STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Callaway Good Life Center, Inc	600 West Kimball Street Callaway, NE 68825

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 49382 Licensure Reference Number 175NAC 12-006.09 C Based on record review and interview the facility failed to ensure a comprehensive resident assessment was completed once every 12 months for 1 resident (Resident #8) of 3 sampled residents, and a Quarterly Assessment (which a non-comprehensive assessment of a resident) was completed at least every 92 days for 1 resident (Resident #4) of 3 sampled residents. The facility census was 28. A. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated October 2024 revealed an comprehensive annual assessment must be completed on an annual basis at least every 366 days. Review of a facility policy titled Comprehensive Assessments dated 03/2022 revealed the annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis or at least every 366 days. A review of Resident #8's electronic medical record completed on 02/06/2025 at 10:30 AM revealed Resident #4 comprehensive annual assessment had an assessment reference date of 01/17/2023 with a completion date of 01/27/2023. Resident #8 did not have another comprehensive assessment scheduled as of 02/06/2025 10:30 AM. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) coordinator (IP/MDS) confirmed that a comprehensive annual assessment had not been completed for Resident #8 since 01/07/2023 which is greater than 366 days. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Administrator (ADM), the ADM confirmed that Resident #8 did not have a comprehensive assessment completed annually or every 366 days per regulatory guidelines. B. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Callaway Good Life Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 600 West Kimball Street Callaway, NE 68825	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated October 2024 revealed the Quarterly assessment for a resident must be completed at least every 92 days. Review of a facility policy titled Resident Assessments dated 05/2022 revealed that the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. A review of Resident #4's electronic medical record completed on 02/06/2025 at 10:30 AM revealed Resident #4 had a Quarterly assessment completed on 10/10/2023 and an Annual or comprehensive assessment completed on 07/01/2024. Tracking only assessments were completed between the dates of 10/10/2023 and 07/01/2024 which is 265 days. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) coordinator (IP/MDS) the IP/MDS confirmed that a Quarterly assessment was not completed every 92 days from 10/10/2023 to 07/01/2024 for Resident #4. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Administrator (ADM), the ADM confirmed that Resident #4 did not have a quarterly assessment completed every 92 days per regulatory guidelines.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-006.09 (B) Based on record review and interview the facility failed to ensure that Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) assessments were completed accurately for 2 (Resident #8 and Resident #25) of 5 sampled Residents. The facility census was 28. A. Review of a facility policy titled Resident Assessments dated 05/2022 revealed that the resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and all persons who have completed any portion of the MDS for must sign the document attesting to the accuracy of the information. Review of Resident #8 Quarterly MDS dated [DATE] revealed in section N 0350 documentation that Resident #8 received insulin injections 7 days a week during the look back period. This section was signed by Licensed Practical Nurse J (LPN-J) on 12/10/2024. Review of Resident #8 Medication Administration Record dated 10/01/2024 to 10/31/2024 on 02/06/2025 revealed no documentation of Resident #8 receiving insulin injections. Resident #8 received Victoza, which is an injectable non-insulin diabetic medication that is used to help control blood sugar levels, injection every day. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Minimum Data Set coordinator (IP/MDS) confirmed that Resident #8 Quarterly MDS dated [DATE] was coded incorrectly in section N 0350. The IP/MDS confirmed that the resident receiving Victoza injection did not qualify as receiving a insulin injection daily as was coded and signed on the MDS. B. Review of Resident #25 Quarterly MDS dated [DATE] revealed in section N 0415 letter E Anticoagulant was coded as yes indicating Resident #25 was taking an anticoagulant medication. Review of Resident #25 Medication Administration Record dated 11/04/2024 to 12/04/2024 on 02/06/2025 revealed no documentation of Resident #25 receiving an anticoagulant medication. Resident #25 received Aspirin, which is a nonsteroidal anti-inflammatory medication daily. This section was signed by Licensed Practical Nurse J (LPN-J) on 12/16/2024. In an interview conducted on 02/06/2025 at 1:00 PM with the facility Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) coordinator (IP/MDS) the IP/MDS confirmed that Resident #25 Quarterly MDS dated [DATE] was coded incorrectly in section N 0415. The IP/MDS confirmed that the resident receiving Aspirin did not qualify as the resident receiving an anticoagulant medication. (continued on next page)

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	285200	A. Building B. Wing	02/10/2025

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 02/06/2025 at 1:00 PM with the facility Administrator (ADM), the ADM stated that LPN-J who coded and signed the MDS for Resident #8 was no longer completing MDS's for the facility. The current IP/MDS would be completing the MDS's for the facility going forward.

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NAME OF PROVIDER OR SUPPLIER Callaway Good Life Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 600 West Kimball Street Callaway, NE 68825	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 49382 Licensure Reference Number 175NAC 12-0006.12 Based on interview and record review the facility failed to ensure residents medication regimen were free from unnecessary medications for 1 resident (Resident #25) of 3 sampled residents. The facility census was 28. Record review of Drugs.com on 02/06/2025 revealed Ketoconazole is an antifungal medication that is only recommended when other effective antifungal therapy is not available or tolerated. Record review of Drugs.com on 02/06/2025 revealed Nystatin Powder is a topical antifungal medication. Record review of Resident #25 Physician Orders on 02/06/2025 revealed Resident #25 had orders to receive Ketoconazole External Cream 2% to affected areas topically at bedtime dated 05/20/2024 and Nystatin External Powder topically every morning and at bed time under the right breast dated 07/02/2024. In an interview completed on 02/04/2025 at 5:10 PM with Resident #25, Resident #25 stated that they self-apply Nystatin Powder under their right breast when it is red and itchy. The resident stated that the nurses apply a cream to the same area at night before they go to bed. In an interview completed on 02/10/2025 at 8:50 AM with Registered Nurse A (RN-A), RN-A stated that Resident #25 has an order for Ketoconazole External Cream 2% to applied topically at bedtime. The RN stated that the nurse on duty applies the cream to the resident's skin folds including under the resident's right breast. In an interview completed on 02/10/2025 at 3:10 PM with the facility Director of Nursing (DON), the DON stated Resident #25 had a physician order to self-administer the Nystatin powder. The DON confirmed that the nurse on duty was also applying the Ketoconazole cream to the same area that the resident was reporting to be applying the Nystatin Powder. The DON confirmed that both medications should not be used to the same area.

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NAME OF PROVIDER OR SUPPLIER: Callaway Good Life Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 600 West Kimball Street Callaway, NE 68825	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49382 Licensure Reference Number 175NAC 12-00006.12 Based on record review and interview the facility failed to ensure that an antipsychotic medication had the correct diagnosis for use. This affected 1 resident (Resident # 3) of 5 sampled residents. The facility census was 28. Record review of a facility policy titled Behavioral Assessment Intervention and Monitoring revealed the facility will comply with regulatory requirements related to the use of medication. Indications and usage for Seroquel (an antipsychotic medication) listed as Schizophrenia (a mental illness that is characterized by disturbances in thought, perception, and behavior, by a loss of emotional responsiveness and extreme apathy, and by noticeable deterioration in the level of functioning in everyday life), and Bipolar Disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone). Review of an Admission Record revealed the facility admitted Resident #3 on 08/30/2023 with diagnoses that included Alzheimer's Disease (a degenerative brain disease of unknown cause that usually starts in late middle age or in old age, that results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood), Dementia (a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior) , and Altered Mental Status (a change in a person's mental function, including their awareness, cognition, or consciousness). Resident #3 did not have a diagnosis of depression. Review of Resident #3 Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 11/12/2024 revealed Resident #3 received an Anti-Psychotic medication daily. Review of Resident #3 Physician Orders on 02/06/2025 revealed Resident #3 had a prescribed order to receive Seroquel (an antipsychotic medication) 25 milligrams at bedtime for a diagnosis of depression dated 05/01/2024. In an interview completed on 02/10/2024 at 3:10 PM with the facility Director of Nursing (DON), the DON confirmed that Resident #3 was receiving an antipsychotic medication with the diagnosis of depression. The DON confirmed that Resident #3 did not have a diagnosis of Schizophrenia or bipolar disorder indications for use of the Seroquel medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49382 Licensure Reference Number 175NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to ensure a medication error of less than 5% with an actual observed medication error rate of 7%. This affected 2 residents (Resident # 13 and Resident #4) of 6 observed medication administrations. The facility census was 28. Review of a facility policy titled Insulin Pen and dated 01/11/2024 revealed to prime the insulin pen by dialing 2 units by turning the dose selector clockwise and with the needle pointing up push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle the turn the selector to the desired dose. In an observation of medication administration completed on 02/05/2025 at 11:27 AM by Registered Nurse-C (RN-C) the following was observed: -RN-C obtained an insulin pen from the medication cart. The RN wiped the tip of the pen with an alcohol wipe and then placed the needle cap onto the end of the insulin pen. RN-C then turned the dose selector to 6 then proceeded to Resident # 13 room and administered the insulin to Resident #13. The RN did not prime the insulin pen with 2 units prior to selecting the dose of insulin to be administered to the resident. -RN-C obtained an insulin pen from the medication cart. The RN wiped the tip of the pen with an alcohol wipe and then placed the needle cap onto the end of the insulin pen. RN-C then turned the dose selector to 14 then proceeded to Resident #4 room and administered the 14 units of insulin to Resident #4. The RN did not prime the insulin pen with 2 units prior to selecting the dose of insulin to be administered to the resident. In an interview completed on 02/05/2025 at 11:58 with RN-C, RN-C confirmed that they did not prime the insulin pen with 2 units prior selecting the dose of insulin to be administered to Resident #13 and Resident #4. The RN stated they thought the insulin pens only had to be primed once when opened prior to the first use of the pen. In an interview completed on 02/10/2025 at 11:00 AM with the facility Director of Nursing (DNS), the DNS confirmed that the facility policy was to prime the insulin pens with 2 units prior to selecting the dose to be administered to the resident with each use of the pen.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49382 Licensure Reference Number 175NAC 12-0006.12(D)(i) Based on observation, record review, and interview the facility failed to ensure that medications were securely stored. This affected 1 resident (Resident #25) of 3 sampled residents. The facility census was 28. Record review of a facility supplied policy titled Storage of Medications dated 11/2020 revealed drugs and biologicals used in the facility are stored in locked compartments. In an observation completed on 02/04/2025 at 5:00 PM an opaque plastic bottle with a white cap and a pharmacy label with Resident #25's name and Nystatin Powder apply to red skin folds may keep at bed side was located within eyesight on the residents over bed table beside the resident's recliner. In an interview completed on 02/04/2025 at 5:10 PM with Resident #25, Resident #25 stated that the Doctor had approved for them to keep the Nystatin Powder in their room and apply it independently when skin folds get itchy. The resident denies staff completing an observation or assessment of them applying the powder. The resident denied staff education to the resident to keep the medication in a secured place and not out in the open where others could access it. In an observation completed on 02/06/2025 at 12:10 PM an opaque plastic bottle with a white cap and a pharmacy label with Resident #25's name and Nystatin Powder apply to red skin folds may keep at bed side was located sitting on the back of Resident #25's toilet in their bathroom. Resident #25 shared a bathroom with their roommate. In an interview completed on 02/10/2025 3:30 PM with the facility Director of Nursing (DON), the DON stated Resident #25 had a physician order to self-administer the Nystatin powder and to keep it in their room. The DON confirmed that a self-administration of medication assessment was not completed for Resident #25 indicating the resident was safe to self-administer and store the Nystatin powder on their own in their room. The DON confirmed that all medications should be stored securely and out of the ability to be accessed by other residents. The DON confirmed that storing the Nystatin powder on the over bed table and back of the toilet was not secure storage of the medication.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50105

Licensure Reference Number 175 NAC 12-006.11(E)

Based on observations, interviews, and record reviews, the facility failed to prepare and serve food in a safe manner to prevent the potential for foodborne illness. This had the potential to affect all facility residents eating out of the kitchen. The facility census was 28.

Findings are:

On 02/04/2025 at 8:28 AM upon initial observation, Dietary Aide-I (DA-I) was observed wearing gloves at the time of meal service. DA-I prepared plates of food to be served to residents sitting in the dining room. DA-I was observed picking up biscuits with gloved hands breaking them open, then picking up the ladle which scooped a white gravy, then poured the product on the biscuit. DA-I picked up a plastic card that contained writing on it and handed the card to Dietary Aide-H (DA-H) and the plate of food, where DA-H then retrieved the plate and brought it out to the resident to eat. DA-H hand sanitized after providing that plate and obtaining another plate for another resident. DA-I did not change gloves until service was completed.

An observation on 02/05/2025 at 8:24 AM Dietary Aide-G (DA-G) was observed wearing gloves and preparing plates of food to be served to residents sitting in the dining room. DA-G was observed to be scooping a piece of breakfast cake with a spatula and pushing the food onto the plate with the gloved hand. DA-G was observed to be opening the refrigerator, managing the plastic dietary cards with gloved hands, delivering plates of food with the same gloved hands, not changing gloves throughout breakfast service.

An observation on 02/06/2025 at 8:21 AM DA-G was observed to be wearing gloves while plating up food. DA-G had a stack of toast on the counter. DA-G was observed to the picking up the toast with the gloved hands and placing them on the plates for service. DA-G was also observed to be opening the refrigerator, managing the plastic dietary cards, delivering plates of food with the same gloved hands.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 02/06/2025 at 9:30 AM meal preparation for lunch service revealed DA-G was to be cooking meatballs without a recipe. When asked about the recipe, the Dietary Manager (DM) printed off a recipe from the Internet and provided me with a recipe that DA-G did not use. DA-G obtained the following products for making the meatballs, 2 6-pound tubes of raw ground beef and 2 large onions. DA-G started the preparation by washing hands and donning gloves. DA-G obtained a knife and stuck it in the center of the tubes of ground meat and sliced in straight though cutting into the meat and pulling the meat out and placing into a container. DA-G then stuck the second tube of meat with the knife and sliced it through and dumped the meat in the container with the other meat. DA-G realized that part of the meat was frozen, so put the partially frozen meat in a separate container and moved aside. DA-G then changed gloves, not washing hands, grabbed the onions and began slicing them and dicing them, then sat the onions aside. DA-G took seasoning bottles and began to sprinkle on top of the meat, celery salt without measuring, black pepper without measuring, and garlic salt without measuring. DA-G began to mix the meat up to incorporate all the seasoning. DA-G then cracks 3 eggs into the meat, the recipe calls for 1 egg per pound of meat. The leftover frozen meat is cut into smaller portions and placed into the microwave oven for 5 minutes, and again for 6 minutes. On 02/06/2025 at 9:52 AM DA-G then cleans up the counter, the onion skins and puts the seasonings away. DA-G took a measuring cup, measures up breadcrumbs and parsley in the same cup, places the breadcrumbs and parsley in the meat mixture, cracked two more eggs, and pulled out the meat in the microwave. The meat in the microwave is partially brown and other parts red and pink. With gloved hands, DA-G mixes the meat together for 9 minutes. The gloves are then changed, and DA-G took a cookie scooper, additional gloves and scoops meat mixture creating a ball and placed in a small lined pan. The onions are then added to the remaining mixture of meat, mixed again. Gloves are changed and meatballs are formed and placed in a larger pan, then placed into the oven on 375-400 degrees at 10:19 AM. DA-G washes hands and gets out frozen potatoes, a can of peas and the butter in a container sitting next to the microwave. The butter is doused on the frying griddle and a scoop of butter is placed in a pot on the stove. DA-G opened the frozen potatoes, put them on the griddle and spreads them out. DA-G then opens the can of peas, drains the can. DA-G then got a large pitcher of water and begins to fill the steam table full of water and turns the table on at 10:30 AM. DA-G began cleaning up the preparation table. DA-G washed hands then dumps the can of peas into the pan of butter, then the pan of peas and butter are placed into the steam table. The potatoes stirred up on the griddle and seasoning is added to the potatoes. DA-G gets out a pan, adds the potatoes to the pan and the pan is placed into the steam table. The griddle was scrubbed down and cleaned using a foam brick and scrapper. Grilled cheese is then being made and prepared for the alternate meal option on the griddle. Once the sandwiches are made, they are added to the steam table at 11:15 AM and covered with a lid. DA-G takes the meatballs out of the oven then without measuring, doused with a bottled barbeque sauce stirred up and placed back into the oven. The temperature of the meatballs are taken reading 133 Fahrenheit. The meatballs go back into the oven then taken out at 11:48 AM and read 165 degrees Fahrenheit and moved to the steam table. At 11:59 AM DA-G put gloves on and lifted the lids to the steam table and grabbed a plastic card that states the resident information about their diet on the card. DA-G read the card and prepared a plate for a resident and handed the plate to a server. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with DA-G on 02/06/2025 at 12:17 PM revealed that the peas and the potatoes being served were never temped for a set or holding temperature. DA-G states they forgot to temp the potatoes and that they did not think temping the peas was necessary. The interview further revealed that thawing the meat in the microwave typically does not happen, however did not take the meat out earlier than expected. An interview with the DM on 02/06/2025 at 1:04 PM revealed that thawing meat in the microwave is not appropriate, and that DA-G was not aware that this shouldn't be done. The interview continued to reveal that temping all foods including ready made foods is necessary and states that staff may not be aware of the process. The interview further revealed that wearing gloves throughout the serving process is not a replacement of washing hands. A record review of the facility policy titled, Policy and Procedure [NAME] for Long Term Care-Food Service dated April 2018 revealed the policy under Food Handling statement: Food will be stored, prepared and served so that the risk of foodborne illness is minimized. Policy interpretation and implementation reveals: 1. This facility recognizes that the critical factors implicated in foodborne illness are: a. Poor personal hygiene of food service employees; b. Inadequate cooking and improper holding temperatures; c. Contaminated equipment; and d. Unsafe food sources. 5. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state specific requirements. Federal standards require that refrigerated food be stored below 41 degrees Fahrenheit, and that freezers keep frozen foods solid. 6. Potentially hazardous foods will be cooked to the appropriate internal temperature and held at those temperatures for the appropriate length of time to destroy pathogenic microorganisms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175 NAC 12-007.04(D) Based on observation and interview, the facility failed to ensure that the ventilation system was operational in in rooms 7, 8, 9, 10, 11, 14, 15, and 19. This affected 8 bathrooms used by 13 residents. facility census was 28. An observation on 02/04/2025 at 11:45 AM revealed that bathrooms in rooms [ROOM NUMBER] did not have functional ventilation as tested when a 1-ply square of toilet paper was held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw, and the ventilation system did not work. An observation on 02/04/2025 at 1:30 PM revealed that bathrooms in rooms 7, 8, 9, 10, and 11 did not have functional ventilation as tested when a 1-ply square of toilet paper was held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw, and the ventilation system did not work. An observation on 02/10/2025 at 4:00 PM with the Administrator (Admin) revealed that bathrooms in rooms 7, 8, 9, 10, 11, 14, 15, and 19 did not have functional ventilation as tested with 1-ply square of toilet tissue held flat against the ventilation cover that did not hold the paper which indicated that there was no air draw, and the ventilation system did not work. An interview with the Admin on 02/10/2025 at 4:10 PM confirmed that the ventilation system was not functioning in the bathrooms of rooms 7, 8, 9, 10, 11, 14, 15, and 19 and that the ventilation system should be working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285200	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Callaway Good Life Center, Inc	600 West Kimball Street Callaway, NE 68825

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49382 Licensure Reference Number 175NAC 12-0006.04(B) Based on record review and interview the facility failed to ensure that Nurse Aides completed the required continuing education hours for 3 of 5 sampled Nurse Aides. The facility census was 28. A record review of a facility supplied document titled Course Completion History dated 02/10/2025 revealed that Nurse Aide M (NA-M) had completed 2.37 hours of continuing education hours from 01/01/2024 to 02/10/2025. A record review of a facility supplied document titled Course Completion History dated 02/10/2025 revealed that Nurse Aide N (NA-N) had completed 1.63 hours of continuing education hours from 01/01/2024 to 02/10/2025. A record review of a facility supplied document titled Course Completion History dated 02/10/2025 revealed that Nurse Aide O (NA-O) had completed 4 hours of continuing education hours from 01/01/2024 to 02/10/2025. In and interview completed on 02/10/2025 at 3:00 PM with the facility Director of Nursing (DON), the DON confirmed that NA-M, NA-N, and NA-O had not completed the minimum of 12 hours of continuing education as of 02/10/2025. The DON confirmed that all Nurse Aides should have a minimum of 12 hours of continuing education completed every year.