

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285190	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/03/2026
NAME OF PROVIDER OR SUPPLIER Alpine Village Retirement Center		STREET ADDRESS, CITY, STATE, ZIP CODE 706 James Street Verdigre, NE 68783	
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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E)Based on record review and interview; the facility failed to present the resident/resident representative with a nonpharmacological treatment option along with the consent for the use of psychotropic medications (medications that alter consciousness, mood and thoughts) for 4 (Resident's 1, 4, 21 and 25) of 5 sampled residents. The facility census was 24.Findings are: A. Review of the facility policy Psychotropic Medication Use Policy last revised 2/15/24 revealed the facility would utilize the least amount of psychotropic medications while still maintaining a safe environment and showed the following: -each resident would have a proper diagnosis; -the pharmacy would routinely monitor and request dose reductions; -the facility would utilize the lowest effective dose; -residents would have interventions in their care plans to assist in re-directing undesired mood and behaviors; -resident/resident representative would be educated on the medications, diagnosis, dose changes and side effects; and -consent forms would be completed with new orders for psychotropic medications and any increase in psychoactive medications. B. Review of the facility policy Antipsychotic Medication Use with a revision date of 7/28/26 revealed the facility only used antipsychotic medications when it was necessary to treat a specific condition. The facility completed consent forms for all new antipsychotic medication orders and with any dose increases. C. Review of the facility policy Residents Rights undated revealed the resident and/or resident representative had the right to be fully informed of their medical condition, to participate in person-centered care and the right to refuse and/or discontinue medications and treatments, and to formulate advanced directives. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Review of Resident 4's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 6/10/26 revealed the resident was admitted [DATE]; was cognitively intact; was independent with dressing, eating, transfers and hygiene; the resident did not exhibit any behaviors; had diagnoses of diabetes, stroke, anxiety, depression, and post-traumatic stress disorder (PTSD); and the resident received antipsychotic, antianxiety and antidepressant medications. Review of Resident 4's Medication Review Report with active medications as of 7/30/26 revealed the resident received the following medications: -ariprazole (an antipsychotic) 20 milligrams (mg) at bedtime for PTSD; -buspirone (an antianxiety) 30 mg twice daily for anxiety; -fluoxetine (an antidepressant) 40 mg daily for depression; and -trazodone (an antidepressant) 75 mg at bedtime for depression. Review of Resident 4's facility forms Psychoactive Medication Therapy Informed Consent Form revealed the following consents: -on 6/9/25 consent for aripirazole was obtained; -on 6/9/25 consent for trazodone was obtained; -on 9/30/25 consent for buspirone was obtained; and -on 5/11/26 consent for fluoxetine was obtained. There was no evidence that the facility documented and offered alternative nonpharmacological treatment intervention options. E. Review of Resident 25's MDS dated [DATE] revealed the resident was admitted [DATE]; had severe cognitive impairment; required staff assistance with dressing, toileting, transfers, and hygiene; had severe cognitive impairment; the resident did not exhibit behaviors; had diagnoses of dementia, anxiety, and depression; and received antidepressant medications. Review of Resident 25's Medication Review Report with active medications as of 7/30/26 revealed the resident received the following medications: -bupropion (an antidepressant) 75 mg twice daily for anxiety and depression; and -venlafaxine (an antidepressant) 150 mg daily for depression. Review of Resident 25's facility forms Psychoactive Medication Therapy Informed Consent Form revealed the following consents: (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 2/18/25 consent for bupropion was obtained; and -on 2/18/25 consent for venlafaxine was obtained. There was no evidence that the facility documented and offered alternative nonpharmacological treatment intervention options. Interview on 7/30/26 with the Director of Nursing (DON) at 2:00 PM confirmed Resident 4 was receiving antipsychotic, antianxiety and antidepressant medications; and Resident 25 was receiving antidepressant medications. Further interview confirmed the facility did not have evidence that alternative nonpharmacological treatment interventions were offered to the resident/resident representative. F. Review of Resident 21's MDS dated [DATE] revealed the resident had severe cognitive impairment, delusions, and other behaviors 1-3 days weekly. The resident had diagnoses of dementia, anxiety and depression. The resident used devices including a bed alarm (notifies staff of attempts to get out of bed unassisted) and wander alarm (lets staff know if the resident attempts to exit the facility). Medications taken were antipsychotic, antianxiety, and antidepressant medications. Review of Resident 21's Medication Administration Record dated July 2026 revealed the following psychotropic medications. -mirtazapine (Remeron) 7.5 mg daily at bedtime dated 1/24/25.-citalopram (Celexa) 20 mg 1 tab daily at bedtime dated 11/12/25. -quetiapine (Seroquel) 25 mg 1/2 tab daily at 12:00 PM dated 3/4/26.-lorazepam (Ativan) 0.5 mg daily at noon dated 3/24/26.-lorazepam (Ativan) 0.5 mg every 4 hours as needed for anxiety and restlessness dated 4/24/26. Review of Resident 21's facility forms Psychoactive Medication Therapy Informed Consent Form revealed the following consents:-on 5/5/25 consent for citalopram 20mg daily was obtained;-on 5/5/25 consent for mirtazapine 7.5mg daily was obtained;-on 3/2/26 consent for quetiapine 12.5mg was obtained;-on 3/17/26 consent for lorazepam 0.5mg daily at 12:00 was obtained;There was no evidence that the facility documented and offered alternative nonpharmacological treatment intervention options. During an interview on 7/29/26 at 3:00 PM the DON confirmed the facility was obtaining consent for the use of psychotropic medications for Resident 21, however the consent contained information about potential therapeutic effects and adverse effects, but no evidence of alternate non-pharmacological treatment options. G. Review of Resident 1's MDS dated [DATE] revealed the resident had severe cognitive impairment, rejected care and wandered 1-3 days in the prior 7 days, required assistance for hygiene needs, dressing, and bathing. Further review of the MDS showed the resident had a diagnosis of dementia and took antipsychotic and antianxiety medication. Review of Resident 1's Medication Administration Record dated July 2026 revealed active orders for the current psychotropic medications;-lorazepam (Ativan) 0.5mg taken twice daily and every 4 hour as needed for anxiety.-quetiapine (Seroquel) 50mg taken 3 times daily for behavior disturbance (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	associated with dementia. Review of Resident 1's facility forms Psychoactive Medication Therapy Informed Consent Form revealed the following consents:-on 6/9/26 consent for quetiapine (Seroquel) was obtained.-on 7/13/26 consent for lorazepam (Ativan) was obtained. There was no evidence that the facility documented and offered alternative nonpharmacological treatment intervention options. During an interview on 7/30/26 at 2:45 PM the DON confirmed the facility had not provided Resident 1 and/or their responsible party of alternative treatment options when obtaining consent for the use of psychotropic medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on record review and interview; the facility failed to test Residents for COVID-19 when they presented with signs and symptoms of a respiratory illness, to prevent the potential spread of infection for 3 (Residents 1, 19, and 26) of 12 sampled residents. The facility census was 24.Findings are: A. Review of the facility policy COVID management with a revision date of 8/14/25 revealed the following:-The facility routinely monitored and provided surveillance of the workplace/facility to determine compliance with infection prevention and control policies and monitored for signs and symptoms of COVID-19. -The facility was alert to signs and symptoms of COVID-19 and tested residents and staff if the following were present: fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea. B. Review of Resident 1's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/17/26 revealed the resident had severe cognitive impairment, rejected care 1-3 days and wandered daily in the prior 7 days, required assistance for hygiene needs, dressing, and bathing. Further review of the MDS revealed the resident had a diagnoses of hypertension (high blood pressure), diabetes and dementia. Review of Resident 1's Progress Notes revealed the following;-On 7/28/26 at 9:18 PM the resident was monitored for respiratory symptoms, was fatigued, and had a nonproductive cough and ongoing assessment (of the residents' condition) would continue. -On 7/29/26 at 2:14 PM the resident had a weak dry cough, increased lethargy, and a body temperature of 99.1. The provider was updated and gave no new orders other than to monitor. -On 7/29/26 at 3:23 PM the resident was given a COVID-19 antigen rapid test with negative results. During an interview on 8/3/26 at 9:12 AM the Director of Nursing (DON) confirmed Resident 1 was not tested for COVID-19 when presenting with a respiratory infection and the facility only tested after the survey team asked for evidence of a COVID test. C. Review of Resident 19's MDS dated [DATE] revealed the resident had diagnoses including coronary artery disease, hypertension, kidney disease, and vascular (affecting circulation) disease affecting the extremities. The resident was not up to date on the COVID-19 vaccine. Review of Resident 19's Progress Notes revealed the following;-On 7/17/26 at 8:30 AM the resident was noted to have a harsh cough, reported a runny nose and chest congestion. -On 7/17/26 at 7:21 PM the resident presented with a consistent cough, coarse lung sounds and was assessed for respiratory complications. -On 7/18/26 at 9:54 PM the resident presented with an occasional cough and nasal sounding voice. -On 7/19/26 at 10:06 AM the resident reported increased cough, reported being tired and was given cough syrup. -On 7/20/26 at 7:30 AM the resident reported coughing caused chest discomfort which radiated down to the groin. The resident requested cough syrup. -On 7/20/26 at 10:21 PM the resident continued to cough, was weak and shaky during transfers (moving from one sitting surface to another). -On 7/21/26 at 10:21 PM the resident continued to cough, was given cough syrup and was assessed as having clear lungs. -On 7/22/26 at 8:00 PM an occasional cough continued. -On 7/23/26 at 7:35 PM an occasional cough persisted. -On 7/24/26 at 10:00 PM the resident was observed to have a cough and assessed as having clear lungs. -On 7/25/26 at 2:08 PM the resident had a weak dry cough and reported feeling a little better but continued to have nasal congestion. -On 7/26/26 at 10:43 AM the resident had a cough but no other symptoms. -On 7/28/26 at 9:39 PM the resident had a weak cough and indicated that ongoing assessment of the resident's respiratory status would continue. There was no evidence the facility completed a COVID-19 test throughout the course of the resident's illness (7/17/26- 7/28/26). During (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 8/3/26 at 9:12 AM the DON confirmed Resident 19 was not COVID-19 tested when symptoms of a respiratory illness were observed. D. Review of Resident 26's MDS dated [DATE] revealed the resident had severe cognitive impairment, complex medical conditions including hypertension, heart failure, kidney disease, diabetes, and dementia. Review of Resident 26's Progress Notes revealed the following: -On 7/17/26 at 8:30 AM the resident was noted to have a congested cough, sore throat, and head/chest congestion. The resident's body temperature was 99.1 and oxygen saturation was 88% (normal being 90-100%). -On 7/17/26 at 10:37 AM the physician was notified via a fax (facsimile) of the residents symptoms. -On 7/17/26 at 3:00 PM a Physician's Assistant (PA) responded and reported a plan to see the resident on 7/22/26. The facility was to call if symptoms worsened. -On 7/17/26 at 11:46 PM the resident had a cough and elevated body temperature of 100.4. -On 7/18/26 at 3:06 PM the resident reportedly dozed in a chair reported feeling terrible and freezing. The resident was given Tylenol for a body temperature of 100.5 and the temperature dropped to 99.3. -On 7/18/26 at 7:00 PM the resident had a cough, eye drainage, coarse lung sounds, and was weak and tired. -On 7/19/26 at 7:15 PM the resident continued to have a frequent congested cough and sounded nasal. The resident was also wheezing. -On 7/20/26 at 8:00 AM the resident continued to cough and cough up gunk and had wheezing lung sounds. -On 7/21/26 at 4:46 AM the resident had coarse lung sounds. -On 7/21/26 at 8:00 AM the resident continued to have a cough and was weak and tired. -On 7/22/26 at 2:52 PM the resident had clear lung sounds, was pale, weak and congested with loose cough. -On 7/23/26 at 2:03 PM the resident remained in the resident room due to coughing, remained lethargic and the medical clinic was updated. -On 7/24/26 at 8:45 AM the provider (doctor) ordered a decongestant (mucinex) and an antibiotic (azithromycin). -further review revealed Resident 26 continued to be monitored, however no COVID-19 test was performed until 7/29/26 at 3:27 PM. During an interview on 8/3/26 at 9:12 AM the DON confirmed Resident 26 was not tested for COVID-19 when presenting with a respiratory illness. The facility only tested after the survey team asked for evidence of a COVID test on 7/29/26. E. During an interview on 7/29/26 at 2:21 PM the Director of Nursing (DON) confirmed the facility was not testing all residents who presented with symptoms of a respiratory infection for COVID 19. Some random tests had been performed and the resident's physician ordered testing if they felt it was needed.		