STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285173	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Florence Home	7915 North 30th Street Omaha, NE 68112

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were protected from potential abuse by allowing an employee who was accused of abuse by Resident 5, to finish their shift. This had the potential to affect Residents in rooms 201-205 and 219-220 on the 200 hall. The facility had a census of 80.Findings are:An interview on 9/24/25 at 1:00pm with the Director of Nursing (DON) revealed the following:On 7/13/2025 the resident (Resident 5) made a statement that they did not want the Nurse Aide (NA-C) to change the resident because the NA throws the resident against the wall. Licensed Practical Nurse D (LPN) assigned another employee to care for the resident for the rest of the evening. The DON confirmed they were not aware of the incident until 7/14/1025 when they read Resident 5's progress notes from the evening before. The DON confirmed they contacted LPN D who wrote the progress note and received a verbal report from LPN D about the incident on 7/14/2025.The DON confirmed LPN-D should have contacted the DON immediately after the incident and LPN-D had not done so.The DON confirmed that LPN-D did not send NA-C home after LPN-D was informed of the incident and should have done so. The DON confirmed they had educated LPN-D verbally about informing management immediately of any accusations of abuse, but the DON had not documented the verbal education. An interview on 9/25/25 at 3:27 PM with the DON revealed NA - C worked on the 200 hall from 6-10 PM covering rooms 201-205 and covering rooms 201-204 and 219-220 from 2-6 PM. The DON confirmed NA-C would have had the potential to affect the residents in these rooms on 7/13/2025.A record review of a progress noted dated 7/13/2025 by LPN D revealed the following:Resident (5) refuses care from their assigned NA - C because they throw me against the wall, nurse educated resident that NA-C will be in the room to help spot the replacement NA since the resident requires 2 people during transfers. LPN-D witnessed brief change and NA-C did not overexert any strength during the brief change.A record review of the facility's Abuse Policy dated 1/28/2025 revealed the following: The policy stated the residents' rights to be free from verbal, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees of the Organization recognize its residents, regardless of cognitive ability, to be vulnerable and will take action to protect and prevent mistreatment, abuse, neglect, and misappropriation of resident property within the facility by:intervening in the situationReporting the situation to the proper authoritiesInvestigating the allegationPreventing abuse, neglect, and misappropriation while the investigation is in process.Document evidence that the Organization intervened, reported, prevented abuse/neglect/misappropriation, and investigated.Not employing individuals who have been:Found guilty of abusing or mistreating individuals by a court of law.Entered into the State Nurse Aide Registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their property.Reporting any knowledge, it has of actions by a court of law against an employee for service as a Nurse Aide to the State Nurse Aide Registry of Licensing Authorities.The facility procedure consists of Pre-hire screening, Volunteer screening, employee and volunteer training, prevention, identification, reporting, immediate intervention, and investigation.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E). Based on interview and record review the facility failed to provide baths according to preference for 2 (Resident 8 and 12) of 2 residents sampled. The facility census was 80. The findings are:A.Record review of Resident 8's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 08-27-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -required limited assistance with upper body dressing and bed mobility.-required extensive assistance with bathing.-required total assistance with toileting, lower body dressing and transfers. Record review of the facility grievance log revealed the following concerns voiced by Resident 8:-06-23-2025 Resident 8 was concerned because it had been over a week since (gender) had a shower.-07-07-2025 Resident 8 was concerned that staff did not provide a shower on 07-04-2025.-07-25-2025 Resident 8 reported (gender) did not get a bath this week. An interview conducted on 09-23-25 at 7:30 AM with Resident 8 revealed Resident 8 wanted 2 baths or showers a week and was not getting them.Observation on 09-23-2025 at 7:35 AM revealed a white board in Resident 8's room that indicated Resident 8 was to get a bath on Monday and Wednesday.Record review of Resident 8's bathing record for July 2025 revealed a shower was given on 07-25-2025. Resident 8 should have received 9 showers in July.Record review of Resident 8's bathing record revealed the following for August 2025:-08-04-2025 shower-08-11-2025 shower-08-19-2025 shower-08-25-2025 showerResident 8 should have had a shower on 08-06-2025, 08-14-2025, 08-20-2025, and 08-28-2025. Record review of Resident 8's bathing record revealed the following for September 2025:-09-03-2025 shower-09-15-2025 showerResident 8 should have had a shower on 09-01-2025, 09-08-2025, 09-10-2025, 09-17-2025, 09-22-2025 and 09-24-2025. Record review of Resident 12's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-BIMS score was 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required extensive assistance with hygiene and bed mobility.-required total assistance with toileting, bathing, dressing and transfers. B.Record review of Resident 12's Comprehensive Care Plan (CCP) dated 11-04-2024 revealed Resident 12 would like 2 baths a week.An interview conducted with Resident 12 on 09-22-2025 at 10:02 AM revealed a preference of 2 baths a week but doesn't always get 2.Record review of Resident 12's bathing record for July 2025 revealed the following:-07-03-2025 shower-07-08-2025 bath-07-29-2025 bathResident 12 should have received a bath or shower on 07-01-2025, 07-10-2025, 07-15-2025, 07-17-2025, 07-22-2025, 07-24-2025 and 07-31-2025. Record review of Resident 12's bathing record for August 2025 revealed the following:-08-12-2025 bed bath-08-19-2025 showerResident 12 should have received a bath or shower on 08-05-2025, 08-07-2025, 08-14-2025, 08-21-2025, 08-26-2025 and 08-28-2025. Record review of Resident 12's bathing record for September revealed the following:09-18-2025 bed bathResident 12 should have received a bath or shower on 09-02-2025, 09-04-2025, 09-09-2025, 09-11-2025, 09-16-2025 and 09-23-2025. An interview conducted with the Director of Nursing (DON) on 09-25-2025 confirmed baths were not provided according to preference and Resident 8 and Resident 12 should have had 2 baths a week.

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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. Based on interview and record review the facility failed to report an allegation of abuse against Resident 5 within the required timeframe. The facility had a census of 80. Findings are:An interview on 9/24/25 at 1:00 PM with the Director of Nursing (DON) revealed the following:On 7/13/2025 the resident (Resident 5) made a statement that they did not want the Nurse Aide (NA-C) to change the resident because the NA throws the resident against the wall. Licensed Practical Nurse D (LPN) assigned another employee to care for the resident for the rest of the evening. The DON confirmed they were not aware of the incident until 7/14/1025 when they read Resident 5's progress notes from the evening before. The DON confirmed they contacted LPN D who wrote the progress note and received a verbal report from LPN D about the incident on 7/14/2025.The DON confirmed LPN-D should have contacted the DON immediately after the incident and LPN-D had not done so.The DON confirmed that LPN-D did not send NA-C home after LPN-D was informed of the incident and should have done so. The DON confirmed they had educated LPN-D verbally about informing management immediately of any accusations of abuse, but the DON had not documented the verbal education. An interview on 9/25/25 at 3:27 PM with the DON revealed NA - C worked on the 200 hall from 6-10 PM covering rooms 201-205 and covering rooms 201-204 and 219-220 from 2-6 PM. The DON confirmed NA-C would have had the potential to affect the residents in these rooms on 7/13/2025.A record review of a progress noted dated 7/13/2025 by LPN D revealed the following:Resident (5) refuses care from their assigned NA - C because they throw me against the wall, nurse educated resident that NA-C will be in the room to help spot the replacement NA since the resident requires 2 people during transfers. LPN-D witnessed brief change and NA-C did not overexert any strength during the brief change.A record review of the facility's Abuse Policy dated 1/28/2025 revealed the following: The policy stated the residents' rights to be free from verbal, physical and mental abuse, corporal punishment, and involuntary seclusion. The administration and employees of the Organization recognize its residents, regardless of cognitive ability, to be vulnerable and will take action to protect and prevent mistreatment, abuse, neglect, and misappropriation of resident property within the facility by:intervening in the situationReporting the situation to the proper authoritiesInvestigating the allegationPreventing abuse, neglect, and misappropriation while the investigation is in process.Document evidence that the Organization intervened, reported, prevented abuse/neglect/misappropriation, and investigated.Not employing individuals who have been:Found guilty of abusing or mistreating individuals by a court of law.Entered into the State Nurse Aide Registry concerning abuse, neglect, and mistreatment of residents or misappropriation of their property.Reporting any knowledge, it has of actions by a court of law against an employee for service as a Nurse Aide to the State Nurse Aide Registry of Licensing Authorities.The facility procedure consists of Pre-hire screening, Volunteer screening, employee and volunteer training, prevention, identification, reporting, immediate intervention, and investigation.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.006.09(H) Based on observation, interview, and record review, the facility failed to ensure compression stockings were applied and weekly weights were completed per the provider's orders for 1 (Resident 89) of 4 sampled residents and failed to monitor and treat 1 (Resident 49) of 4 sampled resident's lower extremity edema. The facility census was 80. Findings are:A record review of the facility's Following Physician's Orders policy with a revised date of 08/2025 revealed all aspects of physician or non-physician practitioner's order must be followed in their entirety. A record review of the facility's Ace Wraps, Compression Stockings (TED HOSE, [NAME] STOCKINGS, SUPPORT HOSE, etc.) guideline revealed the staff were to apply ace wraps or stockings to the resident per the provider's order. A.A record review of Resident 89's Profile Face Sheet dated 09/24/2025 revealed the resident was admitted to the facility 02/28/2025. The resident had diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Orthostatic Hypotension (decrease of blood pressure on standing), and Cerebellar Ataxia (lack of muscle coordination and balance). A record review of Resident 89's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 08/20/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15 which indicated the resident was cognitively aware. The resident required limited assistance for bed mobility, transfer, and toilet use and was independent for eating. The resident was not on therapy. A record review of Resident 89's Care Plan dated 03/20/2025 - 11/20/2025 revealed the resident was at risk for impaired skin integrity related to age, diagnoses, and decreased mobility, but did not reveal interventions for compression stockings (garments worn on the legs to apply pressure, promote blood flow, and reduce swelling). A record review of Resident 89's Physician's Orders dated 09/24/2025 revealed an order for compression stockings or equivalent on in AM (morning), off on PM (afternoon) for fluid overload. A record review of Resident 89's Grievance/Complaint Report dated 08/12/2025 revealed the resident told the Veteran's Administration (VA) staff that the residents TED hose had not been put on every day and the VA staff notified the facility. An observation on 09/22/2025 at 10:17 AM revealed Resident 89 was seated in a wheelchair in the resident's room and the resident had significant swelling from edema (a condition where excess fluid builds up in the body causing swelling) in the bilateral lower extremities (BLE)(both legs and feet). The observation did not reveal the resident had compression stockings on but did reveal 2 pairs of compression stockings hanging on a walker in the northwest corner of the room. An observation on 09/22/2025 at 3:12 PM revealed Resident 89 was seated in a wheelchair in the resident's room and the resident had edema in the BLE with not compression stockings on but there were 2 pairs of compression stockings hanging on a walker in the northwest corner of the room. An observation on 09/24/2025 at 8:11 AM revealed Resident 89 was seated in a wheelchair in the resident's room and the resident had edema in the BLE. The observation did not reveal the resident had compression stockings on but did reveal 2 pairs of compression stockings hanging on a walker in the northwest corner of the room. An observation on 09/25/2025 at 9:06 AM revealed Resident 89 was seated in a wheelchair in the resident's room and the resident had edema in the BLE. The observation did not reveal the resident had compression stockings on but did reveal 2 pairs of compression stockings hanging on a walker in the northwest corner of the room. An observation on 09/25/2025 at 9:12 AM with Licensed Practical Nurse (LPN)-A that was the charge nurse revealed Resident 89 was seated in a wheelchair in the resident's room and the resident had edema in the BLE. The observation did not reveal the resident had compression stockings on but did reveal 2 pairs of compression stockings hanging on a walker in the northwest corner of the room. In an interview on 09/22/2025 at 10:17 AM, Resident 89 confirmed the facility's staff had not offered to put the resident's compression stockings on for the last 2 days. In an interview on 09/25/2025 at 9:06 AM, Resident 89 confirmed the facility's staff had not offered to put the resident's compression (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stockings on and the resident had been out of bed since 6:30 AM. In an interview on 09/25/2025 at 9:12 AM, LPN-A confirmed the resident did not have compressions stockings on and should have had. The compression stockings should be put on when the nursing assistants (NA) assist Resident 89 out of bed in the mornings. B.A record review of Resident 89's Physician's Orders dated 09/24/2025 revealed an order for Document Weight Weekly to be done every week per the resident's physician. A record review of Resident 89's Medication Record For 08/2025 - 09/2025 dated 08/2025 and 09/2025 revealed weekly weights were not completed 08/15/2025, 08/29/2025, and 09/12/2025. A record review of Resident 89's Resident Weight Tracking System Report dated 09/25/2025 revealed the resident had not been weighed 08/15/2025, 08/29/2025. In an interview on 09/25/2025 at 12:15 PM, the facility's Director of Nursing (DON) confirmed Resident 89's weights were not being completed weekly and should have been. C.A record review of Resident 49's Profile Face Sheet dated 09/25/2025 revealed the resident was admitted to the facility 06/12/2025. The resident had diagnoses of Malignant Neoplasm Of Intrathoracic Nodes (cancer in the lymph nodes in the chest), Malignant Neoplasm Of Liver And Bile Duct, Atherosclerotic Heart Disease (plaque buildup in the arteries of the heart), Chronic Obstructive Pulmonary Disease (COPD), Type 2 Diabetes Mellitus (uncontrolled blood sugars) and Hypothyroidism (underactive thyroid gland). A record review of Resident 49's MDS dated [DATE] revealed the resident had a BIMS of 15 which indicated the resident was cognitively aware. The resident was independent with dressing, eating, toileting and mobility. The resident required setup or clean-up assistance with bathing, personal hygiene (cleaning) and footwear. The resident was not on therapy. The resident was not on hospice and was not on a diuretic. A record review of Resident 49's Care Plan dated 03/20/2025 - 11/20/2025 revealed the resident was at risk for impaired skin integrity related to age, diagnoses, and decreased mobility, and had an intervention to notify the medical doctor of any areas of impaired skin and skin check per facility protocol. but did not reveal interventions for compression stockings (garments worn on the legs to apply pressure, promote blood flow, and reduce swelling. The resident had cancer and was receiving chemotherapy (cancer treatment). A record review of Resident 49's Physician's Orders dated 09/24/2025 revealed an order for weekly skin assessment but did not reveal and order for edemawear or a diuretic (a medication used to eliminate excess fluid from the body). A record review of Resident 49's Medication Record dated 07/2025 - 09/2025 revealed weekly skin assessment marked completed 7/16/2025, 07/30/2025, 08/27/2025, 09/03/2025, and 09/17/2025. Refused 07/09/2025, 07/23/2025, 08/06/2025, 08/20/2025, and 09/24/2025. The medication records were marked the resident was out of the facility 07/02/2025, 08/13/2025, and 08/10/2025. A record review of the facility's Skin Evaluation Form dated 07/01/2025 - 09/25/2025 revealed two evaluations done, 1 on 07/30/2025 and only skin concern was a great toenail concern 07/30/2025 and no issues on 08/27/2025. An observation on 09/22/2025 at 9:41 AM revealed Resident 49's right ankle and foot had edema and was red on the top from above the ankle and entire foot and scab on the lateral side (outside). An observation on 09/22/2025 at 12:12 PM revealed Resident 49's left lower extremity (LLE)(left lower leg and foot) had edema. The resident did not have compression stockings on or in the room. An observation on 09/23/2025 at 2:54 PM with Registered Nurse (RN)-B revealed the resident had BLE swelling with 3 plus (+) pitting edema in the LLE and cellulitis (skin infection) on the right lower extremity (RLE). In an observation on 09/24/2025 at 8:28 AM revealed edema in BLE and RLE appeared to have improved in color. No compressions stockings on resident or in the room. In an observation on 09/25/2025 at 9:06 AM revealed edema in BLE and RLE appeared to have improved in color. No compressions stockings on resident or in the room. In an observation on 09/25/2025 at 9:25 AM with the DON revealed edema in BLE. No compressions stockings on resident or in the room. In an interview on 09/23/2025 at 3:16 PM, RN-B confirmed Resident 49 did have BLE edema and resident had 3+ pitting on LLE that was not being treated. RLE had cellulitis and that was being treated with and antibiotic. RN-B confirmed RN-B seen the resident earlier in the morning and RN-B did not notice the LLE edema. In an interview on 09/25/2025 at 9:06 AM, LPN-A confirmed RN-B (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had contacted hospice regarding LLE edema on 09/23/2025, but Resident 49's physician had not been contacted, and no treatment changes had been made. In an interview on 09/25/2025 at 9:37 AM the DON confirmed the resident had BLE edema and treatment was not being completed for the LLE and should have been. The DON confirmed the staff were not doing weights and skin assessments as ordered.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1 & 2). Based on observation, interview and record review, the facility failed to conduct weekly skin evaluations to prevent the potential for pressure ulcer development and failed to evaluate and monitor a new wound for 1 (Resident 19) of 2 sampled residents. The facility census was 80. The findings are:Record review of the facility policy titled Pressure Ulcer Prevention and Interventions dated 08-2025 revealed any resident with a Braden Scale (a tool healthcare professionals use to assess a patient's risk of developing a pressure ulcer) score of 16 or below will be assessed by a nurse every week with individualized skin interventions based on the Braden score. Record review of the facility policy titled Skin Protocol dated 02-2024 revealed the purpose of the policy was to provide clear expectations regarding reporting and subsequent documentation of skin issues. Weekly skin checks are to be done on all residents by a nurse. Anytime a new skin concern is found the nurse wo is on duty is responsible for: assessing the skin condition, including measurements and description. Record review of Resident 19's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-25-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13-15 indicates a person cognitively intact. - required extensive assistance with hygiene, and bed mobility.-required total assistance with dressing, toileting, bathing and transfers.-had a pressure ulcer. Record review of Resident 19's Electronic Health Record (EHR) revealed a Braden Scale dated 09-17-2025 scored at a 14, which indicated a mild risk of pressure ulcer development. Record review of Resident 19's Electronic Health Record revealed weekly wound evaluations but no weekly skin evaluations. An observation on 09-24-2025 at 10:00 AM of Registered Nurse (RN) B and the Assistant Director of Nursing (ADON) performing wound care for Resident 19 which revealed a large stage 4 pressure ulcer to the right buttock approximately 8 centimeters (cm) length by 3 cm width by 3 cm depth. The observation also revealed another wound to the right buttock that was approximately 4 cm in length by 2 cm in width by 0.1 cm in depth with yellow slough present in the wound bed. Record review of Resident 19's wound evaluations for 09-07-2025 and 09-14-2025 revealed only one wound to the right buttock, not 2. Interview with the ADON on 09-25-2025 at 2:00 PM revealed the second wound on the right buttock was identified by the facility staff on 09-15-2025 and confirmed the wound was not assessed or monitored since 09-15-2025 and should have been upon discovery and weekly going forward. An interview with the Director of Nursing (DON) on 09-25-2025 confirmed weekly skin evaluations were not conducted for Resident 19 and should have been.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(a). Based on observation, interview and record review the facility failed to ensure ready to hang tube feeding was not in use beyond 24 hours for 1 (Resident 12) of 1 residents sampled. The facility census was 80. The findings are:Record review of the facility policy Gastric Tube Feeding Via Pump revealed the purpose of the policy is to provide nutritional support for residents who are unable to obtain nourishment orally. Furthermore, tube feeding and tubing can hang up to 24 hours.Record review of Resident 12's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-BIMS score was 14. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-required extensive assistance with hygiene and bed mobility.-required total assistance with toileting, bathing, dressing and transfers.-had a feeding tube.Observation on 09-22-2025 at 9:00 AM revealed Resident 12 was in the room and tube feeding was disconnected from Resident 12 and the bottle and tubing were still hanging on the tube feeding pole. The bottle was Jevity 1.5 dated 09-22-2025 at 3:50 AM.Observation on 09-23-2025 at 9:30 AM revealed the tube feeding had been disconnected from Resident 12 and a bottle of Jevity 1.5 dated 09-22-2025 at 3:50 AM was still hanging on the tube feeding pole. An interview on 09-23-2025 at 2:15 PM with Registered Nurse (RN) E revealed the bottle of Jevity 1.5 dated 09-22-2025 at 3:50 AM was still running at 6:00 AM on 09-23-2025 and confirmed the bottle of Jevity 1.5 should have been changed at or before 3:50 AM on 09-23-2025. An interview with the Director of Nursing (DON) on 09-25-2025 at 10:55 AM confirmed ready to hang tube feeding should not be used beyond 24 hours.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Licensure Reference Number 175 NAC 12-006.09 (H). Based on record review and interview the facility failed to hold a blood pressure medication according to the prescribed blood pressure parameters for 1 (Resident 19) of 6 resident's sampled. The facility census was 80. The findings are:Record review of Resident 19's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 06-25-2025 revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13-15 indicates a person cognitively intact. - required extensive assistance with hygiene, and bed mobility.-required total assistance with dressing, toileting, bathing and transfers.-had a pressure ulcer. Record review of Resident 19's Medication Administration Record (MAR) for August 2025 revealed an order for Midodrine 5 milligram (mg) tablet take 1 tablet 3 times a day, hold if Systolic Blood Pressure (SBP: the top number of a blood pressure reading) was above 120. The following entries revealed a SBP of above 120.-08-15-2025 at 8:00 AM Blood Pressure (BP) was 127/79 and documented as administered.-08-25-2025 at 8:00 AM BP was 125/84 and documented as administered. Record review of Resident 19's MAR for September 2025 revealed an order for Midodrine 5 mg take 1 tablet 3 times a day, hold if SBP was above 120. The following entries revealed a SBP of above 120.-09-18-2025 at 8:00 AM BP was 133/82 and documented as administered.-09-21-2025 at 8:00AM BP was 122/69 and documented as administered.-09-12-2025 at 12:00 PM BP was 121/75 and documented as administered.-09-22-2025 at 12:00 PM BP was 127/72 and documented as administered-09-18-2025 at 5:00 PM BP was 133/82 and documented as administered.-09-22-2025 at 5:00 PM BP was 132/79 and documented as administered. An interview conducted on 09-25-2025 at 1:40 PM with Director of Nursing confirmed that Midodrine 5mg should have been held for the dates identified in August and September. Record review of the facility policy titled Following Physician's Orders dated 08-2025 revealed the purpose of this policy is to provide guidelines for following physician's and non-physician provider orders. If a physician order is present and is failed to be administered according to specific orders, it may result in a medication discrepancy.