| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285177 | A. Building<br>B. Wing | 02/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Good Samaritan Society - Atkinson | 409 Neely Street<br>Atkinson, NE 68713 |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Licensure Reference Number 175 NAC 12-006.04(D)Based on record review and interview; the facility failed to ensure sufficient staffing to ensure call lights were answered in a timely manner. This had the potential to affect all facility residents who utilized a call device. This had the potential to effect all residents in the building. The facility census was 28.Findings are: A. Review of the facility policy Call Light, last revised 7/8/25 revealed the following:-the purpose was to ensure resident had a method of calling for assistance and to promptly answer the resident's call lights;-when resident's call lights were observed, staff were to go to the resident's room promptly, -staff were to respond to the request as soon as possible, turn the call light off and inquire about the resident's request;-when leaving a room, staff were to place call lights within easy reach of the resident;-for resident's unable to use a call light, appropriate interventions would be care planned; and-each facility was responsible for having an alternate method of communication during a loss of power or call light system failure. B. Review of the facility policy Nursing Services, last revised 10/14/25 revealed the purpose was to provide appropriate staff for resident care and revealed the following:-the facility must have sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment;-the facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans;-the Director of Nursing Services responsibilities would include and be delegated as appropriate which included implementation of day-to-day resident care practices within the nursing department, ensuring equality of care was provided and working with the medical director to ensure that medical needs of residents were met; and-the facility would use the services of a registered nurse for at least eight consecutive hours a day, seven days a week. C. Review of the Device Activity Report (record of call light activations and responses from 2/6/26-2/9/26) revealed the following call light response times greater than 20 minutes:-2/9/26 at 10:06 PM answered at 22 minutes, 16 seconds;-2/9/26 at 9:08 PM answered at 45 minutes, 31 seconds;-2/9/26 at 7:51 PM answered at 21 minutes, 30 seconds;-2/9/26 at 5:06 PM answered at 39 minutes, 22 seconds;-2/9/26 at 3:23 PM answered at 22 minutes, 28 seconds;-2/9/26 at 2:26 PM answered at 29 minutes, 0 seconds;-2/9/26 at 1:37 PM answered at 26 minutes, 26 seconds;-2/9/26 at 1:32 PM answered at 28 minutes, 55 seconds;-2/9/26 at 1:30 PM answered at 22 minutes, 7 seconds;-2/9/26 at 11:52 AM answered at 24 minutes, 0 seconds;-2/9/26 at 11:30 AM answered at 27 minutes, 15 seconds;-2/9/26 at 11:30 AM answered at 26 minutes, 42 seconds;-2/9/26 at 9:21 AM answered at 24 minutes, 29 seconds;-2/9/26 at 8:09 AM answered at 52 minutes, 9 seconds;-2/9/26 at 8:08 AM answered at 31 minutes, 32 seconds;-2/9/26 at 7:40 AM answered at 37 minutes, 7 seconds;-2/8/26 at 8:52 PM answered at 39 minutes, 37 seconds;-2/8/26 at 8:52 PM answered at 39 minutes, 47 seconds;-2/8/26 at 8:44 PM answered at 42 minutes, 46 seconds;-2/8/26 at 6:22 PM answered at 30 minutes, 14 seconds;-2/8/26 at 5:14 PM answered at 48 minutes, 49 seconds;-2/8/26 at 5:05 PM answered at 30 (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 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | minutes, 12 seconds;-2/8/26 at 3:39 PM answered at 55 minutes, 14 seconds;-2/8/26 at 3:30 PM answered at 22 minutes, 56 seconds;-2/8/26 at 3:29 PM answered at 25 minutes, 10 seconds;-2/8/26 at 1:34 PM answered at 34 minutes, 57 seconds;-2/8/26 at 1:08 PM answered at 21 minutes, 23 seconds;-2/8/26 at 11:05 AM answered at 22 minutes, 37 seconds;-2/8/26 at 11:04 AM answered at 21 minutes, 5 seconds;-2/8/26 at 8:39 AM answered at 44 minutes, 54 seconds;-2/8/26 at 8:08 AM answered at 55 minutes, 47 seconds;-2/8/26 at 8:06 AM answered at 32 minutes, 56 seconds;-2/8/26 at 8:06 AM answered at 41 minutes, 28 seconds;-2/8/26 at 8:06 AM answered at 24 minutes, 58 seconds;-2/8/26 at 7:51 AM answered at 21 minutes, 5 seconds;-2/8/26 at 7:47 AM answered at 42 minutes, 25 seconds;-2/8/26 at 7:41 AM answered at 26 minutes, 10 seconds;-2/8/26 at 7:22 AM answered at 26 minutes, 26 seconds;-2/8/26 at 7:18 AM answered at 49 minutes, 51 seconds;-2/7/26 at 7:40 PM answered at 29 minutes, 12 seconds;-2/7/26 at 1:42 PM answered at 25 minutes, 36 seconds;-2/7/26 at 1:17 PM answered at 21 minutes, 47 seconds;-2/7/26 at 8:36 AM answered at 29 minutes, 57 seconds;-2/7/26 at 7:49 AM answered at 35 minutes, 11 seconds;-2/6/26 at 10:02 PM answered at 20 minutes, 14 seconds;-2/6/26 at 9:31 PM answered at 26 minutes, 26 seconds;-2/6/26 at 9:09 PM answered at 90 minutes, 52 seconds;-2/6/26 at 7:02 PM answered at 49 minutes, 19 seconds;-2/6/26 at 4:06 PM answered at 21 minutes, 47 seconds;-2/6/26 at 2:45 PM answered at 53 minutes, 21 seconds;-2/6/26 at 2:36 PM answered at 31 minutes, 22 seconds;-2/6/26 at 2:18 PM answered at 21 minutes, 16 seconds;-2/6/26 at 11:00 AM answered at 35 minutes, 11 seconds;-2/6/26 at 9:03 AM answered at 130 minutes, 25 seconds;-2/6/26 at 8:58 AM answered at 71 minutes, 38 seconds;-2/6/26 at 8:48 AM answered at 35 minutes, 7 seconds;-2/6/26 at 8:46 AM answered at 45 minutes, 55 seconds;-2/6/26 at 8:43 AM answered at 25 minutes, 55 seconds;-2/6/26 at 8:42 AM answered at 74 minutes, 32 seconds;-2/6/26 at 8:10 AM answered at 29 minutes, 13 seconds;-2/6/26 at 8:06 AM answered at 33 minutes, 8 seconds;-2/6/26 at 8:02 AM answered at 46 minutes, 37 seconds;-2/6/26 at 7:55 AM answered at 63 minutes, 12 seconds;-2/6/26 at 7:25 AM answered at 29 minutes, 55 seconds;-2/6/26 at 7:24 AM answered at 26 minutes, 48 seconds; and-2/6/26 at 7:01 AM answered at 21 minutes, 45 seconds. D. Interview on 2/10/26 at 9:10 AM with the Administrator revealed call lights were expected to be answered within 20 minutes and after reviewing the facility Device Activity Report confirmed multiple resident call light (66 activations) response times for 2/6/26 through 2/9/26 exceeded the 20-minute expectation. |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Licensure Reference Number 175 NAC 12-006.04(D)Based on record review and interview; the facility failed to ensure 8 hours of consecutive Registered Nurse (RN) coverage in a 24-hour period 7 days per week as required. This had the potential to affect all facility residents. The facility census was 28.Findings are: A. Review of the facility policy Nursing Services, last revised 10/14/25 revealed the purpose was to provide appropriate staff for resident care and revealed the following:-the facility must have sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment;-the facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans; and -the facility would use the services of a registered nurse for at least eight consecutive hours a day, seven days a week. B. Review of the Nursing Staff Schedule for August 2025 revealed no documentation of 8 hours of RN coverage on 8/9, 8/10, 8/30, and 8/31.C. Review of the Nursing Staff Schedule for January 2026 revealed no documentation of 8 hours of RN coverage on 1/3 and 1/4.D. Interview on 2/10/26 at 10:05 AM with the Director of Nursing confirmed the facility did not have 8 hours of consecutive RN coverage on 8/9, 8/10, 8/30, and 8/31 in August 2025 and 1/3 and 1/4 in January of 2026. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>Licensure Reference Number 175 NAC 12-006.05(I)Based on record review and interview; the facility failed to implement their Quality Assessment and Performance Improvement (QAPI) plan to maintain a system to prevent repeat deficient practices including accidents, weight loss, sufficient staffing, unnecessary medications and Emergency Preparedness. This had the potential to affect all facility residents. The facility census was 28. Findings are: Review of the facility policy Quality Assurance and Performance Improvement (QAPI) dated 5/20/25 revealed the facility implemented and maintained an ongoing comprehensive data driven program to address the unique needs of those served and a full range of care and services provided.-The program was ongoing and addressed the complexity and uniqueness of the care and services provided. -The quality program measured, analyzed, and tracked quality indicators, adverse events, and other aspects of performance that enabled assessment of care, services and operations. -The Governing body provided oversight through plan implementation and evaluation. -The QAPI program utilized data to monitor the effectiveness and safety of the services and quality of care; identified and prioritized problems and process improvement opportunities and took action to address areas in need of improvement.-Problem areas were defined as areas where procedures or processes had historically produced unsatisfactory results. Review of the facility QAPI information reviewed during the survey on 2/10/26 revealed no evidence the facility was meeting at least quarterly and/or evaluating current data to ensure identified performance improvement concerns and or previously cited areas on non-compliance were being monitored or addressed. During an interview on 2/10/2026 at 10:32 AM the facility Administrator confirmed the facility had no evidence the facility QAPI team was meeting at least quarterly and the QAPI program had failed to maintain a plan to prevent repeat deficient practices including accidents, weight loss, sufficient staffing to ensure prompt response to call lights, unnecessary medications and Emergency Preparedness. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175 NAC 12-006.18 Based on observation, record review, and interview; the facility failed to prevent the potential for cross contamination as the staff failed to utilize the required Personal Protective Equipment (PPE-items such as gowns, gloves, masks, goggles, face shields, and foot coverings) when performing personal/catheter cares for Resident 7 who was on Enhanced Barrier Precautions (EBP-use of PPE to reduce the transmission of multi drug-resistant organisms (MDRO- organisms resistant to at least one or more classes of antimicrobial agents) between residents) and to ensure ongoing surveillance of infections. The total sample size was 20 and the facility census was 28.<br><br>Findings are:<br><br>A. Review of the facility policy Standard, Enhanced Barrier, and Transmission-Based Precautions with a revised date of 7/7/25 revealed the following:<br><br>-standard precautions were a group of infection prevention practices that applied to all residents in any setting in which healthcare was delivered, to prevent the spread of infection.<br><br>-standard precautions included hand hygiene, the use of PPE, respiratory hygiene/cough etiquette, cleaning, and disinfection practices, laundry handling, and safe injection practices.<br><br>-EBP expanded the use of PPE beyond situations in which exposure to blood and body fluids was anticipated and referred to the use of gloves and gown during high-contact resident care activities that provide opportunities for transfer pf multi-drug resistant organisms (MDRO- germ that is resistant to many antibiotics)<br><br>-an order for EBP would be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.<br><br>-PPE use for EBP was only necessary when performing high-contact care activities<br><br>which included dressing, transferring, providing hygiene, changing briefs or linens, toileting assistance, and wound care.<br><br>-EBP should be used for the duration of the affected residents' stay. For a resident on EBP for a wound or an indwelling medical device only, the precautions could be discontinued when the wound is resolved or the device was removed.<br><br>B. During an observation of personal/catheter care for Resident 7 on 2/9/26 at 11:19 AM the following was identified:<br><br>-an 8 inch by 10 inch laminated sign was posted on the outside of the resident's room door which indicated the resident was on EBP. On the outside of the bathroom door was an isolation caddy which contained disposable gloves/gowns and clear plastic bags. A covered trash receptacle was positioned inside of the resident's room with a sign that indicated the receptacle was for disposal of PPE.<br><br>-the resident was lying in bed with the head of the bed elevated.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Nurse Aide (NA)-I and Licensed Practical Nurse (LPN)-A entered the resident's room, performed hand hygiene, and put on clean gloves.<br><br>-NA-I, without use of a gown or goggles, placed a plastic measuring container underneath of the resident's urinary catheter drainage bag, opened the drainage tube, and emptied the urine into the container. NA-I clamped the drainage tube and took the container with urine into the bathroom and emptied into the toilet. NA-I returned to the resident's bedside, used an alcohol wipe t cleanse the drainage tube and then placed back into the holder on the side of the drainage bag.<br><br>-NA-I removed gloves, performed hand hygiene, and placed on clean gloves. Still without use of a disposable gown, NA-I and LPN-A removed the resident's disposable urinary incontinent brief after an involuntary loose stool and proceeded with the provision of incontinence/catheter cares.<br><br>-NA-I and LPN-A repositioned the resident from side to side, cleansed the resident's groin, and perineal area which including the foley catheter insertion site. NA-I removed gloves, performed hand hygiene, and then put on new gloves. The resident was positioned onto right side and NA-I provided hygiene to the resident's buttocks which were covered with feces. Staff removed soiled gloves, performed hand hygiene, and positioned the sling for the full lift underneath the resident.<br><br>-11:32 AM NA-I exited the resident's room and then re-entered with the lift. NA-I placed on clean gloves but did not utilize a disposable gown.<br><br>-the resident had complaints of nausea from staff turning the resident from side to side. LPN-A opened the room door and walked into the corridor and then re-entered the room with an emesis basin. LPN-A placed on clean gloves but did not put on a gown. Resident 7 indicated the resident no longer wanted to get up as the resident was still having nausea and discomfort.<br><br>-11:42 AM LPN-A removed gloves and performed hand hygiene, then again exited the room to get a clean soaker pad for the resident. LPN-A re-entered the room and assisted NA-I to position the resident for comfort, placed a clean incontinence brief on the resident and covered the resident with bed linens. NA-I and LPN-A removed gloves, washed hands, and left the resident's room.<br><br>During an interview on 2/10/26 at 7:44 AM, the Director of Nursing (DON) confirmed due to use of an indwelling urinary catheter the resident was on EBP. When staff provided the resident with any kind of direct cares such as dressing, repositioning, incontinence care or catheter cares, the staff were to wear a gown and gloves. In addition, the DON confirmed the resident had an isolation caddy on the outside of the bathroom door which held PPE supplies, a receptacle next to the exit door to dispose of used PPE and a sign on the outside of the resident's room which indicated the resident was on EBP.<br><br>During an interview with Resident 7 on 2/10/26 at 9:42 AM, the resident verified the staff were supposed to wear gowns/gloves when providing the resident cares as the resident was on EBP. The staff do forget to use the PPE on occasion, and the resident will have to remind them before they utilize.<br><br>C. Review of the facility policy Surveillance, last revised 9/30/25 revealed the purpose was to systematically identify, track, and control infectious diseases and healthcare-associated infections (HAIs) to protect residents, employees, and visitors. The policy revealed the following:<br><br>-infection surveillance was an ongoing, systematic collection, analysis, interpretation, and<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | dissemination of data to detect and monitor infectious diseases, identify outbreaks, evaluate the effectiveness of prevention efforts, and implement interventions to control the spread of infections;<br><br>-a two-tiered approach may be utilized to provide a comprehensive strategy for preventing the spread of infection and included: Process Surveillance was the review of practices by employees directly related to resident care to identify whether employees complied with infection prevention and control procedures, and Outcome Surveillance was the review of resident data to identify and report evidence of a suspected/confirmed HAI or communicable disease using standardized definitions of infections; and<br><br>-the Infection Preventionist (IP) would complete ongoing infection surveillance activities selected by the location.<br><br>The process of infection surveillance may include:<br><br>-selection of process and outcome surveillance events based on the resident population and healthcare setting;<br><br>-utilize standardized definitions of infections to ensure accurate and valid comparisons of surveillance data;<br><br>-utilize a data collection tool to collect surveillance data for process and outcome surveillance events (sources included the medical record, laboratory results and employee interviews);<br><br>-analyze surveillance data to identify patterns or trends, evaluate for potential causes of infections, and identify areas for improvement; and<br><br>-report infection surveillance findings to the interdisciplinary team and develop corrective action as needed.<br><br>D. Review of the facility infection surveillance on 2/10/26 revealed no evidence that infections and antibiotic use had been tracked for January and February 2026.<br><br>E. Interview on 2/10/26 at 11:55 AM with the IP confirmed the facility did not have evidence of ongoing infection surveillance for January and February of 2026. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(D)(E)Based on record review and interviews; the facility failed to obtain informed consent for the use of psychotropic medications and/or information for alternate treatment options for Residents 3, 6, 24, and 30. The sample size was 5 and the facility census was 28.<br><br>Findings are:<br><br>A. Review of the facility policy Psychotropic Medications with a revision date of 12/9/25 revealed the following: -The purpose was to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate unnecessary medications. - A consent form must be signed for the use of psychotropic medications. - If a resident was admitted on psychotropic medications or returned from the hospital on new psychotropic medications, the reduction committee was informed, the family/legal representative and resident were notified, Permission for Use of Psychotropic Medications form was to be completed, and the family/representative and/or resident were informed of the risks and benefits of the medication. -With a change of psychotropic medication, the Permission for Use of Psychotropic Medications was to be completed.<br><br>B. Review of Resident 3's Medication Administration Record (MAR) dated February 2026 revealed the resident was taking the psychotropic medication Celexa (antidepressant) 10 milligrams (mg) daily with a start date of 7/15/22.<br><br>Review of Resident 3's Care Plan with a revision date of 12/3/25 revealed the resident had quadriplegia secondary to a spinal cord syndrome following a fall on the ice. In addition, the resident had a mood disorder for which Celexa was being taken and the facility monitored for adverse effects.<br><br>Review of Resident 3's Electronic Medical Record (EMR) revealed no evidence the resident and/or the resident's representative were informed of the benefits, risks, potential side effects or alternative treatments of the medication Celexa.<br><br>During an interview on 2/10/26 at 11:41 AM the Director of Nursing (DON) confirmed the facility did not obtain the required informed consent or provide the resident/representative alternative treatment options for Resident 3's antidepressant medication Celexa.<br><br>C. Review of Resident 24's MAR dated February 2026 revealed the resident had orders for the psychotropic medication Lorazepam (antianxiety) 0.5 mg's every 4 hours as needed with a start date of 2/2/25. Review of Resident 24's had an anxiety disorder, had impaired cognition including delirium and hallucinations. The resident had a diagnosis of vascular dementia. The resident was to be monitored for the side effects of psychotropic medication use.<br><br>Review of Resident 24's Electronic Medical Record (EMR) revealed no evidence the resident and/or the resident's representative were informed of the benefits, risks, potential side effects or alternative treatments to the antianxiety medication Lorazepam.<br><br>During an interview on 2/10/26 at 11:41 AM the Director of Nursing (DON) confirmed the facility did not obtain the required informed consent or provide the resident/representative alternative treatment options for Resident 3's antianxiety medication Lorazepam.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | D. Review of Resident 30's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 1/14/26 revealed the resident was admitted on [DATE] with a diagnoses of Non-Alzheimer Dementia, Anxiety and Depression; had severe cognitive impairment; required substantial assistance with dressing, transfers and bed mobility; was dependent on staff for toileting hygiene; and received an antipsychotic medication.<br><br>Review of Resident 30's Care Plan with a revision date of 1/26/26 revealed the resident required extensive assist with dressing, transfers, bed mobility, was dependent on staff for toileting and received Seroquel (an antipsychotic medication) for a diagnosis of Dementia with Agitation.<br><br>Review of Resident 30's January 2026 MAR revealed the resident received Seroquel 25 mg one time daily for a diagnosis of Dementia with Behaviors with a start date of 1/8/26 and a stop date of 1/16/25. On 1/16/26 Seroquel was increased to 25 mg two times daily for a diagnosis of Dementia with Behaviors.<br><br>Review of Resident 30's Permission for use of Psychotropic Medications revealed no documentation of consent for the Seroquel increase on 1/16/26 had been obtained prior to administration or alternative treatments of the medication Seroquel.<br><br>Interview on 2/9/26 with Registered Nurse (RN)-O confirmed that the facility did not obtain the required informed consent or provide the resident/representative alternative treatment options for Resident 30's antipsychotic medication Seroquel.<br><br>E. Review of Resident 6's MAR dated February 2026 revealed the resident was taking the antipsychotic Seroquel (medication used to treat schizophrenia, bipolar disorder, and major depressive disorder) 25 mgs to be taken at bedtime for diagnosis of major depressive disorder.<br><br>Review of Resident 6's Care Plan with a revision date of 7/25/25 revealed the resident had diagnosis of anxiety, major depressive disorder, and agitation with an order for Seroquel and the facility monitored for potential side effects of the antipsychotic medication.<br><br>Review of Resident 6's EMR revealed no evidence the resident and/or the resident's representative were informed of the benefits, risks, potential side effects, or alternative treatments of the Seroquel.<br><br>During an interview on 2/9/26 at 2:22 PM the DON confirmed the facility had no documentation to indicate the required informed consent was received from the resident's representative or that the representative was provided information regarding alternative treatment options for Resident 6's antipsychotic medication Seroquel. |

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| | 285177 | A. Building<br>B. Wing | 02/10/2026 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Licensure Reference Number 175 NAC 12-006.05(S) Based on observations, record review, and interviews; the failed to ensure Resident 7 was treated with respect and dignity during the provision of personal cares. The sample size was 1 and the facility census was 28.Findings are: A. Review of the Resident's Rights for Skilled Nursing Facilities (undated) policy revealed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. B. During an observation of personal/catheter care for Resident 7 on 2/9/26 from 11:19 AM to 11:42 AM, the following was identified:-the resident was lying in bed with the head of the bed elevated. The resident's bed was positioned directly next to a large picture window and the curtains had been left open. No shades or blinds were in place to the window. In addition, there was no privacy curtain in the semiprivate room.-Nurse Aide (NA)-I and Licensed Practical Nurse (LPN)-A entered the resident's room, performed hand hygiene, and put on clean gloves. NA-I removed Resident 7's bed linens and gathered the resident's gown underneath the resident's breast. The resident was involuntary of stool and NA-I and LPN-A removed the resident's disposable urinary incontinent brief and proceeded with the provision of incontinence/catheter cares. The resident's torso and lower extremities were exposed and the window next to the resident's bed remained open and the resident was visible to anyone walking outside by the resident's room.-NA-I and LPN-A repositioned the resident from side to side, cleansed the resident's groin, and perineal area which included the indwelling catheter insertion site. Staff positioned the sling for the full lift underneath the resident. -11:32 AM NA-I exited the resident's room to retrieve the full lift. Staff failed to drape the resident and the resident remained exposed as staff opened the door and the resident was visible to any staff, visitors, or other residents in the corridor.-11:34 AM NA-I opened the room door again while the resident remained exposed and entered the room with the lift.-the resident had complaints of nausea from staff turning the resident from side to side. LPN-A opened the room door and walked into the corridor and then re-entered the room with an emesis basin. The resident continued to have torso and lower extremities uncovered. Resident 7 indicated the resident no longer wanted to get up as the resident was still having nausea and discomfort.-11:42 AM LPN-A exited the room to get a clean soaker pad for the resident. The resident remained uncovered with lower body and torso visible to anyone in the corridor outside the resident's room. LPN-A re-entered the room and assisted NA-I to position the resident for comfort, placed a clean incontinence brief on the resident and covered the resident with bed linens. During an interview on 2/10/26 at 7:44 AM, the Director of Nursing (DON) indicated the staff should always pull the curtains closed or if available should close blinds or shades to the residents' windows when providing cares for the resident. In addition, the staff should not open a resident's room door if the resident is exposed. The resident should always be covered or else the privacy curtain and window curtains were to be closed to prevent exposing the resident. During an interview on 2/10/26 at 9:42 AM, the resident indicated it upset the resident when the staff left the curtains open during cares. The resident stated this did not happen all the time but it did happen occasionally. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Licensure Reference Number 175 NAC 12-006.05(G) Based on record review and interview; the facility failed to ensure Resident's 6's medication regimen was free from unnecessary medications due to failure to monitor for potential side effects of a psychotropic medication. The sample size was 5 and the facility census was 28.Findings are: A. Review of the facility policy Psychotropic Medications with a reviewed/revised date of 12/9/25 revealed the purpose of the policy was to evaluate behavior interventions and alternatives before using psychotropic medications and to eliminate the use of unnecessary medications. Each resident had the right to be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical signs and symptoms. Each resident's drug regimen was to be free from unnecessary drugs. An unnecessary drug was any drug when used:-in excessive dose including duplicative drug therapy.-for excessive duration.-without adequate monitoring.If the Primary Care Provider (PCP) prescribed an antipsychotic for the resident. a Registered Nurse (RN) was to complete an Abnormal Involuntary Movement Scale (AIMS). Throughout the administration of psychotropic medications, the facility was to monitor potential side effects, or if a side effect occurred, worsening of the side effect. The AIMs assessment was to be completed every 6 months. If there was a change in the assessment, the PCP, and the family/legal representative must be notified and documented in the medical record. B. Review of Resident 6's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 11/26/25 revealed the resident was admitted with diagnoses of non-traumatic brain dysfunction, diabetes, Alzheimer's disease, Non-Alzheimer's dementia, anxiety, and depression. The following was assessed regarding the resident:-impaired cognition.-no behaviors or mood indicators.-required substantial to maximal assistance with dressing, personal hygiene, bed mobility, and transfers.-condition or a chronic disease that may result in a life expectancy of less than 6 months.-use of antipsychotic, antidepressant, antianxiety and opioid medication. Review of Resident 6's Nursing Progress Notes revealed the following:-7/25/25 at 4:13 PM the resident refused to let the staff obtain a blood pressure reading and yelled, it hurts, it hurts.-7/27/25 at 9:42 PM the resident was seated in the lobby area sleeping. When staff attempted to awaken for bed the resident swatted at staff.-7/29/25 at 8:41 AM the resident spit out medications.-7/29/25 at 8:31 PM the resident slapped the staff when the staff attempted to prepare the resident for bed.-8/3/25 at 7:31 PM the resident spit out medications with 3 attempts to administer.-8/7/25 at 8:46 PM the resident's Primary Care Physician (PCP) was at the facility and ordered Seroquel (antipsychotic medication used to treat schizophrenia, bipolar disorders, and major depressive disorder) 25 milligrams 1 daily before bedtime. Review of the resident's Electronic Medical Record (EMR) revealed no evidence that the facility staff had completed an AIMs assessment prior to administering the Seroquel 25 mg daily. Review of a Recommendations for Nursing Staff Only form dated 9/5/25 revealed the Consultant Pharmacist (CP) had identified antipsychotic medications had the capacity to cause tardive dyskinesia (involuntary movement disorder caused by use of antipsychotic medications) and other movement disorders. The CP made a recommendation to complete an AIMS test now and every 6 months to monitor for potential side effects of the medication. Review of a Recommendations for Nursing Staff Only form dated 10/7/25 revealed a second recommendation for the facility to complete the AIMs assessment due to continued use of the Seroquel. Review of the resident's EMR revealed an AIMs Assessment was completed 11/4/25 (2 months after the recommendation by the CP) at 3:52 PM. During an interview with the Director of Nursing (DON) on 2/9/26 at 2:22 PM, the DON confirmed the resident was started on Seroquel 25 mg daily on 8/9/25. Staff failed to complete an AIMs assessment when the medications was first initiated. The CP made recommendations on 9/5/25 and on 10/7/25 to complete the assessment to monitor for potential side effects of the medication but an assessment was not completed until 11/4/25, 3 months after the medications was started and 2 months after the CP first recommended completion. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Licensure reference: 175 NAC 12-006.02(H)Based on record review and interview: the facility failed to report an allegation of potential staff to resident abuse and to send the results of an investigation to the State Agency within the required timeframes for Resident 7. The sample size was 2 and the facility census was 28. Findings are:A. Review of the facility Abuse and Neglect policy with a revision date of 4/7/25 revealed the purpose of the policy was to:-ensure the staff were knowledgeable regarding the reporting and investigative process of abuse and neglect allegations. -ensure the location had an effective system in place that, regardless of the source, prevented mistreatment, neglect, exploitation and misappropriation of their property. -ensure residents were not subjected to abuse by anyone including but not limited to employees, other residents, consultants, volunteers, employees of other agencies, family members or legal guardians, friends, or other individuals. -ensure all identified events of alleged or suspected abuse/neglect including injuries of unknown origin were promptly reported and investigated.-ensure a complete review by the investigation team to identify events, such as suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse to determine the direction of the investigation. Alleged or suspected violations involving any mistreatment, neglect, exploitation, or abuse, including injuries of unknown origin, were to be reported immediately to the administrator or designee with the following actions taken:-intervene in any situation to protect the residents. -remove any individual from the location if necessary for the protection of residents or employees including but not limited to employees, visitors, contractors, or family members.-call local law enforcement or assistance with interventions necessary for the protection of residents or employees. -an investigation was completed and the results of all investigations were to be reported to the Administrator and to other officials in accordance with state law, including the state survey and certification agency within 5 working days of the event. B. Review of Resident 7 's Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 10/29/25 revealed the resident was admitted with diagnoses of traumatic brain injury, high blood pressure, diabetes, depression, and anxiety. The following was assessed regarding the resident:-cognitively intact.-required extensive to total staff assistance with bed mobility, transfers, dressing, toilet use and personal hygiene.-always incontinent of bowel and had an indwelling urinary catheter.-almost constant pain rated at an 8 out of 10 which limited day to day activities. Review of a facility Grievance dated 8/15/25 (no time) revealed the resident had a concern regarding Nurse Aide (NA)-I. Resident 7 had requested assistance as the resident was involuntary of bowel. Initially NA-I had refused to provide the resident assistance with cares. NA-I did relent and provided assist but was very rough with the resident's catheter and was short tempered. The resident indicated the staff member slammed things around and staff did not clean the resident or do cares very well. When the resident had asked NA-I not to empty the urinary catheter drainage bag into the resident's handwashing sink, the staff had asked the resident what are you going to do about it. The resident had stated the resident did not want NA-I in the resident's room anymore. Review of facility investigations of potential abuse/neglect from 1/15/25 through 2/5/26 revealed no evidence Resident 7's allegations of NA-I treating the resident roughly and speaking to the resident rudely was reported to the State Agency. The facility did do an investigation of the resident's allegation and NA-I was directed not to provide care assistance to Resident 7. There was no evidence the investigation was then submitted to the State Agency within the required timeframe. During an interview on 2/10/26 at 9:46 AM, the Social Service Director (SSD) confirmed the grievance by Resident 7 on 8/15/25 was not reported and even though an investigation was completed, the results of the investigation were never submitted to the State Agency. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(A)Based on record review and interview; the facility failed to notify the Ombudsman of facility discharges for Residents 1 and 34. The sample size was 2 and the facility census was 28. Findings are: A. Review of the facility policy Discharge and Transfer dated 1/15/26 revealed the facility ensured discharges and/or transfers were documented in the medical record and appropriate information was communicated to the receiving health care provider. The facility allowed each resident to remain in the facility unless discharge or transfer was necessary for the resident's welfare and/or the resident's needs could not be met, and the discharge was appropriate. The facility provided sufficient preparation and orientation to residents to ensure safety and orderly transfer or discharge. With a transfer or discharge the facility sent a copy of an approved discharge form to the office of the State Long-Term Care Ombudsman. B. Review of Resident 1's Electronic Medical Record (EMR) revealed the resident was admitted to the facility on [DATE] and discharged on 1/31/26. There was no evidence the facility notified the State Ombudsman of the resident discharge. C. Review of Resident 34's EMR revealed the resident was admitted to the facility on [DATE] and discharged on 12/7/25. There was no evidence the facility notified the State Ombudsman of the resident discharge. D. During an interview on 2/9/26 at 4:07 PM the facility Administrator confirmed the facility had no evidence of Ombudsman notifications of facility discharges for Residents 1 or 34. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on interview and record review; the facility failed to address Resident 28's nutritional status and risk for weight loss on the resident's comprehensive plan of care and failed to involve Resident 12's legal guardian in the development of the resident's care plan. The total sample size was 20 and the facility census was 28.<br><br>Findings are:<br><br>A. Review of the Care Plan Policy with a revised/reviewed date of 12/1/25 revealed the purpose of the policy was to develop a comprehensive care plan using an interdisciplinary approach. A comprehensive care plan was to include measurable objectives, and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Each resident was to have an individualized person-centered, comprehensive plan of care that included measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, emotional, psychosocial, and educational needs. Any problems, needs, and concerns identified were to be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI- a comprehensive, standardized, and mandatory system used in skilled nursing facilities to evaluate the functional, medical, and psychosocial status of residents) and review of physician orders. A baseline care plan was to be developed on admission according to federal and state regulations. The facility must provide the resident and the resident representative with a written summary of the baseline care plan and document the meeting with the resident and the representative and any significant discussion that occurred. The care plan was to be modified to reflect the care currently required/provided for the resident. The resident, family and/or the legal representative were to have the opportunity to participate in the planning of their care to the extent practicable.<br><br>B. Review of Resident 28's Minimum Data Set (MDS, federally mandated comprehensive assessment tool used to develop resident care plans) dated 10/22/25 revealed diagnoses of diabetes, cancer, end stage renal disease, parastomal hernia with obstruction (incisional hernia that allows protrusion of abdominal contents through the abdominal wall/ostomy), anxiety, bipolar disorder, and depression. Further review of the assessment revealed the resident's cognition was intact, the resident required setup assistance and supervision with eating/drinking, did not have a condition or a chronic disease that could result in a life expectancy of less than 6 months and the resident's weight was 142 pounds (lbs.). The resident had a weight loss of 5 percent (%) in the last month or loss of 10% or more in the last 6 months.<br><br>Review of a Mini-Nutritional assessment dated [DATE] at 9:57 AM revealed the resident's score was a 6.0 indicating the resident was malnourished. Further review revealed the resident had a decline in food/fluid intakes, had a weight loss greater than 7 lbs. in the last 3 months and the resident had severe dementia or depression.<br><br>Review of Resident 28's comprehensive care plan with a revision date of 11/3/25 revealed the resident had impaired cognitive function and/or thought process with confusion and memory loss related to anxiety, bipolar and schizophrenic disorders. The resident had been diagnosed with breast cancer with secondary cancer to the bone. The resident was independent with eating but required verbal cues to ensure adequate intakes.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a Mini-Nutritional assessment dated [DATE] at 10:57 AM revealed the resident remained at risk for malnutrition.<br><br>Review of a Nutritional Progress Note by the Registered Dietician (RD) dated 1/27/26 at 1:54 PM revealed the resident's weight on 1/16/26 was 131 lbs., indicating a severe weight loss of 12% in 180 days as weight on 7/22/25 was 149 lbs. The resident was identified as receiving nutritional supplement of choice due to weight concerns. The RD made a recommendation to discontinue the current nutritional supplement and to start Med Pass 2.0 120 cubic centimeters (cc) to provide more calories and protein to the resident.<br><br>Further review of Resident 28's care plan revealed no evidence the facility had addressed the resident's risk for altered nutrition and the resident's current weight loss interventions.<br><br>During an interview on 2/10/26 at 7:58 AM, the Director of Nursing (DON) confirmed Resident 28's current care plan did not address the resident's nutritional status and did not identify any interventions developed/implemented for the resident's weight loss.<br><br>C. Review of Resident 12's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 1/14/26 revealed the resident was admitted on [DATE] with a diagnoses of Congestive Heart Failure (CHF), and Stroke; was cognitively intact; hearing was highly impaired, resident had no speech; was independent with dressing, toileting cares, transfers/ambulation, bed-mobility; hospice care; and received an antidepressant medication.<br><br>Review of Resident 12's Care Plan revealed the resident was cognitively intact; diagnosis of CHF and stroke; was independent with dressing, toileting cares, transfers/ambulation, bed mobility; received hospice care; and received an antidepressant medication. The resident had a communication problem related to deafness evidenced by unable to hear, used sign language, read lips, used gestures and white board to communicate. Review of facility form Care Plan Review Log revealed that Resident 30's Care Plan was reviewed on 1/9/26.<br><br>An interview on 2/5/26 at 1:19 PM with Resident 12's Legal Guardian/Sister revealed that family had not been invited to a Care Plan meeting for over a year.<br><br>An interview on 2/9/25 at 4:45 PM with Social Services Director confirmed that there was not any facility documentation to confirm that the Legal Guardian/Sister had been invited to Resident 12's Care Plan meetings or who attended the resident's Care Plan meetings when the meetings occurred. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l)(i)(3) Based on record review and interview; the facility failed to revise current fall interventions and/or develop new interventions to prevent ongoing falls for Resident 6. The sample size was 6 and the facility census was 28.Findings are: A. Review of the Fall Prevention and Management policy with revised/reviewed date of 10/14/25 revealed the purpose of the policy was to promote resident well- being by developing and implementing a fall prevention and management program, identifying risk factors, and implementing interventions before a fall occurs. If a resident fall occurs, the following procedure was identified:-assess the resident and perform a full body examination.-notify the Primary Care Physician (PCP) and the resident's representative.-complete a Fall Scene Huddle Worksheet to determine causal factors and fall interventions.-document the incident in the Safe Event-Incident Report. B. Review of Resident 6's Minimum Data Set (MDS: a federally mandated comprehensive assessment tool used for care planning) dated 11/26/25 revealed the resident had diagnosis of non-traumatic brain dysfunction, diabetes, Alzheimer's disease, Non-Alzheimer's dementia, anxiety, and depression. The resident's cognition was impaired and the resident required substantial to maximal assistance with personal hygiene, toileting hygiene, dressing, bed mobility, and transfers. The resident used bed/chair alarms daily. Review of a Safe Event-Incident Report dated 10/22/25 at 6:30 AM revealed the resident was found on the floor of the resident's room. Review of a Fall Huddle Worksheet dated 10/22/25 revealed the resident was barefoot at the time of the fall. New intervention was developed for the resident to always wear gripper socks. Review of a Safe Event-Incident Report dated 11/19/25 at 11:30 AM revealed the staff heard the resident's fall alarm and the resident was found on the floor of the resident's room. Review of a Fall Huddle Worksheet dated 11/19/25 revealed the resident had self-transferred, lost balance, and fell. The resident was wearing gripper socks; the fall alarm was in place and functional; and the resident's assistive devices were in reach. Further review revealed no new fall interventions were developed and current interventions were not revised. Review of a Safe Event-Incident Report dated 11/30/25 at 7:15 PM revealed the staff heard a muffled fall alarm sounding and when the resident was checked, the resident was on the floor. Review of a Fall Huddle Worksheet dated 11/30/25 revealed the staff had assisted the resident from the dining room to the resident's room after the evening meal. Staff received education to assist the resident to the bathroom immediately after meals. Review of a Safe Event-Incident Report dated 12/9/25 at 12:30 PM revealed the resident was found on the floor and facing the recliner with the floor mat moved out of reach. The resident indicated a need to use the bathroom. Review of a Fall Huddle Worksheet dated 12/9/25 revealed the staff received re-education on making sure the residents' fall alarms were in place and functional. There was no evidence which staff received the education and how the information was provided to the remainder of the staff. Review of a Safe Event-Incident Report dated 12/13/25 at 11:30 AM revealed the resident was found on the floor outside of the bathroom and the resident indicated a need to use the bathroom. Review of a Fall Huddle Worksheet dated 12/13/25 revealed the resident's chair alarm was not underneath the resident and had not been plugged in. Further review revealed no new fall interventions were developed and current interventions were not revised. Review of a Safe Event-Incident Report dated 12/18/25 at 2:30 PM revealed the resident was found lying on the bathroom floor of the resident's room. The resident had removed the chair alarm from the wheelchair and then used the wheelchair to transfer into the bathroom. Review of a Fall Huddle Worksheet dated 12/18/25 revealed the resident had been toileted 30 minutes prior but was now incontinent of bowel and bladder. No additional fall interventions were identified to prevent further falls. Review of a Safe Event-Incident Report dated 2/8/26 at 4:15 PM revealed the resident was found on the floor of the resident's room. Review of a Fall Huddle Worksheet dated 2/8/26 revealed the facility had the family bring in new slippers as current slippers had no tread and<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | increased the resident's risk for falls. During an interview on 2/9/26 at 1:41 PM with the Director of Nursing (DON) and the Registered Nurse Consultant verified the following regarding the residents' falls: -10/22/25 at 6:30 AM a new intervention was developed to make sure the resident was always wearing gripper socks or slippers.-11/19/25 at 11:30 AM the fall investigation revealed the resident's alarm was working at time of the fall, the walker was in place and the resident was wearing gripper socks. No new fall interventions were listed. -11/30/25 at 7:15 PM a new intervention was identified to assist the resident to the bathroom before and after meals. -12/9/25 at 12:30 PM the staff received re-education to make sure the residents' fall alarms were in place and functional. No evidence who received this re-education and how all the staff were re-educated.-12/13/25 at 11:30 AM review of the investigation revealed the resident's fall alarm had not been placed under the resident and was not plugged into the sensor box. No new interventions were developed and current interventions were not revised. -12/18/25 at 2:30 PM discussed the resident's toileting schedule with the staff but no documentation if any new interventions.-2/8/26 at 4:15 PM family brought new slippers in for the resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285177 | A. Building<br>B. Wing | 02/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Good Samaritan Society - Atkinson | 409 Neely Street<br>Atkinson, NE 68713 |

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

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(J)(i)(1)Based on record review and interview; the facility failed to implement nutritional interventions to address a weight loss for 1 (Resident 28) of 2 sampled residents. The facility census was 28.Findings are:A. Review of the Weight and Height Policy with a reviewed/revised date of 9/30/25 revealed the purpose of the policy was to ensure residents maintained an acceptable parameter of nutritional status, accurately measure weights and monitored weight loss or gain in residents. The facility was to inform the resident, the resident's representative, the Primary Care Physician (PCP), and the Registered Dietician (RD) when there was a significant change in the resident's weight. The policy further indicated if a weight varied by more than 3 percent (%) staff were to reweigh the resident. B. Review of Resident 28's Minimum Data Set (MDS, federally mandated comprehensive assessment tool used to develop resident care plans) dated 10/22/25 revealed diagnoses of diabetes, cancer, end stage renal disease, parastomal hernia with obstruction (incisional hernia that allows protrusion of abdominal contents through the abdominal wall/ostomy), anxiety, bipolar disorder, and depression. Further review of the assessment revealed the resident's cognition was intact, the resident required setup assistance and supervision with eating/drinking, did not have a condition or a chronic disease that could result in a life expectancy of less than 6 months and the resident's weight was 142 pounds (lbs.). The resident had a weight loss of 5 percent (%) in the last month or loss of 10% or more in the last 6 months. Review of Resident 28's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed the following weights:-7/22/25 149 lbs.-8/21/25 144 lbs.-9/30/25 142 lbs. Review of a Mini-Nutritional assessment dated [DATE] at 9:57 AM revealed the resident's score was a 6.0 indicating the resident was malnourished. Further review revealed the resident had a decline in food/fluid intakes, had a weight loss greater than 7 lbs. in the last 3 months and the resident had severe dementia or depression.Review of Weights and Vitals Summary Sheet revealed the resident's weight on 10/25/25 was 133 lbs.Review of a Nutritional Status Dietician assessment dated [DATE] at 11:19 AM revealed the resident was at risk for malnutrition. The resident had a recent hospitalization for small bowel obstruction and had a history of breast cancer with metastasis to the bone. Due to these diagnosis the residents' intakes varied. To continue to provide the resident supplement of choice 120 cubic centimeters (cc) twice a day.Review of Weights and Vitals Summary Sheet revealed the following weights for Resident 28:-11/23/25 131 lbs.-12/26/25 131 lbs. Review of a Mini-Nutritional assessment dated [DATE] at 10:57 AM revealed the resident remained at risk for malnutrition. Review of a Nutritional Progress Note by the Registered Dietician (RD) dated 1/27/26 at 1:54 PM revealed the resident's weight on 1/16/26 was 131 lbs., indicating a severe weight loss of 12% in 180 days as weight on 7/22/25 was 149 lbs. The resident was identified as receiving nutritional supplement of choice due to weight concerns. The RD made a recommendation to discontinue the current nutritional supplement and to start Med Pass 2.0, 120 cc to provide more calories and protein to the resident. Review of a Facsimile (fax) Communication to the Physician form dated 1/27/26 revealed the resident's PCP was notified of the resident's weight and per the RD's recommendation a request was made to discontinue the supplement of choice and to start Med Pass 2.0, 120 cc twice a day. Further review of the form revealed the PCP failed to address the RD's request to change the nutritional supplement to prevent further weight loss for the resident. Review of Weights and Vitals Summary Sheet revealed the following weights for Resident 28:-2/3/26 121 lbs.-2/10/26 123 lbs. During an interview on 2/10/26 at 7:58 PM, the Director of Nursing (DON) confirmed the following regarding Resident 28's weight loss:-the resident has had ongoing weight loss. -the resident has received treatment for cancer and when taking these medications, will have a decline in intakes.-concerns with the scales at the facility and having to get scales fixed/calibrated as do not feel all the resident's weights have been correct.-the resident has been receiving a<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | nutritional supplement but on 1/27/26 the RD made a recommendation to change the supplement to one with additional calories and protein. The PCP was notified of the residents' weight loss and the RD's recommendations but the PCP had failed to address the RD's recommendations. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Licensure Reference Number 175 NAC 12-006Based on record review and interview; the facility failed to ensure the daily staff posting had the required information. This had the potential to affect all facility residents. The facility census was 28.Findings are: Review of the facility policy Nursing Staff Daily Posting, last revised 12/1/25 revealed the purpose was to post the location's daily staff according to federal Centers for Medicare and Medicaid Services (CMS) staff posting requirements and revealed the following:-the facility would post daily the staffing and resident census at the beginning of each shift and update as appropriate (for each shift) and it would include the following information- location name, current date, resident census, total number and actual number of hours worked by categories of registered nurses, licensed nurses, certified nursing assistants and certified medication assistants;-this information must be prominently displayed in a clear and readable format where residents, staff members, and the public may view; and-records must be kept for 18 months or as required by state law, whichever is greater. Review of the facility form Daily Nursing Staffing for January 1 through 31, 2026 and February 1 through 9, 2026 revealed no documentation that the facility census was included on the forms. Interview on 2/9/26 at 5:10 PM with the Director of Nursing confirmed the staff daily posting did not contain the census which was required. |