STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285215	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elwood Care Center	607 Smith Avenue Elwood, NE 68937

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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(B)Based on record review and interview the facility failed to accurately code the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for 5 residents (Resident 2, 3, 25,16, and 29) of 12 sampled residents. The facility census was 30.Findings are:A. A record review of a 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 4/24/26 for Resident 2 revealed under: -Section A states Resident 2 had a readmission from a hospital on 3/10/26. -Section C reveals Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score: 3/15 whereas 0-7: reveals the resident has a severe impairment. -Section N reveals Resident 2 took the following high risk drug class medications during the look back period of the last 7 days until the date of the MDS of 4/24/26: -Antipsychotic (medications used to treat psychosis (delusions/hallucinations), schizophrenia, bipolar disorder, and severe depression.) -Antidepressant (medications used to treat depression, anxiety, PTSD, and chronic pain.) -Anticoagulant (medications that prevent harmful blood clots from forming or growing by inhibiting clotting factors.) -Antibiotic (medications that treat bacterial infections by killing bacteria or inhibiting their growth.) -Diuretic (medications that reduce high blood pressure, heart failure, and edema by aiding the kidneys in removing excess sodium and water via increased urination.) -Hypoglycemic (medication that rapidly raises blood sugar.) A record review of an Order Summary dated 5/4/26 for Resident 2 reveals an order for: Clonazepam (a medication used to treat anxiety (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it) and/or a seizure disorder) tablet; (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
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	0.5 milligram (mg); amout:1 tablet; oral three times a day 8:30 AM, 12:00 PM, 8:00 PM with an order start date of 12/11/2025. An interview with the Assistant Director of Nursing (ADON) on 5/6/26 at 11:50 AM revealed not knowing how to identify the medication Clonazepam on the MDS, therefore not listing it on the high-risk drug class medication being taken by Resident 2. B. A record review of an MDS dated [DATE] for Resident 3 revealed under: -Section A states Resident 3 had a readmission from a hospital on [DATE]. -Section C reveals Resident 3 retains a BIMS score of 15/15 whereas 13-15: reveals the resident is cognitively intact -Section N reveals Resident 3 took the following high risk drug class medications during the look back period of the last 7 days until the date of the MDS of 4/24/26: -Antidepressant -Anticoagulant -Diuretic -Hypoglycemic (medication that rapidly raises blood sugar) -Opioid (medication used for moderate-to-severe pain) A record review of an Order Summary dated 5/4/26 for Resident 3 reveals an order for: -gabapentin (an anticonvulsant medication used to treat partial seizures and neuropathic pain) capsule; 300 milligram (mg); amount: 1 capsule every morning 5:00 AM and Gabapentin capsule; 400 mg; amount: 1capsule; oral twice a day 3:00 PM, 9:00 PM with an order start date of 4/30/25. An interview with the ADON on 5/6/26 at 11:50 AM revealed not knowing how to identify the medication Gabapentin on the MDS, therefore not listing it on the high-risk drug class medication being taken by Resident 3. C. A record review of an MDS dated [DATE] for Resident 25 revealed under: -Section A states Resident 25 had an admission from a hospital on [DATE]. -Section C reveals Resident 25 retains a BIMS score of 10/15 whereas 8-12: reveals the resident is (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moderately impaired. -Section N reveals Resident 25 took the following high risk drug class medications during the look back period of the last 7 days until the date of the MDS of 3/27/26: -Antipsychotic -Antidepressant -Diuretic -Hypoglycemic -Opioid A record review of an Order Summary dated 5/4/26 for Resident 25 reveals an order for: -gabapentin capsule; 100 mg; amount: 1 capsule oral three a day 7:30 AM, 12:00 PM, 5:00 PM with an order start date of 4/9/26. A record review of a Medication Administration Review (MAR; a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 25 dated 3/1/26 through 3/27/26 revealed an order for gabapentin capsule; 300 mg three times a day with a start date of 10/13/25-4/9/26. Medications were administered as ordered. An interview with the ADON on 5/6/26 at 11:50 AM revealed not knowing how to identify the medication gabapentin on the MDS, therefore not listing it on the high-risk drug class medication being taken by Resident 25. D. Record review of the Quarterly MDS with the Assessment Reference Date of 03/13/2026 revealed Resident 16 had an initial admission date to the facility of 07/14/2025. The MDS was coded that the resident did not receive an anticonvulsant medication during the look back period for the MDS. Record review of Resident 16's Orders on 05/05/2026 revealed that Resident 16 had an order for Gabapentin (an anticonvulsant medication) with instructions to give 300 milligrams at bed time, with an order start date of 08/12/2025. Record review of Resident 16's Medication Administration Record (MAR) for the month of March 2026 revealed Resident 16 was administered the Gabapentin medication as prescribed every day of the month. All of the administrations were signed as completed by facility staff. In an interview completed on 05/06/2026 at10:16 AM with the facility Assistant Director of Nursing (ADON) who acts as the MDS Coordinator (the individual responsible for compiling and entering data into the MDS), the ADON confirmed that Resident 16 received the Gabapentin medication every day during the month. The ADON confirmed that the Quarterly MDS dated [DATE] was not coded correctly and should have been coded that the the resident received the anticonvulsant medication and was not. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of the facility policy titled Comprehensive Care Plans (a written interdisciplinary comprehensive plan to meet the resident's needs that are identified in the resident's comprehensive assessment) dated 2/11/25 revealed that the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, and mental psychosocial needs that are identified in the resident's comprehensive assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be used in developing the plan of care. Record review of the MDS assessment dated [DATE] for Resident 29 revealed that Resident 29 admitted into the facility on 9/25/25. The MDS revealed that Resident 29 had a diagnosis of atrial flutter (A type of abnormal heart rhythm (arrhythmia) where the upper chamber of the heart beats too fast. This condition can lead to other problems, like a stroke or heart attack. Atrial flutter medications include anticoagulants (blood thinners) to prevent blood clots that can cause a stroke or heart attack). The MDS section for documenting current resident medication types revealed that anticoagulant was not marked as a medication that Resident 29 was taking. The MDS revealed that antiplatelet (A medication that prevents platelet blood cells from sticking together and clumping. Antiplatelets work by a different mechanism than anticoagulants) was a medication that Resident 29 was taking. Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a resident at a facility by a health care professional) for the month of February 2026 for Resident 29 revealed that Resident 29 had a physician's order for Xarelto (a prescription anticoagulant to prevent blood clots) 15 milligrams daily. Staff documented administration of the Xarelto daily as ordered for 2/1/26 through 2/28/26. Record review of the Care Plan for Resident 29 dated 5/4/26 revealed that Resident 29 takes medications with a Black Box Warning (prescription medications with severe, life-threatening, or permanently disabling adverse reactions). The care plan revealed that Resident 29 requires care for the black box medication Xarelto. The care plan intervention dated 1/5/26 revealed that if anticoagulation must be discontinued, consider coverage with another anticoagulant. Interview on 5/6/26 at 11:17 AM with the facility Assistant Director of Nursing (ADON) confirmed that the MDS for Resident 29 was coded incorrectly. The ADON confirmed that Resident 29 takes an anticoagulant. The ADON confirmed that Resident 29 does not take an antiplatelet. The ADON confirmed that the MDS should be marked that Resident 29 is taking an anticoagulant and not marked as taking an antiplatelet medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 1-005.06(D)Licensure Reference Number 175 NAC 12-006.18(B)Based on observation, record review, and interview the facility failed to ensure that staff performed hand sanitization (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) between resident contacts to prevent the potential for cross contamination. This affected 12 of 12 residents observed (Residents 9, 31, 10, 3, 17, 30, 25, 2, 22, 23, 14, and 26). The facility census was 30.Findings are:Record review of the facility policy titled Hand Hygiene (hand sanitization) dated 1/22/25 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 within the facility. Hand hygiene will be performed between resident contacts, after handling contaminated objects, after handling items potentially contaminated with body fluids and secretions/excretions, and when in doubt. Observation on 5/4/26 at 2:55 PM on the facility 200 hallway revealed that Nurse Aide-D (NA-D) exited the room of Resident 9 with a used water mug and sat it on the 3 shelf cart in the hall. NA-D did not perform hand sanitization. NA-D entered the room of Resident 31 and then exited with a used mug and sat it on the 3 shelf cart. NA-D did not perform hand sanitization. NA-D entered the room of Residents 10 and 3 (roommates). NA-D exited the room with 4 used mugs cradled against their uniform top with the left arm. NA-D sat the mugs on the 3 shelf cart. NA-D did not perform hand sanitization. NA-D entered the room of Residents 17 and 30 (roommates). NA-D exited the room with used mugs and placed them on the 3 shelf cart. NA-D did not perform hand sanitization. NA-D entered the room of Resident 25 and then exited the room with a used mug. NA-D sat the mug on the 3 shelf cart. NA-D did not perform hand sanitization. NA-D entered the room of Resident 2. NA-D exited the room with a used mug and sat it on the 3 shelf cart. NA-D did not perform hand sanitization. NA-D pushed the 3 shelf cart from the 200 hallway to the 100 hallway. Observation on 5/4/26 at 2:57 PM on the facility 200 hallway revealed that Nurse Aide-E (NA-E) pushed a 3 shelf cart with mugs of water to the doorway of Resident 6. NA-E carried a mug into the room of Resident 6. NA-E exited the room and went to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E removed a mug from the 3 shelf cart and carried it into the room of Resident 9. NA-E exited the room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E removed a mug from the 3 shelf cart and carried it into the room of Resident 31. NA-E sat the mug on the overbed table in the room. Resident 31 was laying in the bed. NA-E picked up the blanket partially covering Resident 31 and recovered the resident with the blanket. NA-E explained to Resident 31 that NA-E brought fresh water. NA-E exited the room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E pushed the cart toward the room of Residents 10 and 3 (roommates). NA-E removed two mugs from the 3 shelf cart and carried them into the room of Residents 10 and 3 (roommates). NA-E exited the room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E removed two mugs and carried them into the room of Residents 17 and 30 (roommates). NA-E exited the room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E pushed the 3 shelf cart towards the room of Resident 25. NA-E removed a mug from the 3 shelf cart and carried it into the room of Resident 25. NA-E exited the resident room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E picked up a mug from the 3 shelf cart and carried it into the room of Resident 2. NA-E exited the room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. NA-E pushed the 3 shelf cart from the 200 hallway into the 100 hallway. NA-E picked up two mugs from the cart and carried them into the room of Residents 22 and 23 (roommates). NA-E exited the room. NA-E did not perform hand sanitization. NA-E pushed the cart towards the room of Residents 14 and 26 (roommates). NA-E removed two mugs from the cart and carried them into the room of Residents 14 and 26. NA-E assisted Resident 14. NA-E exited the resident room and returned to the 3 shelf cart. NA-E did not perform hand sanitization. Observation on 5/5/26 at 2:23 PM on the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility 200 hall revealed that NA-E pushed a 3 shelf cart to room of Resident 6. NA-E entered the room and exited with a used water mug. NA-E did not perform hand sanitization. NA-E entered the room of Resident 9 and exited with a used water mug. NA-E did not perform hand sanitization. NA-E pushed the 3 shelf cart down the hall to the next set of rooms. NA-E went into the room of Residents 10 and 3 (roommates) and exited with used water mugs. NA-E did not perform hand sanitization. NA-E went into the room of Resident 31 and exited with used water mug. NA-E did not perform hand sanitization. NA-E continued to enter and remove used water mugs from the rooms of Residents 17, 30, 25, and 2 without performing hand sanitization. Interview on 5/6/26 at 9:39 AM with the facility Assistant Director of Nursing (ADON) confirmed that all staff are expected to perform hand hygiene on exit from a resident room. The ADON confirmed that hand sanitization should have been performed by staff between resident rooms during water pass.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(E) Based on record review and interview, the facility failed to document that the residents or resident representatives were educated in advanced about the risks, benefits, and alternate interventions of psychotropic medications when new medications were prescribed or current medications were increased for 2 residents (Resident 9 and Resident 20), of 5 sampled residents. The facility census was 30. Findings are:A. Review of the Minimum Data Set (MDS) (a standardized assessment tool used in long-term care settings, that serves as a comprehensive screening and assessment instrument that collects essential information about residents' clinical and functional status and assists in determining care needs, guiding treatment plans, and facilitating reimbursement processes for skilled nursing facilities) created on 3/27/2026 revealed Resident 9 was admitted to the facility on [DATE]. Resident 9 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated normal thinking and memory. The MDS also revealed that Resident 9 had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, malnutrition, anxiety disorder, depression, and insomnia. Record review of the facility policy dated 4/20/2020 Behavioral Health Services revealed it is the policy that all residents receive necessary behavioral healthcare and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. The policy further stated the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The process included the use of ongoing monitoring of mood and behaviors, care plan development, implementation, and evaluation. Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated. Record review of an email sent to the facility from the facility's consulting pharmacist on 10/01/2025 revealed that the pharmacist wanted to touch base with the facility about issues that other facilities had been having with their annual surveys. The consulting pharmacist revealed the following: Essentially any new psychotropic order or change to a current psychotropic (either dose increase or decrease) must have consent documented prior to that order being initiated. This means documentation is required before the first dose is given. But please note, the written/signed consent form is not required here since that is typically not feasible before the first dose/ A simple progress note saying consent was received via telephone with family is perfectly acceptable at first, but it just needs to be before that first dose. The consulting pharmacist then forwarded the actual verbiage from the Centers for Medicare and Medicaid Services (CMS) as it related to the use of psychotropic medications (drugs that affect mood, behavior, thoughts, or perception, primarily by altering brain chemistry) and informing the resident or resident representative about the risks and benefits of a dose increase, decrease, or when a new psychotropic medication is started. Record review of the document titled (Facility Name) Psych April 2026 for Resident 9 revealed that the resident was admitted to the facility with the orders for Abilify (an psychotropic medication (drugs that affect mood, behavior, thoughts, or perception, primarily by altering brain chemistry) used for the diagnosis of major depressive disorder) on 4/15/2025. There was an order for a gradual dose reduction on 6/24/2026 that the family refused at that time. Then on 1/19/2026 another GDR was documented to reduce the medication. The document also revealed that the resident was admitted with the medication Zoloft (a medication for depression) and had a gradual dose reduction completed 9/23/2025 which failed and the medication was then increased on 2/3/2026. Trazadone (an (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant) was added as an antidepressant on 3/5/2026. on 3/16/2026, Remeron (an antidepressant) was added to stimulate the appetite. Record review of the Physician Orders printed on 5/6/2026 revealed that Resident 9 takes the following psychotropic medications: 1. Aripiprazole (a psychotropic medication that affects brain function, particularly the activity of neurotransmitters such as dopamine and serotonin, which regulate mood, behavior, and thought processes and used for severe depression) 2 milligrams (mg) once daily for major depressive disorder without psychotic features 2. Mirtazapine (an antidepressant medication) 7.5 mg for moderate protein calorie malnutrition. 3. Sertraline (an antidepressant medication) 150 mg for major depression without psychotic features. 4. Trazadone (an antidepressant medication) 50 mg for insomnia. Review of the Nursing Progress Notes printed on 5/6/2026 revealed there was no documentation of the actual risks and benefits about the psychotropic medications ordered for Resident 9 when the resident entered the facility, when medications were increased, when medications were increased, or when new medications were added. Notes from the progress notes included the following: 6/25/2025; There is an entry in the Nursing Progress Notes that revealed there was information given to the resident representative as to why the facility wanted to try to do a gradual dose reduction (decrease the medication) of aripiprazole, but the resident representative refused. Nothing was documented about the risks or benefits revealed about the aripiprazole medication. 9/23/2025; Received order from PCP in regard to pharmacy review. Order to decrease Sertraline to 100mg QD. Resident Representative notified. 1/9/2026: There is an entry in the Nursing Progress Notes that revealed there was an order to change the aripiprazole, and the staff spoke at length about risks and benefits of decreasing medication. Ensured POA that monitoring for side effects such as change in mood, sleep, and appetite for example are documented if updates to Primary Care Physician need to be done. 2/3/2026; Received order from PCP to increase. Sertraline to 150mg QD. Resident Representative notified 2/17/2026; Documentation that staff received an order to start Trazadone 25mg for sleep on an as needed basis when Resident 9 requests something for sleep. Resident Representative notified. 3/5/2026; Received order from Primary Care Physician make Trazodone 50 mg routine per resident request and give every night at bedtime per Resident 9's request. 3/16/2026; Fax sent from Primary Care physician with new orders: Remeron (mirtazapine) 15 mg- 1/2 tablet at bedtime. Resident Representative notified. In a confirmation interview with the Director of Nursing (DON) on 5/5/2026 at 11:40 AM it was confirmed that although there is information in the progress notes that the residents and families are (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified of the medication changes, it is not documented that there is anything related to the actual risks of adding or discontinuing the medications or the risks associated with the medications. The DON also confirmed that there is not an actual document used by the facility to document the risks and benefits of psychotropic medications. In a confirmation interview with the Assistant Director of Nursing (ADON) on 5/5/2026 at 11:42 AM revealed that the care plan (a written plan of care that describes how a facility will care for an individual resident) contains the information as it relates to the risks and benefits but that what is discussed with the residents or resident representatives at the care plan meetings representatives is not documented on the care plan as the facility staff only document that residents and families are told about the medication changes in the progress notes but what specifically is discussed is not documented. ADON stated that the facility is working on documentation and trying to improve that throughout the facility. B. Record review of a Resident Face Sheet for Resident 20 revealed that the facility admitted Resident 20 on 03/23/2026 with diagnosis of generalized anxiety disorder (a persistent, excessive, and uncontrollable worry about everyday things that often causes significant distress, physical symptoms, and interferes with daily life), and major depressive disorder (a serious, common mental health condition characterized by persistent, severe low mood, loss of interest, and low energy that affect daily functioning). Record review of Resident 20's comprehensive 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) with an Assessment Reference Date (ARD) of 03/27/2026 revealed the MDS was coded to reflect that the resident received routine antipsychotic (a psychotropic mood altering drug) and antidepressant (a psychotropic mood altering drug) medications on a routine basis during the look back period. Record review of a untitled document dated 03/11/2026 revealed the residents name and a listed medication order of Quetiapine 25 milligram tablet to be administered at bed time and Citalopram 20 milligram tablet to be administered in the morning. Record review of Resident 20's Medication Administration Record for the month of March 2026 revealed documentation that Resident 20 received the Quetiapine (an antipsychotic psychotropic medication) and Citalopram (an anti-depressant psychotropic medication) medications every day since admission to the facility. Record review of Resident 20's Progress Notes revealed no documentation that the resident or their representative was educated about the risks, benefits, and alternate interventions used for Resident 20 due to receiving the Antipsychotic, and Anti-Depressant medications. Record review of Resident 20's Electronic Medical Health Record revealed no documentation that that the resident or their representative was educated about the risks, benefits, and alternate interventions used for Resident 20 due to receiving the Antipsychotic, and Anti-Depressant medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview completed on 05/05/2026 at 11:40 AM with the facility Director of Nursing (DON), the DON confirmed that there was no documentation that the resident or their representative were educated about the risks, benefits, and alternate interventions used for Resident 20 for the use of the psychotropic medications that the resident had been receiving since admission to the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(4) Based on record review and interview, the facility failed to ensure that comprehensive person-centered care plans were developed and implemented with measurable goals and objectives to meet the required needs of each resident for 2 residents (Resident 9 and Resident 35) of 14 sampled residents. The facility census was 30. Record review of the facility policy dated 4/1/2024 Comprehensive Care Plans revealed the policy is to develop and implement a comprehensive person-centered care plan (a detailed document that outlines a patient's medical history, current health status, and the coordinated care needed to meet their health needs) for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The definition of person-centered was to focus on the resident as the locus (center) of control and support the resident in making their own choices and having control over their daily lives. The policy explanation and compliance guidelines started that the care planning process revealed the following: 1.) The care planning process would include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing goals of care. 2.) The plan would be developed within 7 days after the completion of the Minimum Data Set (MDS) assessment (a standardized, federally mandated evaluation of a nursing home resident's health, functional status, and care needs, used to guide care planning and determine reimbursement) and all areas triggered by the MDS would be considered in the formation of the plan of care. Other factors identified by the interdisciplinary team or in accordance with the resident's preferences would be addressed. 3.) The comprehensive care plan would include at a minimum the following: a. The services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services as a result of Preadmission Screening and Resident Review (PASARR) (a federally mandated assessment to ensure individuals with serious mental illness or intellectual disabilities are appropriately placed in nursing facilities and receive the services they need.) d. the resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans as appropriate. F. Resident specific interventions that reflect the resident's needs and preferences. 5.) The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment and as appropriate as changes arise. 6.) The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs, and the objectives will be utilized to monitor the resident's progress. A.Review of the Minimum Data Set (MDS) (a standardized assessment tool used in long-term care settings, that serves as a comprehensive screening and assessment instrument that collects essential information about residents' clinical and functional status and assists in determining care needs, guiding treatment plans, and facilitating reimbursement processes for skilled nursing facilities) created on 3/27/2026 revealed Resident 9 was admitted to the facility on [DATE]. Resident 9 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated normal thinking and memory. The MDS also revealed that Resident 9 had diagnoses of Alzheimer's disease, non-Alzheimer's dementia, malnutrition, anxiety disorder, depression, and insomnia.Record review of the facility policy dated 4/20/2020 Behavioral Health Services revealed it is the policy that all residents receive necessary behavioral healthcare and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning. The policy further stated the facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The process included the use of ongoing monitoring of mood and (continued on next page)

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	285215	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elwood Care Center	607 Smith Avenue Elwood, NE 68937

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors, care plan development, implementation, and evaluation. Pharmacological interventions shall only be used when non-pharmacological interventions are ineffective or when clinically indicated.Record review of the Comprehensive Care Plan last reviewed and revised on 04/27/2026 revealed that Resident 9 was taking medications with a black box warning (the FDA's most serious safety alert, indicating that a drug carries risks of severe or life-threatening adverse effects) which included: Remeron (an antidepressant) also called mirtazapine, Trazadone (an antidepressant), Abilify (a psychotropic medication) also called aripiprazole, Lasix (a medication that increases urine production to help remove excess salt and water from the body), sertraline (a medication from depression), Synthroid (a medication that replaces or supplement the naturally occurring thyroid hormone produced by the body), and Tylenol also called acetaminophen. One goal listed for all the medications stated, Resident 9 will not have any adverse reactions to medications by the next care plan meeting. The following approaches and specific goals and objectives were documented for the following medications; Remeron - approach; being used for appetite stimulation, monitor for clinical signs of mood changes, suicidality or unusual chances in behavior. No specific measurable goals and objectives were created for this medication. Trazadone - approach; drug may increase risk of suicidal thinking. Monitor patients for signs or symptoms of increased suicidal thinking. No specific measurable goals and objectives were created for this medication. Abilify (aripiprazole) - approach; monitor patients for worsening or emergence of suicidal thoughts and behaviors. No specific measurable goals and objectives were created for this medication. Lasix - approach; drug is a potent diuretic and can cause severe diuresis (too much fluid loss) with water and electrolyte depletion. Monitor patient closely and adjust dose carefully. No specific measurable goals and objectives were created for this medication. Sertraline- approach - warning for clinical worsening and suicide risk, suicidal thoughts and behaviors. No specific measurable goals and objectives were created for this medication. Tylenol - approach; drug can cause acute liver failure which may require a liver transplant or cause death. Most cases of liver failure are associated with drug doses exceeding 4000 milligrams (mg)/day and often involve more that on acetaminophen containing product. Many over-the-counter and prescription products contain acetaminophen, be aware of this when calculating total daily dose. No specific measurable goals and objectives were created for this medication. There were other approaches as they related to Resident 9. The Abnormal Involuntary Movement Score (AIMS) (a 12-item clinician-rated scale to assess severity of involuntary facial movements in patients taking psychotropic (any drug that affects behavior, mood, thoughts, or perception) medications was to be completed as scheduled, but no identification of when these were to be scheduled. The consulting pharmacist was to do gradual dose reductions of the psychotropic medications as required but no indication as to what that timeline was.Interview on 5/5/2026 at 10:58 AM with Nurse Aide (NA) A revealed that nurses let us (nurse aides and medication aides) know in report when there is someone that we have to be monitoring for behaviors. Then they will also tell us the last day we have to observe for behaviors. We chart what we observe about the residents in the electronic medical record. We have a category for behaviors that we - as a CNA - chart in. We watch for anything abnormal and we see anything, we just let the charge nurse know. As for Resident 9, I will need to check with the charge nurse because I don't think we are monitoring Resident 9 for anything anymore.Interview with the Assistant Director of Nursing (ADON) on 5/5/2026 at 11:04 AM who revealed that the behaviors are charted in the Progress notes.Interview with the Director of Nursing (DON) on 5/5/2026 at 11:05 AM who revealed that the progress notes are the only place that we chart a resident's behaviors. We chart when there is a medication change for a period of 30 days. This includes new starts for medications or a discontinuance of a medication. We also chart for 30 days when there is a witnessed change in behaviors.Interview with the ADON on 5/5/2026 at 11:08 AM who revealed that the behaviors are also charted with the MDS if they occur in the look back period - a period of about 5 days when we are doing that assessment - but we always include them in the care plans.Interview with the DON on 5/5/2026 at 11:35 AM revealed that the care plans used to be too long and nobody (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would take the time to read them. What looks to be all about the medications is mostly just the information for the black box warnings. There is a part of the care plan document that tells more about behaviors and moods. The staff document changes in the medications and moods for a total of 30 days. That includes the decreases of medications for a period of 30 days and when there are any increases in the medications. They do have this captured in the care plan. However, it is broad. The facility staff are going to work on narrowing this in the care plan to be more specific as it relates to each of the medications or at least insert the information as it correlates to the moods into the other aspects of the care plan. The moods and behaviors should be in a different area of the care plan. We will work on creating measurable goals and objectives, so they are more clearly understood for those using the care plan to care for the residents.In a confirmation interview with the ADON on 5/5/2026 at 11:35 AM who revealed that some goals and objectives are buried in other portions of the care plan. The ADON confirmed that the goals do not have measurable and objective goals related to each medication identified and are not person-centered as it would relate only to this resident.B.Record review of the quarterly MDS dated [DATE] revealed Resident 35 was admitted on [DATE]. Resident 35 wore glasses, had a BIMS score of 7 (a score that indicated severe cognitive impairment, suggesting significant difficulty with memory, orientation and thinking skills), used a walker for ambulation, needed minimal to moderate assistant with activities of daily living such as toileting, bathing, dressing, and oral cares, was occasionally incontinent of urine, had medically complex issues including hypertension (high blood pressure), renal insufficiency (kidney were starting to work inefficiently), diabetes, difficulty speaking, an anxiety disorder, asthma or chronic obstructive pulmonary disorder (difficulty with breathing), anemia (a deficiency of healthy red blood cells or hemoglobin, leading to insufficient oxygen delivery to the body's tissues), and difficulty swallowing, and was at risk of developing pressure ulcers but currently had no skin conditions or open areas of the skin.Record review of the Physician admission Orders dated 10.2.2025 revealed that Resident 35 was admitted with diagnoses of atrial fibrillation (Irregularly irregular heart rhythm), high blood pressure, and hypothyroid (low thyroid).Record review of the Office Clinic Notes dated 12/22/2025 revealed that Resident 35 was seen for failure to thrive (FTT) (a syndrome of physical, cognitive, and functional decline, often marked by weight loss, poor nutrition, decreased activity, and social withdrawal.). FTT was added to Resident 35's list of diagnoses.Record review of the Office Clinic Notes dated 01/26/2026 revealed the office visit was a follow up to Resident 35's edema (swelling from extra fluid in the body), weakness, loss of appetite, and leg pain. Added to Resident 35's list of diagnoses was chronic kidney disease (long term disorder of the kidneys not working properly to secrete urine), pitting edema in which the provider added furosemide (a diuretic medication that helps the kidneys produce more urine to eliminate extra bodily fluids via the kidneys),and leg pain in which the provider order acetaminophen with codeine (codeine is an opioid medication for more severe pain).Record review of the inhouse visit with an Advanced Practice Registered Nurse (APRN) dated 02/03/2026 revealed that the facility staff wanted Resident 35 to be seen for a sore on the right ankle, sores to both buttocks, and weight loss. The staff also asked for an order to have Hospice re-evaluate Resident 35. After seeing Resident 35, the diagnosis included congestive heart failure (CHF) (a chronic condition in which the heart cannot pump blood efficiently, leading to fluid buildup and symptoms like shortness of breath and swelling), blisters and cellulitis with skin breakdown on both buttocks. The APRN ordered doxycycline (an antibiotic medication for infections) for the infection control.Record review of the inhouse facility visit dated 02/12/2026 with an APRN revealed the facility staff wanted Resident 35 to be seen for a follow up about Resident 35's congestive heart failure, blisters that had turned into sores on a foot, the right foot which was purple and cold to touch, edema in both legs, shortness of breath with activities, and lack of appetite. The APRN added levothyroxine to the daily medications, and changed the medication being used for pain control.Record review of the comprehensive care plan last reviewed and revised on 01/28/2026 revealed that that care plan had not been updated to include the addition of the opioid medication given for pain, did not (continued on next page)

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