for Residents 11 and 12. This affected 3 out of 3 sampled residents. The facility census was 30. Findings are: A. Record review of the facility's Hand Hygiene policy, last revised 02/25 revealed staff are to wash hands vigorously, lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds, or longer under a moderate stream of running water, at a comfortable temperature, rinse hands thoroughly under running water, hold hands lower than wrists do not touch finger tips to inside of sink and then dry hands thoroughly with paper towels and then turn off faucets with a clean dry paper towel, discard paper towels in trash. A review of facility policy Enhanced Barrier Precautions last revised on 04/16/2024 revealed that the facility policy statement stated EBP are utilized to reduce the transmission of multi-drug-resistant organisms to residents. The facility policy interpretation and implementation included EBP are used as an infection prevention and control to reduce transmission of multi-drug-resistant organisms to the residents. The staff are to wear gloves and gowns prior to performing high contact resident care activity. The facility examples of when to wear PPE are device care or use (central line, urinary catheter, feeding tube), wound care (any skin opening requiring a dressing.) The policy further confirmed that wounds to be included in PPE are chronic wounds such as pressure ulcers, diabetic foot ulcers, venous stasis ulcers and unhealed surgical wounds. Record review of Resident 1's Face Sheet revealed an admission date of 7/24/24. Record review of Resident 1's Diagnosis List revealed that Resident 1 had type 2 Diabetes Mellitus without complications, hypertension (high blood pressure), chronic venous hypertension with ulcers of the bilateral lower extremities, and peripheral vascular disease. Record review of Resident 1's Order Summary dated 5/19/2026 revealed orders to: -Apply small edema wear to bilateral lower extremities from base of toes to just below knees on in the AM and off in the PM. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Paint blisters on bilateral lower extremities with betadine swab. -Assess blisters on bilateral lower legs weekly and document in wound management until resolved by facility protocol. -Resident 1's right great toe is to be assessed weekly and document in wound management until resolved. -Resident 1 is to have a weekly skin assessment on Thursday. Record review of Resident 1's undated care plan revealed Resident 1 had peripheral vascular disease and had a history of weeping vascular areas on their lower extremities. Resident 1 was at risk for further issues with the skin on their legs. There was a goal for Resident 1's open areas to heal without complication for Resident 1 to not experience an infection related to the open areas. The facility had the following approaches to assist in keeping Resident 1's bilateral lower extremities free from wounds: -Notifying the doctor if Resident 1's blisters, or open areas become worse or infected. -Resident 1 will wear edema wear as ordered. -Complete wound cares to Resident 1's lower extremities as ordered. -Staff are to encourage Resident 1 to elevate lower extremities while in bed or chair. -Facility staff to complete skin checks per facility protocol. During an observation on 05/19/2026 at 10:55 AM of Licensed Practical Nurse (LPN-G) obtained wound care supplies for Resident 1's lower extremities. LPN-G placed Vaseline gauze, gloves, scissors, a dry bordered foam dressing, and A & D ointment directly on Resident 1's bed. During a continued observation on 05/19/2026 at 10:56 AM, LPN-G washed hands with soap and water for 15 seconds and used the same paper towel to shut water off. Resident 1's right great toe was observed to have a black scab intact. LPN-G put on gloves, removed an old brown foam dry dressing from Resident 1's lower extremity and placed the soiled dressing directly on Resident 1's recliner seat. LPN-G completed hand hygiene (HH) via soap and water for 20 seconds, then wet a white towel with soap and water, put on new gloves and washed Resident 1's bilateral lower extremities, and then placed the soiled towel directly on the recliner cushion. LPN-G took off their gloves and performed HH with an ABHR (alcohol-based hand rub). LPN-G applied new gloves, cut small pieces of Vaseline gauze and applied to left lower extremity; LPN-G then placed a dry brown foam dressing over the gauze. LPN-G took off their gloves and performed HH with ABHR. LPN-G applied new gloves and then applied vitamin A & D ointment to Resident 1's right lower extremity and around the dressing to their left lower extremity. LPN-G then placed the A & D ointment tube back on Resident 1's bed. LPN-G performed HH with ABHR, applied gloves, and then painted small open areas to Resident 1's right and lower extremities with a betadine swab. LPN-G took off their right-hand glove and placed it directly on Resident 1's bed. LPN-G placed the used betadine swab in a trash can, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtained a clear trash bag and placed the soiled towel in trash bag, then removed their left-hand glove and placed it in the trash can. LPN-G then completed HH via soap and water for 20 seconds, removed wound care supplies from Resident 1's bed and placed them back in the treatment cart without first disinfecting them. During an observation on 05/20/2026 at 2:59 PM there was no Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms in nursing homes. EBP involves wearing a gown and gloves during high contact resident care activities, such as wound care) signage noted on the outside of Resident 1' s door or inside Resident 1's room. During an observation on 05/20/2026 at 3:00 PM Resident 1's room contained gloves, but no other PPE was noted in the room. During an interview on 05/19/2026 at 1:45 PM LPN-G confirmed that a soiled foam dressing should not have been placed on Resident 1's recliner cushion, the soiled towel should not have been placed on Resident 1's recliner, and the soiled glove should not have been placed on Resident 1's bed or used for a surface area for wound care supplies. LPN-G further confirmed that a gown should have been worn during Resident 1's wound care. During an interview on 05/20/2026 at 3:21 PM Director of Nursing (DON) confirmed that Resident 1's door should have an EBP sign and PPE should be in Resident 1's room. It was further confirmed that a gown should have been worn during wound care to Resident 1's bilateral lower extremities. The DON further confirmed that hand washing should have been at least 20 seconds. It was further confirmed that LPN-G should not have laid a soiled towel on a recliner or have wound supplies on resident bed for a clean surface and placed a soiled glove on resident bed. B. Record review of the facility policy titled Peri-care last revised 2/2025 revealed under Purpose: Perineal care should be done every time a patient is incontinent and/or every morning and every evening. Female peri-care: Wipe only front to back, use a different section of the disposable wipe, wash the buttocks and the anal area. Record review of the facility's Hand Hygiene policy last revised 2/2025 revealed under policy interpretation and implementation: Number 6: use an alcohol-based hand rub containing at least 62% alcohol or soap and water, b. before and after direct contact with residents. h. before moving from a contaminated body site to a clean body site during resident care. and m. after removing gloves. Record review of Resident 12's face sheet revealed the resident admitted to the facility on [DATE] with a diagnosis of age-related physical debility and disorientation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 12's diagnosis list revealed that urge incontinence was added 7/16/2025, major depressive disorder, anxiety and dementia diagnosis were added on 8/30/2025, palliative care was added 9/2/2025 and constipation was added 2/24/2026. Record review of Resident 12's quarterly Minimum Data Set (MDS) (a federally mandated assessment that aides the facility in identifying care needs for the resident) dated 3/5/2026 revealed under Section C: a Brief Interview for Mental Status (BIMS)(a brief screening tool that assists in assessing a residents cognition, scoring 0 to 15 with 15 being cognitively intact) score of 99, which indicated the resident was unable to complete the interview and was cognitively impaired. In Section E the MDS revealed the was no rejection of cares and the resident wandered occurred daily. In Section GG it revealed the resident required assist of 2 for toileting, transfers and bed mobility. In Section O it revealed the resident was on hospice care. Record review of Resident 12's care plan last revised 12/18/2025 revealed under the Activities of Daily Living problem that the resident required assist of one to aid with dressing, toileting hygiene and locomotion. Under the Pressure Ulcer risk problem last revised 3/18/2026, staff were to provide incontinence care after each episode of incontinence. An observation on 5/20/2026 from 6:38 AM to 7:10 AM of Medication Aide (MA) - C and Nurse Aide (NA) - B providing morning cares to Resident 12 revealed the nurse aides entering the room and donning gloves without performing hand hygiene (HH). NA-B dressed Resident 12 part-way and sat the resident up on the side of the bed, put shoes on and brought the mechanical sit/stand lift close to the resident. After the staff buckled the resident in, the resident stood and the staff raised the lift and wheeled to toilet in the resident room where NA-B removed the resident's brief, which was visibly soaked, and then changed gloves without first performing HH. NA-B obtained two disposable wipes and wiped the resident from front to back with two swipes and without obtaining a new wipe, nor did NA- B cleanse the buttocks or hips of the resident. NA-B removed gloves and donned a new pair without first performing HH. NA-B then applied a new brief which MA-C pulled up, along with the resident's pants. The resident was then placed in the wheelchair utilizing the lift. MA-C washed their hands with soap and water for 12 seconds, dried them and left the room with the mechanical lift. NA-B then removed the resident's gown and applied a shirt. MA-C took the lift out of the room and did not complete HH. NA-B changed gloves without the benefit of HH and placed the resident at the sink, turned on the water and obtained a washcloth, towel, toothbrush and paste for the resident. Then NA-B applied toothpaste to the brush and removed gloves. NA-B then made the bed, applied one glove to right hand, removed the trash, obtained a bag for the dirty gown, left the room to put the linen and trash bags in the proper receptacle and then went directly across the hall to room [ROOM NUMBER] to assist another resident, without performing any type of hand hygiene. An interview with the Director of Nursing on 5/20/2026 at 2:25 PM confirmed that the expectation for peri-care would be to remove the resident's brief, clean front to back, including the buttocks, changes gloves before applying a new brief and that HH should be completed between glove changing and after resident cares. The DON confirmed the staff did not follow the policy and that no one was currently doing any peri-care audits to provide oversite to the staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review of the facility policy titled Peri-care, last dated 2/2025 revealed wiping front to back starting in the middle working outward, never wash upward.Use clean section of cloth for each wipe. Pat the area dry in the same direction used for washing, wash buttocks working front to back. Record review of the facility's Hand Hygiene policy last revised 2/2025 revealed under policy interpretation and implementation: Number 6: use an alcohol-based hand rub containing at least 62% alcohol or soap and water, b. before and after direct contact with residents. h. before moving from a contaminated body site to a clean body site during resident care and m. after removing gloves. Record review of Resident 11's Face Sheet revealed the resident was admitted on [DATE] with a diagnosis of schizoaffective disorder, bipolar type (a mental disorder that can cause hallucinations, delusion, elevated mood, or impulsive behavior.) Record review of Resident 11's MDS dated [DATE] revealed the following: - BIMS score of 99 (which indicated the resident was unable to complete the interview) -Toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) revealed Resident 11 was dependent (resident does none of the effort to complete the activity.) -Always incontinent of bowels. -Dependent on helper for the following, toilet transfer, change in position while in bed or wheelchair. Record review of Resident 11's Care Plan, dated 3/19/2026 revealed the following: -risk for complete loss of activities of daily living (ADL) task completion; requires two assist with bed mobility and toileting, transfers -risk for skin integrity impairment; reposition with incontinent checks t/o night while laying in bed. An observation on 5/19/2026 from 9:40 AM to 9:56 AM of NA-D and NA-E providing cares for Resident 11 revealed the NAs entering the room and donned gloves without performing hand hygiene (HH). Both NAs used the mechanical full body lift to transport the resident from the tilt in space wheelchair to the bed. The nurse aides removed the resident's pants and each untaped one side of the brief and NA-D grabbed the premoistened wipes from the resident's nightstand. With the same soiled gloves, the NA reached in the package and began wiping the resident, one wipe was used for right side of the perineum, NA-D then grabbed a second wipe from the package and wiped the left side of the perineum, and then reached in the package for a third wipe while still wearing the same gloves, which was used to wipe down the middle of the perineum. Then both NAs rolled the resident to the left and NA-D removed the visibly soaked brief and discarded it in the trash. The outside layer of the brief had a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brown color marking from the front to the back. NA-D then pushed the wipes down in the package and closed the top, all the while with soiled gloves. Both NAs, while still wearing the same soiled gloves, placed a new brief on the resident without providing peri-cares to the resident's buttock region. NA-D doffed gloves and both NAs continued to pull up the resident's pants. NA-E then doffed their gloves and both NAs continued to reposition the resident without first performing HH. NA-E removed the mechanical lift and tilt and space wheelchair from the room and placed them in the hallway opposite the resident's room. NA-E then came back into the room and performed HH and left the resident's room again. NA-D lowered the resident's bed to the lowest position and gave the resident a stuffed bear off the resident's nightstand. NA-D then performed HH right before leaving the room. An interview on 5/19/2026 at 9:50 AM with NA-D confirmed Resident 11's brief had been soiled. An interview with NA-B on 5/20/2026 at 2:00 PM confirmed the incontinence briefs used in the facility have a color indicator strip located from the front of the brief to the back which changes color when the brief detects moisture. An interview with the Director of Nursing (DON) on 5/20/2026 at 2:25 PM confirmed that the expectation for peri-care would be to remove the resident's brief, clean front to back, including the buttocks, changes gloves before applying a new brief and that HH should be completed between glove changing and after resident cares. The DON confirmed the staff did not follow the policy and that no one was currently doing any peri-care audits to provide oversite to the staff.