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	04/22/2026

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1)Licensure Reference Number 175 NAC 12-006.04(B)(ii)(2)The facility failed to ensure that 12 hours of required ongoing education was documented for nurse aides and medication aides who had been working in the facility for longer than one year and who required 12 hours of yearly training for 3 of 3 sampled staff. This had the potential to affect all residents. The census was 29.Findings were:Record review of the facility policy Abuse, Neglect, and Exploitation dated 12/01/2025 and signed by the Former Facility Director (FFA) revealed that existing staff will receive annual education through planned in-services and as needed.Record review of the facility policy Resident Rights with a copy right date of 2016 revealed that the nursing facility must provide a safe, clean, comfortable environment ensuring that the residents can receive care and services safely.In an interview with the Facility Administrator (FA) on 4/21/2026 at 10:15 AM it was revealed that the Director of Nursing (DON) had all of the information pertaining to the continuing education for employees including the 12 hours of mandatory education required by both nurse aides and medications aides. In a confirmation interview with the Director of Nursing (DON) on 4/21/2026 at 3:10 PM, the DON confirmed that all medication aides and nurse's aides must have 12 hours of continuing education every year based on the hire date to hire date anniversary of each employee. The DON confirmed that Medication Aide (MA)-E, MA-F and MA-G did not have 12 hours of continuing education documented in the employee files. The DON also stated that the education hours from the year 2024 were missing and unaccounted for therefore the facility could not show that the employees had received any education during that time frame. A.Record review of the Facility Employee List with the dates of hire revealed that Medication Aide (MA) E was hired as a medication aide on 6/24/2022.Record review of the continuing education hours for MA-E whose revealed a total of 6.74 hours of continuing education logged and documented in the previous year. MA-E had 3.87 hours of confirmed in-house training and 2.87 hours of online Relias computer training encompassing a time period of 6/24/2024 to 6/24/2025. B. Record review of the Facility Employee List with the dates of hire revealed that Medication Aide (MA) F was hired as a medication aide on 8/22/2019.Record review of the continuing education hours for MA-F revealed a total of 9.55 total hours of continuing education logged and documented in the previous year. MA-F had 3.8 hours of confirmed in-house training and 5.75 hours of online Relias computer training encompassing a time period of 8/22/2024 to 8/22/2025. C.Record review of the Facility Employee List with the dates of hire revealed that Medication Aide (MA) G was hired as a medication aide on 8/10/2022.Record review of the continuing education hours for MA- G revealed a total of 6.17 hours of continuing education logged and documented in the previous year. MA-G had 3.8 hours of confirmed in-house training and 2.37 hours of online Relias computer training encompassing a time period of 8/10/2024 to 8/10/2025.

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Licensure Reference Number 12-006.12(D)(i)Based on observation and record review the facility failed to ensure items the medication room refrigerator was stored separately by route of administration and food stuff items were not stored with medication items. This had the potential to affect all the residents in the facility. The facility census was 28.Findings are:Record review of a facility policy titled Medication Storage and dated 01/21/2026 revealed Medications are stored separately ensuring proper sanitation and segregation.In an observation completed on 04/21/2026 at 11:30 PM of the facilities medication room a square dorm sized refrigerator was in the medication room. Inside the refrigerator on the bottom shelf were multiple boxes of insulin pens (an injectable medication) and medication bottles with suppositories (a medication placed inside the rectum) kept in them. On the same bottom shelf were 8-ounce plastic containers of liquid nutritional supplement drinks (a food stuff item).In an interview completed on 04/21/2026 at 2:45 PM with the Director of Nursing, the DON confirmed that items stored in the medication room refrigerator should be stored separately by route of administration and food stuff items should not be stored with medication items in the refrigerator and were.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to ensure that the Payroll Based Journal was submitted for the first quarter of 2026 by the due date of February 14, 2026. This had the potential to affect all residents. The facility census was 29. Record review of the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report (PBJ) (a CMS-mandated system for nursing facilities to electronically report auditable staffing data, including hours worked, job roles, and pay types, to ensure transparency and quality of care, revealed that the PBJ data which must be submitted and received by the end of the 45th calendar day (11:59 PM Eastern Standard Time) after the last day in each fiscal quarter to be considered timely) was not submitted to or received by CMS by the date that the PBJ was required. The PBJ Staffing Data Report for the first quarter of 2026 dated October 1 to December 31, 2025, was due on February 14, 2026. In an interview with the Facility Administrator (FA) on 4/20/2026 at 9:05 AM revealed that the FFA would look into this as the information should have been submitted and received by CMS prior to the date that the information was due. In a confirmation interview on 4/21/2026 at 2:30 PM with the Business Office Manager (BOM) confirmed that the PBJ report for the time period of 10/01/2025 to 12/31/2025 had not been submitted to CMS by the date required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, record review, and interview the facility failed to ensure that staff delivered resident meals in a sanitary manner to prevent the potential for foodborne illness and cross-contamination. This affected 15 of 22 residents in the facility dining room (Residents 22, 28, 19, 10, 35, 27,15, 20, 17, 16, 23, 21, 18, 25, and 9). The facility census was 29.Findings are:Record review of the facility policy titled Hand Hygiene (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among residents and health care personnel) dated 1/21/26 revealed that all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations of the facility. Hand hygiene is indicated and will be performed between resident contacts, after handling contaminated objects, before and after handling clean or soiled items. Record review of the FDA (Food and Drug Administration) Food Code 2022 revealed that clean tableware (forks, knives, spoons, bowls, cups, serving dishes, tumblers, and plates) is to be handled to prevent contamination. Clean tableware will be handled so that contamination of food and lip contact surfaces is prevented. Observation on 4/20/26 at 12:14 PM in the facility dining room revealed that Dietary Aide-A (DA-A) carried a plated meal to Resident 11 and sat the plate on the table in front of the resident. DA-A's hands contacted the table top in front of the resident. DA-A returned to the service counter (DA-A did not perform hand sanitization). DA-A picked up a plated meal and carried the plated meal to Resident 22. DA-A sat the meal on the table in front of the resident. DA-A returned to the service counter and picked up two plated meals from the service counter. (DA-A had not performed hand sanitization). DA-A carried a plate in the left hand with the thumb on the top surface of the plate (food surface) and carried a plate with the right hand with the thumb on the top surface of the plate. DA-A sat a plate on the table in front of Resident 28 and the other plate on the table in front of Resident 19. DA-A went to the beverage counter and picked up 2 drink glasses. (DA-A had not performed hand sanitization). DA-A went to the beverage cart and used the scoop to put ice in a glass. DA-A opened a container of juice and poured the juice into the glass and delivered it to Resident 10. DA-A sat the glass on the table in front of Resident 10 and then returned to the beverage cart. DA-A used the scoop to put ice into a glass. DA-A carried the glass with ice and a can of diet coke to Resident 10. DA-A opened the can of diet coke and poured it into the glass and sat the glass in front of Resident 10. DA-A returned to the service counter. (DA-A did not perform hand sanitization). DA-A picked up a plated meal with the thumb of the right hand on the food surface of the plate. DA-A carried the plate to Resident 35 and sat the plate on the table in front of the resident. DA-A returned to the service counter. (DA-A did not perform hand sanitization). DA-A picked up a plated meal and carried it to Resident 27 with the thumb of the right hand on the top of the plate. DA-A sat the plate on the table in front of Resident 27. DA-A went to the beverage cart and picked up the pitcher of iced tea. (DA-A did not perform hand sanitization). DA-A went to the table of Resident 15 and picked up the used tea glass from the resident with the left hand. DA-A poured tea into the glass (a refill) and sat the glass back on the table in front of the resident. DA-A sat the iced tea pitcher back on the beverage cart. (DA-A did not perform hand sanitization). DA-A walked to the table where Resident 20 was seated in a wheelchair. DA-A put their right hand on the handle on the back of the wheelchair and rested the left hand on the table in front of the resident. DA-A offered a choice of dessert to Resident 20. DA-A went to a dessert cart and picked up a plate with a piece of chocolate cake and delivered it to Resident 20. (DA-A did not perform hand sanitization). DA-A walked over to Resident 17 seated at a table. DA-A placed the right hand on the wheelchair handle on the back of the resident's wheelchair and rested the right hand on the table in front of the resident. DA-A offered Resident 17 a choice of pie or cake. DA-A went to the dessert cart and picked up a plate with a serving of chocolate cake and sat it on the table in front (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident 17. The time was now 12:19 PM. (DA-A did not perform hand sanitization). DA-A went to the plastic drawers next to the beverage counter. The four wheel walker of Resident 16 sat in front of the drawers. DA-A grabbed the handles of the walker with both of the hands and repositioned the walker. DA-A reached into a drawer and grabbed two containers of tartar sauce. (DA-A did not perform hand sanitization). DA-A carried the tartar sauce to Resident 27. DA-A pulled the seal off of the two tartar sauce containers and sat them on the table for Resident 27. DA-A went to the beverage counter and grabbed a drink glass. (DA-A did not perform hand sanitization). DA-A carried the glass to the beverage cart and used the scoop to put ice into the glass. DA-A filled the glass with water and took it to Resident 23. DA-A sat the glass on the table in front of the resident. (DA-A did not perform hand sanitization). DA-A went to the table of Resident 21. DA-A picked up the used knife and fork from Resident 21. DA-A used the knife and fork to cut up the chicken into bite sized pieces for the resident. Nursing Assistant-B (NA-B) went to the kitchen service counter and picked up a plate of food. NA-B held the plate with the thumb on the top of the plate and carried it to Resident 18. NA-B sat the plate on the table in front of the resident. NA-B went to the kitchen service counter and performed hand sanitization with alcohol based sanitizer. DA-A walked to the drawers next to the beverage counter. (DA-A did not perform hand sanitization). DA-A removed two containers of barbecue sauce from a drawer and took them to Resident 18. DA-A peeled the seal off of the barbecue sauce and picked up Resident 18's knife. DA-A used the knife to remove barbecue sauce from the containers and put it on the resident's meat on the plate. DA-A walked over to Resident 25 at a different table. (DA-A did not perform hand sanitization). DA-A placed their left hand on one of the wheelchair handles of Resident 25's wheelchair and rested their right hand on the table in front of the resident. DA-A went to the kitchen service counter and picked up two plated meals. (DA-A did not perform hand sanitization). DA-A carried one plate with the thumb of the left hand on the top of the plate and the other plate with the thumb of the right hand on the top of the plate. DA-A sat one of the plated meals on the table in front of Resident 23 and the other plated meal in front of Resident 9. DA-A returned to the kitchen service counter. (DA-A did not perform hand sanitization). DA-A picked up a plated meal and carried the plate to Resident 10. DA-A sat the plate on the table in front of the resident. DA-A returned to the kitchen service counter. (DA-A did not perform hand sanitization). DA-A picked up a plated meal and carried the plate to Resident 25. DA-A sat the plate in front of Resident 25. (DA-A did not perform hand sanitization). Interview on 4/21/26 at 4:17 PM with the facility Dietary Manager (DM) confirmed that staff are required to perform hand sanitization between resident contacts while delivering resident meals during meal service. The DM confirmed that hand sanitization is required after touching objects that may be contaminated. The DM confirmed that plates are to be carried without the thumb or fingers on the top food surface of the plate next to the food.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Licensure Reference Number 175 NAC 12-006.12(A)Based on record review and interview the facility failed to ensure a prescribed psychotropic medication had an approved diagnosis or indication for use for 1 resident (Resident 5) of 5 sampled residents. The facility census was 28.Findings are:Record review of a facility policy titled Use of Psychotropic Medication and dated 01/21/2026 revealed an adequate indication for use means that the medication administered is consistent with manufacturer's recommendations.Record review of a document titled Highlights of Prescribing Information (www.fda.gov/drugsatfda) and dated 2013 revealed Seroquel or Quetiapine Fumarate (an antipsychotic psychotropic medication) had indications and usages listed as Schizophrenia, Bipolar 1 disorder, and bipolar disorder.Record review of an admission Record revealed the facility admitted Resident 5 on 08/30/2023 with diagnosis of Dementia(a progressive decline in cognitive function that effects memory, language, and behavior), Psychotic disturbance of mood and Anxiety (a severe anxiety or mood disorder), and Depression (a common serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and cognitive difficulties, lasting at least two weeks). Record review of Resident 5's Medication Administration Record (MAR) for the month of April 2026 revealed Resident 5 had a physician order to receive Seroquel oral tabled 25 milligrams once daily for an indication or diagnosis of mind dementia with agitation. This medication was documented as to have been administered every day of the month at a listed time of 1:00 PM. A physician order to receive Quetiapine oral tablet 25 milligrams once daily at bedtime for an indication or diagnosis of depression. This medication was documented as to have been administered every day of the month at a listed time of 7:00 PM.In an interview completed on 04/22/2026 at 1:45 PM with the facility Director of Nursing, (DON), the DON confirmed that the diagnosis or indication for use of Resident 5's Seroquel and Quetiapine medication did not meet the facility policy stated adequate indication for use as the listed indication or use of mild dementia with agitation and depression were not manufacturer recommended uses for these/this medication.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Licensure Reference Number 175 NAC 12-006.09(G)(ii)Based on record review and interview, the facility failed to complete a summary or recapitulation of stay as required for 1 resident (Resident 32) of 2 sampled residents. The facility census was 28.Findings are:Record review of Resident 32's Electronic Medical Health Record (EMHR) revealed the facility admitted Resident 32 on 02/05/2026 and discharged Resident 32 on 02/14/2026.Record review of Resident 32's Progress Notes revealed that on 02/14/2026 at 9:55 AM the facility discharged Resident 32 from the facility to their private home accompanied by their spouse and that personal belongings, discharge instructions, and a medication list was provided to the resident's spouse. There was no documentation of a summary or recapitulation of the residents stay at the facility in the progress notes.In an interview conducted on 04/22/2026 at 2:45 PM with the facility Director of Nursing (DON), the DON confirmed that Resident 32 discharged from the facility on 02/14/2026. The DON confirmed that a summary or recapitulation of the residents stay at the facility was not completed upon the residents' discharge from the facility and should have been.

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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** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review and interview the facility failed to accurately code the 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) for 2 residents (Resident 5 and Resident 6) of 5 sampled residents and failed to comprehensively complete the Care Area Assessment (CAA) a critical component of MDS that functions as a decision making frame work to determine if a specific person centered care plan intervention is required) for 1 residents (Resident 5) of 5 sampled residents, and failed to complete an Prospective Payment System (PPS) a standardized, Medicare-required evaluation used to classify patients into payment groups based on clinical needs) Discharge assessment as required for 1 resident (Resident 1) of 5 sampled residents. The facility census was 28.Findings are:A.Record review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 dated October 2025 revealed Section O Special treatments, procedures, and programs coding instructions check all treatments, procedures, and programs that the resident received or performed with in the last 14 days of the Assessment Reference Date (ARD).Record review of Resident 5's Treatment Administration Record for the month of January 2026 revealed the resident had a physician's orders for a CPAP to be applied every night at its current settings at bedtime for sleep apnea. This order was documented to have been performed as ordered every night for the month of January 2026.The comprehensive MDS assessment for Resident 5 dated 01/14/2026 revealed in Section O Special Treatments, Procedures, and Programs, item G1 non-invasive mechanical ventilator (a machine that provides respiratory support without and artificial airway using a mask to deliver positive pressure to assist breathing) was not checked as being used at any time in the 14 days prior to the ARD of 01/14/2026.In an interview completed on 04/22/2026 at 11:30 AM with the facility Director of Nursing (DON), the DON confirmed that Resident 5 utilized a CPAP machine every night. The DON confirmed that this should have been coded on the MDS dated [DATE] and was not. The DON confirmed that the MDS was not coded correctly.B.Record review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 dated October 2025 revealed Section K 0520 Nutritional Approaches coding instructions to check all nutritional approaches that were performed with in the last 7 days of the ARD of 02/10/2026.Record review of Resident 6's Physician Orders on 04/21/2026 revealed the resident was prescribed a regular diet with regular texture and liquid consistency. The comprehensive MDS assessment for Resident 6 dated 02/10/2026 revealed in Section K 0520 the resident was coded to have received an mechanically altered diet.In an interview completed on 04/22/2026 at 10:05 AM with the Dietary Manager (DM), the DM stated that Resident 6 received a regular diet and had no dietary restrictions.In an interview completed on 04/22/2026 at 11:30 AM with the facility DON, the DON confirmed that Resident 6 was prescribed and received a regular diet. The DON confirmed that the comprehensive MDS dated [DATE] was not coded correctly due to the resident not receiving a mechanically altered diet.C.Review of a facility policy titled MDS 3.0 Completion and dated 12/18/2025 revealed Key findings regarding a resident's status are documented in the CAA's including the nature of the condition, complications and risk factors that affect the care planning decision factors that must be considered.Record review of Resident 5's CAA Worksheet for the comprehensive MDS dated [DATE] revealed the following:-The Cognitive Loss or Dementia CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Visual Function CAA in the analysis of finding area no identification if the problem or need was actual or potential, no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Communication CAA in the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Urinary Incontinence CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Psychosocial Well-Being CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Falls CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Nutritional Status CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Pressure Ulcer or Injury CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.-The Psychotropic Drug Use CAA in the analysis of findings area no narrative or description of the problem or the condition affecting the resident, no description of the impact of the problem or need on the resident and the rational for the care plan decision.In an interview completed on 04/22/2026 at 11:30 AM with the facility DON, the DON confirmed that Resident 5's CAA's were not completed comprehensively and should have been.D. Review of a facility policy titled MDS 3.0 Completion and dated 12/18/2025 revealed Part A PPS Discharge Assessment is required when a resident's Medicare Part A (Medicare) stay ends but the resident remains in the facility.Record review of Resident 1's Clinical Census on 04/21/2026 revealed the resident admitted to the facility on [DATE] with Medicare Replacement listed as a primary payor. On 11/11/2025 Resident 1's primary payor source changed to Medicaid. Record review of Resident 1's Clinical MDS list on 04/21/2026 revealed an Entry MDS was completed on 10/29/2025, an Admission/Medicare 5 day MDS was completed on 11/05/2026, and a Quarterly-None PPS MDS was completed on 02/05/2026. There was no PPS Discharge MDS Assessment completed on the date of 11/11/2025 when Resident 1's payor source changed.In an interview completed on 04/22/2026 at 11:30 AM with the facility DON, the DON confirmed that Resident 1's primary payor source changed from Medicare to Medicaid on 11/11/2025 and no PPS Discharge MDS Assessment was completed as required.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09FBased on record review and interview the facility failed to complete a baseline care plan (a written plan required to be developed within 24 hours of admission detailing the instructions needed for staff to provide initial effective and person-centered quality care for a resident) within 24 hours as required for 1 of 3 residents (Resident 15) and failed to provide a written summary of the baseline care plan to the resident/resident representative for 1 of 3 residents (Resident 16). The facility census was 29.Findings are:A.Record review of the facility policy titled Baseline Care Plan dated 2/18/26 revealed that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission (the baseline care plan is required to be developed within 24 hours in Nebraska). The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including initial goals, physician orders, dietary orders, therapy services, and social services. The admitting nurse shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative. Initial goals shall be established that reflect the resident's stated goals and objectives. Interventions will be initiated that address the resident's current needs. Record review of the admission Record for Resident 15 dated 4/22/26 revealed that Resident 15 admitted into the facility on [DATE]. Record review of the progress note dated 12/5/25 at 10:45 AM revealed that Resident 15 admission was on 12/5/25 at 10:45 AM. Resident's siblings were present during admission.Record review of the baseline care plan for Resident 15 dated 12/7/25 revealed that the baseline care plan was completed and signed by the nurse on 12/7/25. (Two days after admission).Interview on 4/21/26 at 4:20 PM with the facility Director of Nursing (DON) confirmed that a baseline care plan is required to be developed within 24 hours of the resident admission to identify care needs of the resident for facility staff caring for the resident. The DON confirmed that the baseline care plan for Resident 15 was not completed within 24 hours as required. B.Record review of the facility policy titled Baseline Care Plan dated 2/18/26 revealed that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission (the baseline care plan is required to be developed within 24 hours in Nebraska). The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including initial goals, physician orders, dietary orders, therapy services, and social services. The admitting nurse shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative. Initial goals shall be established that reflect the resident's stated goals and objectives. Interventions will be initiated that address the resident's current needs. A written summary of the baseline care plan will be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any services and treatments to be administered by the facility and personnel acting on behalf of the facility. The written summary of the baseline care plan will be provided to the resident and representative by completion of the comprehensive care plan. The person providing the written summary of the baseline care plan shall obtain a signature from the resident/representative to verify that the summary was provided and make a copy of the summary for the medical record. Record review of the admission Record for Resident 16 dated 4/22/26 revealed that Resident 16 admitted (continued on next page)

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	285200	A. Building B. Wing	04/22/2026

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the facility on 9/5/25. Record review of the baseline care plan for Resident 16 dated 9/5/25 revealed that the baseline care plan was completed and signed by the nurse on 9/5/25.Record review of the medical record for Resident 16 revealed no documentation that a baseline care plan was reviewed with the resident/resident representative. The medical record revealed no documentation that a written summary of the baseline care plan was provided to the resident/resident representative as required. Interview on 4/21/26 at 4:20 PM with the facility Director of Nursing (DON) confirmed that a baseline care plan is required to be developed within 24 hours of the resident admission to identify care needs of the resident for facility staff caring for the resident. The DON confirmed that a written summary must be reviewed with and provided to the resident and/or resident representative prior to the completion of the resident comprehensive care plan. The DON confirmed that there had been gaps in the facility process to ensure that this occurred.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Licensure Reference Number 175 NAC 12-006.09(E)(i)Based on record review and interview the facility failed to develop a comprehensive care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident based on the resident comprehensive assessment) for resident care needs identified in the resident assessment for 2 of 2 residents reviewed (Residents 16 and 12). The facility census was 29.Findings are:A.Record review of the facility policy titled Comprehensive Care Plans dated 2/18/26 revealed that it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The care planning process will include an assessment of the resident's strengths and needs. The comprehensive care plan will be developed within 7 days after completion of the comprehensive Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) assessment. The comprehensive care plan will describe at a minimum the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The comprehensive care plan will include measurable objectives to meet the resident's needs as identified in the resident's comprehensive assessment. Record review of the admission Record dated 4/22/26 for Resident 16 revealed that Resident 16 admitted into the facility on 9/5/25. Diagnoses included dehydration, overactive bladder, and urinary tract infection.Record review of the MDS assessment for Resident 16 dated 9/11/25 revealed that it was the admission assessment for Resident 16. The MDS assessment documented that Resident 16 had an active diagnosis of a urinary tract infection and was currently taking an antibiotic. Record review of the progress note for Resident 16 dated 9/6/25 at 3:29 AM revealed that Resident 16 is currently on an antibiotic to treat a urinary tract infection.Record review of the progress note for Resident 16 dated 1/2/26 at 3:00 PM revealed that the facility received a call from the clinic that Resident 16 was positive for a urinary tract infection and an antibiotic medication was ordered by the provider.Record review of the progress note for Resident 16 dated 4/7/26 at 7:23 PM revealed that Resident 16 has been more confused today. Resident 16 has a history of having a urinary tract infection. Foul odor was noted in the resident's brief. The resident's brief was saturated and appeared to have been on for some time. Record review of the progress note for Resident 16 dated 4/8/26 at 4:33 PM revealed that the provider gave orders to start an antibiotic related to probable urinary tract infection.Record review of the current comprehensive care plan for Resident 16 dated 4/20/26 revealed that it did not include resident ability or need of assistance for toileting. The care plan did not include a care focus for resident urinary tract infections and risk for urinary tract infections. The care plan did not include any interventions to monitor Resident 16 for urinary tract infections or interventions to prevent urinary tract infections.Interview on 4/21/26 at 4:20 PM with the facility Director of Nursing (DON) confirmed that care needs identified in the resident MDS assessment are to be included in the resident's comprehensive care plan. The DON confirmed that resident risk of urinary tract infection should be identified and included in the resident care plan to direct staff on cares to monitor and prevent urinary tract infection.B.Record review of the admission Record dated 4/22/26 for Resident 12 revealed that Resident 12 admitted into the facility on 3/9/26. Diagnoses included diabetes and edema (swelling caused by excess fluid trapped in the body's tissues).Record review of the MDS assessment for Resident 12 dated 3/17/26 revealed that it was the admission assessment for Resident 12. The MDS assessment documented that Resident 12 had an active diagnosis of high blood pressure, edema, and diabetes. Record review of the order summary (a list of all physician orders for a resident) for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 12 dated 4/21/26 revealed that Resident 12 had physician orders for insulin (a medication injected into the skin to treat high blood sugar due to diabetes) 4 times daily. Record review of the progress note for Resident 12 dated 3/9/26 at 10:50 AM revealed that Resident 12 was admitted into the facility from the hospital after treatment for hyperglycemia (high blood sugar in the bloodstream) and weakness.Record review of the progress note for Resident 12 dated 3/31/26 at 3:39 PM revealed that Resident 12's feet and legs remain edematous (swollen or puffy due to an abnormal accumulation of excess watery fluid).Record review of the current comprehensive care plan for Resident 12 dated 4/20/26 revealed that it did not include a focus area of resident medical care needs for diabetes or edema. Interview on 4/21/26 at 4:20 PM with the facility Director of Nursing (DON) confirmed that care needs identified in the resident MDS assessment are to be included in the resident's comprehensive care plan. The DON confirmed that resident diabetes and edema should be identified and included in the resident care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. Licensure Reference Number 175 NAC 12-006.09(F)Based on observation, record review, and interview, the facility failed to ensure a residents Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) was revised reflecting a resident current fall prevention intervention was listed for 1 resident (Resident 5) of 5 sampled residents. The facility census was 28.Findings are:Record review of a facility policy titled Comprehensive Care Plans dated 02/18/2026 revealed it is the policy of the facility to develop and implement a comprehensive care plan for each resident.In an observation completed on 04/21/2026 at 2:45 PM Resident 5 was observed to be lying in their bed with both of their legs over the edge of the bed on the floor and a alarm was sounding in the resident's room. Staff entered the room and assisted the residents with care needs.In an interview completed on 04/22/2026 at 8:15 AM with Medication Aide F (MA-F), MA-F stated that Resident 5 had a history of falls. The MA stated that one of the interventions to prevent the resident from falling was to have a personal alarm on to alert staff to when the resident was attempting to self-transfer.Record review of Resident 5's Electronic Medical Health Record (EMHR) the EMHR revealed that on 04/07/2026 the resident's provider approved an order for the resident to have a bed and chair alarm.Record review of Resident 5's Medication Administration Record (MAR) for the month of April 2026 revealed an order to maintain bed fall alarm and chair fall alarm twice daily with a start date of 04/07/2026. This was signed as completed twice daily from 04/07/2026 to 04/21/2026.Record review of Resident 5's CCP revealed the focus of Resident 5 being at risk for falls. There was no intervention on the residents CCP for a chair and bed alarm.In an interview completed on 04/23/2026 at 11:50 AM with the Director of Nursing (DON), the DON confirmed that a bed and chair alarm were being utilized as a fall prevention intervention for Resident 5. The DON confirmed that this was not listed on the residents CCP and should have been.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC, 12-006.09Based on observation, interview, and record review the facility failed to ensure a topical medication gel was applied in the amount as ordered by the provider for 1 resident (Resident 20) of 1 sampled resident. The facility census was 28.Findings are:Record review of a facility policy titled Administering Medications and dated 2019 revealed medications are administered in accordance with prescriber orders.Record review of Resident 20's Order Summary on 04/21/2026 revealed a provider order stating Diclofenac Sodium External Gel (a medication that is applied topically to relieve pain) 1% with directions to apply 2grams topically to joints every 6 hours as needed.In an observation completed on 04/21/2026 at 9:57 AM of medication administration to Resident 20 by Medication Aide F (MA-F), MA-F squeezed an unmeasured amount of a opaque white gel onto their gloved hand. The MA rubbed the unmeasured amount of the gel onto the residents' left hip. The MA then squeezed another unmeasured amount of the gel onto their gloved hand and rubbed the unmeasured amount of the gel onto the residents left shoulder. The MA then squeezed another unmeasured amount of the gel onto their gloved hand and rubbed the unmeasured amount of the gel onto the residents left elbow.In an interview completed on 04/21/2026 at 10:05 am with MA-F, MA-F confirmed that the cream that they applied to Resident 20's left hip, shoulder, and elbow was Diclofenac Sodium Gel. The MA confirmed that the prescribed amount of the gel to be applied to the joints was 2 grams and each dose should be measured prior to applying using the clear marked measuring device. The MA confirmed that they did not measure the amount of the gel that they applied to Resident 20's left hip, shoulder, and elbow ensuring that the prescribed 2 grams was applied to each joint as ordered.In an interview completed on 04/22/2026 at 2:45 PM with the facility Director of Nursing (DON), the DON confirmed that MA-F should have used the clear measuring device to measure out each dose of gel that they applied to Resident 20's joints and did not. The DON confirmed that the providers' orders were not followed.