STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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** Number of residents sampled: 5Number of residents cited:4 Licensure Reference Number 175 NAC 12-006.12Based on record review and interview; the facility failed to have signed informed consent in advance for the use of psychotropic medications (medications which alter consciousness, mood and thoughts) for Residents 1, 2, 11, and 21. The sample size was 5 and the facility census was 30. Findings are:A. Review of the facility policy Psychotropic Medication Use dated 7/2022 revealed the following: -residents wound not receive medications that were not clinically indicated to treat a specific condition, -psychotic medications were subject to prescribing, monitoring, and review requirements that were specific to psychotropic medications, -residents would not be given these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record, and - residents and/or representatives were educated on the risks related to not taking the medications as well as appropriate alternatives. B. Review of Resident 11's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 8/22/25 revealed the resident was admitted [DATE]; had severe cognitive impairment; had behaviors of hallucinations, delusions, verbal behaviors, and wandering; received assistance with dressing and supervision with toileting and hygiene; had diagnoses of Non-Traumatic Brain Dysfunction, Dementia, Parkinson's Disease, Anxiety, and Depression; and received anti-anxiety, anti-psychotic, and anti-depressant medications. Review of Resident 11's Care Plan with a revision date of 9/6/25 revealed the resident received psychotropic medications for behavior management; behaviors included delusion, grabbing, wandering, rejection of care, physical aggression, agitation, and anxiety; and the resident required supervision and/or cueing assistance with hygiene and toileting. Review of Resident 11's Medication Administration Records (MAR's) revealed the following orders: -an increase of Fluoxetine (an anti-depressant medication) started 4/13/25, (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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	-an order of for Lorazepam (an anti-anxiety medication) started 5/13/25 -an increase in Seroquel (an anti-psychotic medication) started 6/13/25, and -an order for Depakote (a psychotropic medication) started 6/17/25. Review of the facility forms Psychoactive Medication Informed Consent regarding Resident 11 revealed the consents were signed on 7/3/25 for the following medications: -Fluoxetine 82 days after the start of the medication, -Lorazepam 52 days after the start of the medication, -Seroquel 21 days after the start of the medication, and -Depakote 17 days after the start of the medication. Interview on 9/22/25 at 2:15 PM with the MDS Coordinator confirmed there was no evidence the consents for psychotropic medications for Resident 11 were obtained prior to the administration of the psychotropic medications. C. Review of Resident 21's MDS dated [DATE] revealed the resident was admitted [DATE]; had severe cognitive impairment; had physical behaviors, verbal behaviors, and rejected care; required assistance with toileting, dressing, transfers, and hygiene; had diagnoses of Dementia, Anxiety, and Depression; and received anti-psychotic, anti-anxiety, and anti-depressant medications. Review of Resident 21's Care Plan last revised 8/4/25 revealed the resident received psychotropic medications for behavior management; behaviors included hitting, kicking, wandering, physical aggression, resistance to cares, delusions, agitation, and anxiety; and the resident was dependent on staff for transfers, toileting, dressing, and hygiene. Review of Resident 21's MAR revealed the following: -an order for Venlafaxine (an anti-depressant) started 12/30/24, -an order for Buspar (an anti-anxiety medication) started 3/5/25, and -an order for Seroquel started 4/12/25. Review of the facility forms Psychoactive Medication Informed Consent regarding Resident 21 revealed the following: -Venlafaxine signed 2/6/25 which was 39 days after the start of the medication, -Buspar signed 5/21/25 which was 78 days after the start of the medication, and -Seroquel signed 5/21/25 which was 40 days after the start of the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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	Interview on 9/22/25 at 2:15 PM with the MDS Coordinator confirmed there was no evidence the consents for psychotropic medications for Resident 21 were obtained prior to the administration of the psychotropic medications. D. Review of Resident 1's MDS dated [DATE] revealed the resident was admitted on [DATE]; had severe cognitive impairment; received assistance with dressing, bathing, toileting and standing up and ambulating; had diagnosis of Stroke, Cancer and Depression; and received an antidepressant medication. Review of Resident 1's Care Plan with a revision date of 7/23/25 revealed the resident received psychotropic medication for depression; resident can be demanding and made negative statements; resident ambulates with 1 assist and walker, 1 assist with dressing upper and lower extremities, bathing and toileting cares. Review of Resident 1's Medication Administration Record (MAR) revealed the following order: -an increase in Sertraline (an anti-depressant medication) started 4/13/25. Review of the facility forms Psychoactive Medication Informed Consent regarding Resident 1 revealed the consent was signed by the Resident Representative on 5/27/25, 44 days after the start of the medication. Interview on 9/22/25 at 8:30 AM with the MDS Coordinator confirmed the consent for psychotropic medication for the increase in Sertraline on 4/13/25 was obtained after the medication was started. E. Review of Resident 2's MDS dated [DATE] revealed the resident was admitted on [DATE]; thinking and memory were normal; resident had physical and verbal behaviors; received assistance with bathing and supervision with toileting hygiene; had diagnosis of Anxiety, Depression and Bipolar Disorder; received an antianxiety and antidepressant medication. Review of Resident 2's Care Plan with a revision date of 8/26/25 revealed the resident received psychotropic medications related to bipolar disorder, mild cognitive impairment, depression and non-compliance with other medical treatment and regimen; behaviors included negativity, repetitive health concerns, repetitive statements, anger, delusions, demanding, yelling, hitting, kicking, grabbing, wandering, abusive language, threatening behavior, rejected cares, throwing items, crying, refusing medications; and the resident received 1 assist with bathing and was supervised with toileting cares. Review of Resident 2's MAR revealed the following: -a decrease in Buspirone (an anti-anxiety medication) started 5/22/25. -a decrease to Trazadone (an anti-depressant medication) started 8/7/25. -an increased to Sertraline (an anti-depressant) started 6/11/27. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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	Review of the facility forms Psychoactive Medication Informed Consent regarding Resident 2 revealed the following: -Buspirone signed 8/26/25 which was 96 days after the start of the medication, -Trazadone signed 8/26/25 which was 19 days after the start of the medication, -Sertraline did not have a Psychoactive Medication Informed Consent signed. An interview on 9/23/25 at 9:20 AM with the MDS Coordinator confirmed the consent for psychotropic medication for the change in dosage for Buspirone and Trazadone was obtained after the medication was started and there was not a consent for psychotropic medication form signed for Sertraline.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number: 175 NAC 12-006.18(A)Based on record review and interviews; the facility failed to offer and/or provide the influenza vaccine to Resident 14 and to ensure Residents 11 and 22 were offered and/or provided the pneumococcal vaccine and the residents were educated about the risks and benefits associated with the vaccines. The sample size was 5 and the facility census was 30. Findings are:A. Review of the undated facility policy Pneumococcal Vaccine revealed the receipt of vaccinations was essential for the prevention of pneumonia/pneumococcal infections. The following procedures were identified:-residents were to be screened prior to or upon admission to determine vaccine eligibility and then offered the vaccine series within 30 days of admission.-before offering the vaccine each resident and/or their representative were to receive education regarding the benefits and potential side effects of the immunizations. Information related to education or refusal of the vaccine was to be documented in the resident's medical record.-the vaccine was to be administered to residents per the facility's physician-approved vaccination protocol.-if refused, appropriate information was to be documented in the resident's medical record indicating the date of refusal.-for each resident who received the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination were to be documented in the resident's medical record.B. Review of Resident 11's electronic medical record revealed the resident was admitted on [DATE]. Review of a Prevnar 20 Consent Form and Administration Record dated 4/28/25 (2 months later) revealed the resident's representative had documented acceptance of the vaccine for the resident. Further review revealed no evidence the resident had received the pneumococcal vaccine. C. Review of Resident 22's electronic medical record revealed the resident was admitted [DATE]. There was no evidence the facility had screened Resident 22 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the pneumococcal vaccine, or the resident was offered and/or received the vaccine. D. Review of the undated Influenza Vaccine policy revealed all residents were to be offered the vaccine unless medically contraindicated on an annual basis. The facility was to provide pertinent information about the significant risks and benefits of the vaccine to the residents and their representative. The following procedure was identified:-between 10/1 and 3/31 each year, the influenza vaccine was to be offered unless medically contraindicated or the resident had already been immunized.-prior to the vaccination, the resident and/or their representative would be provided information and education regarding the benefits and potential side effects.-provision of the education was to be documented in the resident's medical record. -for those who received the vaccination, staff were to document the date of vaccination, lot number, expiration date, the person administering, and the site of the vaccination in the resident's medical record.-a resident/representative refusal was to be documented on the informed consent for the influenza vaccine. E. Review of Resident 14's electronic medical record revealed the resident was admitted [DATE]. These was no evidence the resident was provided education regarding risks and benefits of the influenza vaccine, or the resident was offered and/or received the vaccine. F. During an interview on 9/23/25 at 8:49 AM, the Infection Preventionist confirmed the following:-Resident 11 was admitted [DATE] but was not provided education regarding the Prevnar 20 vaccine until 4/28/25. The resident's representative signed a consent on 4/28/25 however, the facility failed to provide the pneumococcal vaccine. -Resident 22 was admitted [DATE] but there was no evidence the resident was provided education regarding the risks and benefits of the pneumococcal vaccine or that the vaccine was offered and/or provided to the resident.-Resident 14 was admitted [DATE] and there was no evidence the resident was provided information regarding the risks and the benefits of the influenza vaccine or was offered and/or provided the vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on observation, record review and interview; the facility failed to report an injury of unknown origin for 1 (Resident 8) of 2 sampled residents. The facility census was 30.Findings are:A. Review of the facility policy Reporting Abuse to State Agencies and other Entities/Individuals dated 12/1/2017 revealed all suspected violations and all substantiated incidents of mistreatment, neglect, injuries of an unknown source or abuse were to be reported to the Administrator or their designee. In addition, the following agencies or persons were to be notified of the incident:-the State licensing/certification agency.-the ombudsman.-the resident's representative.-Adult Protective Services (APS). -the resident's physician. Notices to the agencies were to be made as soon as possible with the maximum notification within 24 hours and if actual harm, APS was to be notified within 2 hours. The Administrator or designee were to then complete an investigation and then send the results of the investigation to the appropriate agencies within 5 working days. B. Review of Resident 8's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/27/25 revealed the resident was admitted on [DATE]; had severe cognitive impairment; was dependent on staff for toileting cares, bathing cares, upper and lower extremity dressing, repositioning in bed, moving from bed to chair and from chair to bed and all wheel chair mobility; had physical behaviors and other behavioral symptoms not directed at others (hitting or scratching self); had diagnosis of Non-Alzheimer Dementia (a progressive decline in cognition ability that is not caused by Alzheimer's Disease) and Psychotic Disorder. Review of a Nursing Progress Note dated 9/16/25 at 4:01PM revealed the physician was notified of yellow bruising to the top of the right foot that measured 15 centimeters (cm) by 13 cm with minimal swelling and purple and yellow bruising to the bottom of the right foot that measured 9 cm by 7 cm with minimal swelling noted. An observation on 9/18/25 at 10:35 AM revealed that the resident had yellow bruising to the top of the right foot and the bottom of the foot had yellow/purple bruising with minimal swelling to foot. Resident had no response when asked if the right foot hurt. An interview on 9/22/25 at 1:00 PM with the Director of Nursing confirmed the following:-The staff did not witness the incident which had caused the injury to Resident 8's right foot.-The facility should have reported the significant bruising and swelling to the resident's right foot as an injury of unknown to the State Agency, and -the facility failed to report the injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on observation, record review and interview; the facility failed to complete an investigation and report the results of the investigation to the State Agency for an injury of unknown origin for 1 (Resident 8) of 2 sampled residents. The facility census was 30.Findings are:A. Review of the facility policy Reporting Abuse to State Agencies and other Entities/Individuals dated 12/1/2017 revealed all suspected violations and all substantiated incidents of mistreatment, neglect, injuries of an unknown source or abuse were to be reported to the Administrator or their designee. In addition, the following agencies or persons were to be notified of the incident:-the State licensing/certification agency.-the ombudsman.-the resident's representative.-Adult Protective Services (APS). -the resident's physician. Notices to the agencies were to be made as soon as possible with the maximum notification within 24 hours and if actual harm, APS was to be notified within 2 hours. The Administrator or designee were to then complete an investigation and then send the results of the investigation to the appropriate agencies within 5 working days. B. Review of Resident 8's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/27/25 revealed the resident was admitted on [DATE]; had severe cognitive impairment; was dependent on staff for toileting cares, bathing cares, upper and lower extremity dressing, repositioning in bed, moving from bed to chair and from chair to bed and all wheel chair mobility; had physical behaviors and other behavioral symptoms not directed at others (hitting or scratching self); had diagnosis of Non-Alzheimer Dementia (a progressive decline in cognition ability that is not caused by Alzheimer's Disease) and Psychotic Disorder. Review of a Nursing Progress Note dated 9/16/25 at 4:01 PM revealed the physician was notified of yellow bruising to the top of the right foot that measured 15 centimeters (cm) by 13 cm with minimal swelling and purple and yellow bruising to the bottom of the right foot that measured 9 cm by 7 cm with minimal swelling noted. Review of the investigation completed by the facility on 9/17/25 revealed the staff determined the resident's foot had potentially bumped into the mechanical lift during a transfer. Further review revealed no staff were interviewed regarding the use of the mechanical lift for the resident or an evaluation was not completed to ensure the staff were transferring the resident safely. An observation on 9/18/25 at 10:35 AM revealed that the resident had yellow bruising to the top of the right foot and the bottom of the foot had yellow/purple bruising with minimal swelling to foot. Resident had no response when asked if the right foot hurt. An interview on 9/22/25 at 1:00 PM with the Director of Nursing and Administrator confirmed that the bruising and swelling to Resident 8's right foot was an injury of unknown origin and that staff failed to complete a thorough investigation to determine the cause of the resident's bruising and swelling to the right foot and no investigation was sent to the Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on observation, record review and interview; the facility failed to identify a change of condition for 1 (Resident 1) of 1 sampled resident. The facility census was 30. Findings are: A. Review of the facility policy Change in a Resident's Condition or Status with a revision date of 8/11 revealed it was the policy of the facility to promptly notify the resident, their physician, and their responsible party of changes in the resident's medical/mental condition and/or status. A significant change of condition was identified as a decline or an improvement in the resident's status that:-would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.-impacts more than one area of the resident's health status.-requires interdisciplinary review and/or revision to the care plan. The policy further revealed the resident's physician was to be notified when there had been:-an incident/accident involving the resident.-a discovery of an injury of unknown source.-a significant change in the resident's physical/emotional/mental condition.-a need to alter the resident's medical treatment significantly. -a need to transfer the resident to a hospital or treatment center. Except in medical emergencies, notifications were to be made within 24 hours of a change occurring in the resident's status. In addition, the Charge Nurse was to document in the resident's medical record information related to the change on the resident's condition or status. B. Review of Resident 1's Care Plan revised 7/23/25 revealed the resident had a history of pneumonia and coughing with fluids (when drank liquids). Observation on 9/18/25 revealed the following:-At 9:25 AM the resident was sitting in recliner with feet elevated. Licensed Practical Nurse (LPN)-E administered oral medications to Resident 1. Resident began coughing forcefully and complaining of increased shortness of breath. LPN-E had resident take swallows of water to get the medications swallowed. -At 11:05 AM staff assisted resident to the bathroom, resident ambulated with walker and with 1 staff member without difficulty. Resident continued to cough.-At 12:10 PM the resident was sitting in the dining room eating noon meal, took bites of food and sips of water without difficulty.-At 1:15 PM the resident sat in the dining room at an activity, refused to drink water when offered, reported being afraid of coughing or choking on the water. Resident stated not liking thick liquids and would refuse to drink if that's what the staff would do. -At 2:45 PM the resident was sitting in recliner in resident's room, cough noted. Review of Nurses Notes on 9/23/25 at 7:30 AM revealed the following:-No documentation of Resident's 1 coughing on 9/18/25 had been documented in the chart.-On 9/20/25 at 12:34 AM the resident had a productive cough with thick white phlegm. Temperature was 98.8, oxygen saturation was 94%. Lung sounds had wheezes in the lower right lung field.-On 9/20/25 at 3:49 AM resident continued to have productive cough, coughing up yellow/green phlegm. -On 9/20/25 at 11:20 AM resident was weak and leaning when sat on the edge of the bed. Temperature was 98.0, respirations were 20, blood pressure was 98/58 and oxygen level was 92%. Lung sounds were diminished with an occasional productive cough. A nurse called the clinic for the resident to be seen. The Director of Nursing was notified. Son was notified that the resident was going to the clinic. The nurse was notified that the resident was being admitted to [NAME] County Hospital with a diagnosis of pneumonia. An interview on 9/22/25 at 10:30AM with the Director of Nursing confirmed that there was no documentation completed on 9/18/25 that resident had a cough after taking morning medications. There were no vital signs, respiratory assessment or oxygen levels charted on 9/18/25 or 9/19/25. The nurses should have been completing vital signs, lung sounds and oxygen levels on 9/18/25 and 9/19/25. The physician was not notified of the residents cough and should have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05Based on record review and interview; the facility failed to ensure Resident 21 had a resident specific rationale as to why a Gradual Dose Reduction (GDR) was not attempted for psychotropic medications (medications which alter consciousness, mood and thoughts). The sample size was 5 and the facility census was 30. Findings are:Review of the facility policy Psychotropic Medication Use dated 7/2022 revealed the following: -residents would not receive medications that were not clinically indicated to treat a specific condition,-psychotic medications were subject to prescribing, monitoring, and review requirements that were specific to psychotropic medications,-residents would not be given these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record, and-residents on psychotropic medications would receive GDR's (gradual dose reduction) unless contraindicated in an effort to discontinue these medications, -if psychotropic medications were identified as possibly causing or contributing to adverse effects, the prescriber would determine whether the medication should be continued and would document the rationale, and- residents and/or representatives were educated on the risks related to not taking the medications as well as appropriate alternatives. Review of Resident 21's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 7/18/25 revealed the resident was admitted [DATE]; had severe cognitive impairment; had physical behaviors, verbal behaviors, and rejected care; required assistance with toileting, dressing, transfers, and hygiene; had diagnoses of Dementia, Anxiety, and Depression; and received anti-psychotic, anti-anxiety, and anti-depressant medications. Review of Resident 21's Care Plan last revised 8/4/25 revealed the resident received psychotropic medications for behavior management; behaviors included hitting, kicking, wandering, physical aggression, resistance to cares, delusions, agitation, and anxiety; and the resident was dependent on staff for transfers, toileting, dressing, and hygiene. Review of the facility form Order Summary Report for Resident 21 revealed the resident had active orders for Venlafaxine (an antidepressant medication and Divalproex ER (a psychotropic medication). Review of the facility form facsimile (fax) to the prescriber regarding Resident 21 revealed on 2/5/25 a GDR for Divalproex ER was sent and was contraindicated for a dose reduction. There was no documentation for a resident specific rationale. Review of the facility form fax to the prescriber for Resident 21 dated 5/21/25 revealed a GDR for Venlafaxine was contraindicated for a dose reduction. There was no documentation for a resident specific rationale. An interview on 9/23/25 at 2:15 PM with the MDS Coordinator confirmed there was no resident evidence of a specific rationale documented for the contraindication of a dose reduction for the Venlafaxine and the Divalproex ER.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18Based on observation, record review and interview; the facility failed to wash hands and change gloves at appropriate intervals during the preparation of medication for administration for Resident 9. The facility census was 30.Findings are:A. Review of the facility's undated Medication Administration policy revealed the following regarding medication handling and administration procedure:-staff were to wash hands prior to beginning medication administration.-oral medications in pill/gel/capsule form in bottles were to be put in medication cups or plastic cups prior to administration and not placed in a gloved hand. B. Review of Resident 9's Medication Review Report dated 8/8/25 revealed the following medications:-Mega (gender) Sport Multivitamin 1 tablet by mouth daily in the morning and -L-Methylfolate Oral Capsule (nutritional supplement for folate deficiency) 15 milligrams by mouth in the morning. C. An observation on 9/18/25 at 8:10 AM revealed the following:-Licensed Practical Nurse (LPN)-E walked up to the medication cart, did not wash hands or use hand sanitizer and put on a pair of disposable gloves. -LPN-E touched the mouse to the computer, pulled the medication cart drawer open with gloved hands, picked up the multivitamin pill bottle and poured a pill out of the bottle into gloved hand, picked up a medication cup and placed the pill into the cup. -LPN-E touched the mouse to the computer and documented the pill was ready to administer. -The bottle of multivitamin was put back into the medication cart and the drawer to the medication was closed using the gloved hand. -LPN-E touched the mouse to the computer with gloved hand, opened the drawer to the medication cart, picked up the bottle of L-Methylfolate and poured a pill out of the bottle into gloved hand, picked up the medication cup and placed the pill into the cup. C. An interview on 9/22/25 at 3:05 PM with the Director of Nursing confirmed that staff were to wash hands before administering medications and medications should not be placed in gloved hands, and the pills should be poured directly into a medication cup.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number: 175 NAC 12-006.18(A)Based on record review and interviews; the facility failed to provide evidence 2 (Residents 11 and 22) of 5 sampled residents were offered the COVID-19 vaccine and/or were educated about the risks and benefits associated with the vaccine. The facility census was 30. Findings are:A. Review of the facility policy Coronavirus (COVID-19) Vaccination of Residents dated 2/21 revealed the policy was based on the Center for Disease Control (CDC) recommendations for infection prevention and control practices for COVID-19. The following procedures were identified: -residents were to be screened at admission to determine vaccine status and eligibility to receive the COVID-19 vaccine.-before offering the vaccine each resident and/or their representative were to receive education regarding the benefits and potential side effects of the immunizations. Information related to education or refusal of the vaccine was to be documented in the resident's medical record. -the vaccine could be offered and administered if the benefits of the vaccine outweighed the risks, the resident or the resident's representative provided consent and the resident's physician approved. -individual resident information was to be documented in the resident's electronic medical health record. B. Review of Resident 11's electronic medical record revealed the resident was admitted on [DATE]. Review of a COVID-19 Consent Form and Administration Record dated 4/28/25 (2 months later) revealed the resident's representative had documented acceptance of the vaccine for the resident. Further review revealed no evidence the resident had received the COVID-19 vaccine. C. Review of Resident 22's electronic medical record revealed the resident was admitted [DATE]. There was no evidence the facility had screened Resident 22 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the COVID-19 vaccine, or the resident was offered and/or received the vaccine. D. During an interview on 9/23/25 at 8:49 AM, the Infection Preventionist confirmed the following:-Resident 11 was admitted [DATE] but was not provided education regarding the COVID-19 vaccine until 4/28/25. The resident's representative signed a consent on 4/28/25 however, the facility failed to provide the COVID-19 vaccine. -Resident 22 was admitted [DATE] but there was no evidence the resident was provided education regarding the risks and benefits of the COVID-19 vaccine or that the vaccine was offered and/or provided to the resident.