STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(3) Based on observations, record review, and interview; the facility failed to ensure residents received assistance with their Activities of Daily Living per their plan of care for 6 (Residents 1, 2, 3, 4, 12, and 19) of 6 sampled residents. The facility identified a census of 36. Findings Are: A record review of the facility policy Activities of Daily Living (ADL), Supporting with a revision date of March 2018 revealed that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. An interview on 6/7/25 at 10:14 PM with Nursing Assistant (NA)-L and NA-M revealed both NA's worked the night shift. NA-M stated that three nights earlier, it was after midnight before the staff finished getting the residents into bed for the night due to the lack of staff that had been available to provide cares for the residents on the evening shift. A. A record review of Resident 1's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 4/15, indicating severe cognitive impairment. The MDS also revealed the resident required partial/moderate to substantial/maximal assistance from staff for their oral, toileting, and personal hygiene. The resident also required substantial/maximal assistance for their shower/bathing needs. A record review of Resident 1's undated Care Plan revealed the resident required 1-person staff assistance with their bathing/showering, dressing, personal hygiene, and toilet use. A record review of facility provided document for Resident 1 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/14/25, 5/17/25, 5/21/25, 5/28/25, and 5/31/25 Not applicable, and on 5/24/25 Resident Refused. There was no other documentation. A record review of the facility document for Resident 1 titled The Spa at Skyview Bathing Schedule from 5/8/25 through 6/9/25 revealed the resident was scheduled to receive showers every Tuesday, Thursday, and Saturday. The documentation revealed the resident received a shower on 5/8/25, 5/27/25 and 6/3/25. (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
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 6/7/25 beginning at 6:00 PM revealed Resident 1 sitting in the dining room in their wheelchair asking for assistance as people walk past. Resident 1 remained sitting in their wheelchair and slowly wheeled self from inside the dining room out into the hallway outside the dining room. Resident 1 intermittently asked to be help and stated they wanted to go to bed. At 7:47 PM Resident 1 was observed telling the administrator they wanted to go to bed. The administrator told the resident that the next Nursing Assistant (NA) they saw, the administrator would have them help the resident. At 8:11 PM, Resident 1 asked to help them to their bed. The facility Administrator heard this and told the resident they would find someone to help. At 8:28 PM, Resident 1 had been taken to their room. Observations conducted on 6/9/25 of Resident 1 revealed the following: -At 9:20 AM Resident 1 was sitting in their wheelchair at a table in the dining room. -At 9:40 AM Resident 1 continued sitting at a table in the dining room but now had food in front of them. -At 10:05 AM Resident 1 remained at the dining room table. The resident had backed their wheelchair about a foot away from the table and they were not eating or drinking. -At 10:52 AM Resident 1 was sitting in the dining room, about 2 feet away from the table. The resident had their eyes closed and their chin was resting on their chest. -At 11:05 AM Resident 1 remained in the same position in the dining room. -At 11:27 AM Resident 1 remained in the same position in the dining room. -At 11:45 AM Resident 1 remained in the same position in the dining room. -At 11:53 AM staff approached Resident 1 and asked the resident if they wanted to scoot closer to the table. Resident 1 declined so then the staff handed the resident a cup of juice, which the resident began drinking. Resident 1 remained in the same position in their wheelchair. -At 11:55 AM the Chief Nursing Officer (CNO) moved Resident 1's wheelchair so the resident was facing their table. -At 12:45 PM Resident 1 remained in the dining room. -At 12:54 PM Resident 1 remained in the dining room. An interview on 6/9/25 at 12:54 PM with the Director of Nursing (DON) confirmed Resident 1 had been in the dining room since just after 9:00 AM. The DON also asked NA-I if anyone had assisted Resident 1 to the toilet during that timeframe and the NA stated, not that I know of. B. A record review of Resident 2's MDS dated [DATE] revealed the resident had a BIMS score of 14/15 indicating they were cognitively intact. The MDS also revealed the resident required partial/moderate assistance with shower/bathing and with toileting hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 2's undated Care Plan revealed the resident required the assistance of 1 person with bathing showering and with toileting use. An interview on 6/7/25 at 6:50 PM with MA-H revealed that Resident 2 had reported the evening prior that they were going to wash their hair in the sink because they had not been bathed in two weeks. An interview on 6/7/25 at 7:04 PM with Resident 2 revealed the resident had not been bathed in two weeks. Resident 2 reported there was one day they did not get bathed because there was no hot water, but otherwise it had been due to there not being staff available to complete bathing. Resident 2 revealed they needed staff assistance with wiping their bottom after they used the toilet, and they sometimes had to wait 30 minutes or more for staff to come assist with this task. An interview on 6/11/25 at 9:52 AM with Resident 2 revealed the resident had been getting bathed routinely prior to the past two weeks when they did not receive any baths. Resident 2 stated they were scheduled to receive their baths every Wednesday and Friday, which they did not like because this meant they had one day between baths and then had to go several days until the next bath. A record review of facility provided document for Resident 2 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/21/25 Shower, and on 5/22/25 and 5/25/25 Not applicable. There was no other documentation. A record review of the facility document for Resident 2 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 2 was scheduled to receive a shower every Wednesday and Friday. The documentation revealed the resident received shower on 5/28/25 and 6/8/25. C. A record review of Resident 3's MDS dated [DATE] revealed the resident had a BIMS score of 14/15 indicating the resident was cognitively intact. The MDS also revealed the resident required partial/moderate assistance from staff for wheeling 150 feet and for shower/bathing. A record review of Resident 3's undated Care Plan revealed staff were to encourage physical activity and daily ambulation, and that resident was to use assistive device if necessary. The care plan also revealed the resident had the potential for ADL self-care performance deficit r/t fatigue, impaired balance, and pain to lower back, right hip, and right knee. The resident required assistance of 1 person for bathing/showering. An interview on 6/7/25 at 7:12 PM with Resident 3 revealed that the prior week had been their third week living in the facility and there had been several staff who had resigned since they were admitted to the facility. Resident 3 stated they felt like it's a crisis due to the facility being low on help. The resident also stated it had been about two weeks since they had been assisted with bathing, so they had just been doing sponge baths on their own in their room. Resident 3 stated that they needed assistance wheeling back to their room in their wheelchair after meals due to their arthritis. Resident 3 also stated that the evening prior, they had to wheel back to their room independently because there was no staff available, and the resident had been having pain to their right hip and leg ever since. A record review of facility provided document for Resident 3 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed no showers had been documented for the resident since their admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility document for Resident 3 titled The Spa at Skyview Bathing Schedule from 5/5 through 6/9 revealed the resident had not been added to the bathing schedule but that the resident had received a shower on 5/17/25 (date of admission), 5/28/25, 5/31/25, and on 6/8/25. D. A record review of Resident 4's MDS dated [DATE] revealed the resident had a BIMS score of 15/15 indicating the resident was cognitively intact. The MDS also revealed the resident was dependent on staff for shower/bathing and toileting. A record review of Resident 4's undated Care Plan revealed the resident required 1-person assistance with bathing/showering and that for toileting, the resident did not have the core strength to sit up on the toilet or commode, so resident needed to be transferred to their bed for peri-cares to be performed. An interview on 6/7/25 at 7:55 PM with Resident 4 revealed that it last week or the week before that since their last bath but the facility staff had not shared a reason for this. A record review of facility provided document for Resident 4 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period, revealed that staff had documented on 5/30/25 that the resident had refused their shower that day. There was no other documentation. A record review of the facility document for Resident 4 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 4 was scheduled to receive a shower every Monday and Friday. The documentation revealed that the resident received a shower on 5/12/25 and 6/9/25. E. A record review of Resident 12's MDS dated [DATE] revealed the resident had a BIMS score of 15/15 indicating the resident was cognitively intact. The MDS also revealed the resident required substantial/maximal assistance with shower/bathing and was dependent on staff for toileting hygiene. A record review of Resident 12's undated Care Plan revealed the resident required substantial assistance by one staff with bathing schedule and as necessary. The Care Plan also revealed the resident required substantial assistance of two staff with the sit-to-stand for toileting. An interview on 6/9/25 at 10:21 AM with Resident 12 revealed Resident 12 had resided in the facility for almost two years and utilized a sit-to-stand lift for transfers. Resident 12 stated that the prior week they had to wait for two hours before staff was able to take them to the bathroom. Resident 12 also revealed that they were supposed to get three showers a week but that they were lucky if they even got one. The resident stated that 9 days was the longest they have had to go without a shower and that this had happened within the last two months. An interview on 6/11/25 at 9:26 AM with Resident 12 revealed that it was about a month ago when they stopped getting bathed 3 times a week like they preferred. A record review of facility provided document for Resident 12 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/16/25 and 5/23/25 Not Applicable, and on 5/21/25, 5/26/25, and 5/30/25 Shower. There was no other documentation. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility document for Resident 12 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 12 was scheduled to receive a shower every Monday, Wednesday, and Friday. The documentation revealed that the resident received a shower on 5/5/25, 5/9/25, 5/12/25, 5/26/25, 5/28/25, 6/3/25, and 6/9/25. F. A record review of Resident 19's MDS dated [DATE] revealed the resident had a BIMS score of 10/15 indicating the resident had moderate cognitive impairment. The MDS also revealed the resident was dependent on staff for their shower/bathing. A record review of Resident 19's undated Care Plan revealed the resident required 1-person assistance with bathing/showering. An interview on 6/11/25 at 10:18 AM with Resident 19 revealed the resident was supposed to get three baths a week but lately it had been pretty hit and miss. Resident 19 stated that it varied, sometimes they would get one or more baths a week and sometimes it would stretch into two weeks. Resident 19 stated that they couldn't say when this started, it was pretty much when the staff started quitting but the resident stated they could not really say how long ago that was either. A record review of facility provided document for Resident 19 titled POC Response History Task: ADL-Bathing Schedule and dated 6/11/25 with a 30 day look back period revealed that staff had documented on 5/16/25 and 5/19/25 not applicable. Staff had also documented Shower on 5/14/25, 5/23/25, 5/24/25, 5/28/25, 5/30/25, 6/4/25, 6/6/25, and 6/9/25. A record review of the facility document for Resident 19 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 19 was scheduled to receive a shower every Monday, Wednesday, and Friday. The documentation revealed that the resident received a shower on 5/9/25, 5/14/25, 5/16/25, 5/26/25, 5/30/25, 5/31/25, 6/4/25, and 6/9/25. An interview on 6/11/25 at 11:24 AM with the DON confirmed baths should be given to the residents at least once a week unless the resident wanted them more frequently. The DON revealed that the facility did not currently have a working bathtub and that there had not been a functional bathtub since prior to their date of hire which was 1/6/25, so all of the residents have had to take showers. An interview on 6/11/25 at 11:45 AM with the CNO revealed baths are given per resident preferences, which are established upon admission but were also reestablished as part of the facility's plan of correction following their recent survey. The CNO stated they went around to all residents and asked what they preferred, and the bathing schedule was developed based on this information.

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	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(3) Based on observations, interviews, and record review; the facility failed to implement interventions of repositioning and failed to re-evaluate and revise ineffective interventions for 1 (Resident 9) of 1 sampled resident with Moisture Associated Skin Damage (MASD, a condition that occurs when skin is repeatedly exposed to various sources of bodily secretions or effluents, often leading to irritant contact dermatitis with inflammation, with or without denudation of affected skin). The facility identified a census of 28. Findings are:A record review of the facility policy provided when the policy related to skin assessments was requested, Prevention of Pressure Injuries with a revision date of April 2020, revealed in the Mobility/Repositioning section the staff were to reposition all resident with or at risk of pressure injuries on an individualized scheduled, as determined by the interdisciplinary team. The policy also revealed in the Monitoring section, the facility was to Review the interventions and strategies for effectiveness on an ongoing basis. A record review of Resident 9's admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident 9's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 5/20/25 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 5/15 which indicated the resident had severe cognitive impairment. The MDS also revealed that Resident 9 had no behaviors of rejection of care during the lookback period, required substantial assistance from staff for rolling left and right, and was always incontinent of bowel and bladder. The resident was identified to be at risk for pressure ulcers and had moisture associated skin damage. A record review of a Braden Scale assessment for Resident 9 dated 8/9/25 revealed a score of 10 which indicated the resident was at high risk for skin breakdown. A record review of Resident 9's undated Care Plan revealed the resident had limited physical mobility, required the assistance of 2 staff for their toileting, and preferred to be changed in bed; often refusing to allow staff to check and change their brief more than once per shift when they were up in their wheelchair. The staff were to continue to encourage the resident to allow frequent brief changes. The care plan also revealed the resident had reoccurring MASD to their coccyx/buttocks and had preventative treatment in place. There was a revision dated 6/4/2025 that revealed the resident had MASD to their coccyx (an area situated at the base of the spine, below the sacrum and above the anus) with a treatment of skin prep/Calmoseptine daily/PRN (as needed). There was also an intervention stating to assist the resident with turning/repositioning while in bed/recliner. A record review of Resident 9's Physician's Orders revealed an order to cleanse their coccyx with wound cleanser or normal saline, apply skin prep (a product that forms a film to protect the skin) to the peri-wound edges, then apply Calmoseptine (an over the counter multi-purpose ointment that acts as a moisture barrier and helps protect and heal skin irritations) to the wound and surrounding tissue every shift and PRN for MASD. This order had a start date of 6/4/2025. A record review of Resident 9's Electronic Medical Records (EMR) revealed they had a physician visit on 6/18/25 with no mention of their MASD. A record review of Resident 9's EMR revealed they had a provider visit on 8/1/25 with no mention of their MASD. A record review of Resident 9's Progress Notes from 6/11/25 through 8/18/25 revealed the following notes related to their MASD:-On 7/9/2025 there was documentation the resident had MASD to their buttocks area and it was healing. -On 7/18/2025 there was documentation the resident had MASD to their buttocks area and it was healing.-On 8/8/2025 there was documentation the resident had MASD with treatment in place. -On 8/13/2025 there was documentation the resident had MASD with treatment in place. A record review of the Weekly Skin Assessments for Resident 9 revealed:-On 6/15/25 there was documentation of, Resident skin warm pink dry and intact except for MASD area at coccyx and surrounding areas. Treatment done per current MD order. Mucous membranes remain pink, moist and intact. Skin turgor good without any tenting noted.-On 6/22/25 there was documentation of, Skin warm pink moist and intact except for shearing and MASD to buttocks. Skin turgor is good without any tenting noted to hands. Mucous membranes remain pink moist and intact.-On 6/29/25 there was documentation of, Resident skin warm pink dry and intact except for MASD and shearing at coccyx and surrounding areas. Treatment done per current MD order. Mucous membranes remain pink, moist and intact. Skin turgor good without any tenting noted.-On 7/6/25 there was documentation of, Skin warm pink dry and intact except for MASD areas to buttocks which are healing well and almost closed again. Calmoseptine applied per current MD order

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	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on record review and interviews, the facility failed to ensure 1 (Resident 4) did not develop pressure ulcers (also known as bed sores, areas of damaged skin caused by staying in one position for too long, commonly formed under boney prominence's) that were unavoidable and failed to provide monitoring, treatment and care as ordered to promote healing for 3 (Residents 4, 6, and 18) of 3 sampled residents' pressure ulcers. The facility identified a census of 36. Findings are: A record review of an undated facility policy Pressure Ulcer Risk Assessment, revealed if pressure ulcers are not treated immediately upon discovery, they can quickly get larger and become very painful and infected for the resident. Pressure ulcers are a serious condition for the resident and once developed, can be extremely difficulty to heal. Resident's skin should be routinely assessed and the condition of the resident's skin documented per the following: -A pressure ulcer risk assessment will be completed upon admission, quarterly, annually, and with any significant changes. -Because a resident at-risk can develop a pressure ulcer within 2-6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. -Nurses will conduct skin assessments at least weekly to identify changes and for any presence of developing pressure ulcers. -Documentation of the skin assessment should be recorded in the resident's medical record and include date and time and size and location of any red or tender areas. A record review of an undated facility policy Pressure Ulcer Treatment revealed pressure ulcer treatment should focus on assessing the resident and the pressure ulcer(s), managing tissue loads, pressure ulcer care, managing infection, education and quality improvement. The policy also revealed documentation should include the following in the resident's medical record after pressure ulcer care: assessment of the wound (color, size, pain, drainage) and resident refusal of treatment. If a resident refuses care, an evaluation of the basis for refusal and the identification and evaluation of potential alternatives is indicated. A. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of an admission Record revealed the facility re-admitted Resident 4 to the facility on 4/23/2025. Resident 4 had diagnoses of Multiple Sclerosis (MS, a disease where the body's immune system mistakenly attacks the protective covering of nerve fibers in the brain and spinal cord that can cause muscles weakness, trouble walking, numbness, and difficulty with controlling bowel and bladder), chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung), nicotine dependence, generalized muscle weakness, and legal blindness. A record review of Resident 4's admission 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) 4/30/2025 revealed Resident 4 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15/15, which indicated Resident 4 was cognitively intact. In Section E regarding behavior, the MDS reflected that Resident 4 had not displayed any rejection of care. Additionally, the MDS revealed Resident 4 had no upper or lower extremity impairment and required maximal assistance for bed mobility and total dependence for toileting, bathing, and transfers. Resident 4 was frequently incontinent of urine and always incontinent of bowel. Furthermore, the MDS revealed Resident 4 was at-risk for developing pressure ulcer but had 0 pressure ulcers, wounds or other skin problems at the time of assessment. Resident 4 did have a pressure reducing device for their chair and orders for application or ointment/medications. A record review of Resident 4's Care Plan with a date of 5/1/2025 revealed Resident 4 required assistance with toileting. Resident 4 had no core strength to sit on the toilet or bedside commode so required to be transferred into their bed for incontinence care. Additional review of Resident 4's Care Plan revealed no focus care area regarding skin integrity or addressing Resident 4's risk for pressure ulcers with preventative interventions. A record review of Resident 4's Progress Notes from 4/23/2025 at 8:49 PM revealed Resident 4 had a 4-centimeter (cm) x 6 cm area of redness on the left groin and mild, generalized redness across their back. There was no evidence if the redness was blanchable (When a skin area blanches, it means the redness or color disappears when you press on it, leaving the skin appearing lighter. If an area of skin doesn't blanch when pressed, it could indicate a more serious condition like a pressure ulcer, non-blanching rash, or other skin damage.) A record review of Resident 4's Weekly Skin Assessment - V 2 with a date of 4/23/2025 revealed Resident 4 had redness on their left groin, diffuse redness across their back with skin intact and had no open areas. A record review of Resident 4's Weekly Skin Assessment - V 2 with a date of 4/30/2025 revealed Resident 4's skin was pink, dry, and intact without skin issues present. A record review of Resident 4's Weekly Skin Assessment - V 2 with a date of 5/6/2025 revealed Resident 4's skin was warm, dry, and intact, with no skin issues present. A record review of Resident 4's Weekly Skin Assessment - V 2 with a date of 5/13/2025 revealed Resident 4's was warm, dry, and intact with a 1 cm open area on their coccyx. There was no evidence the provider had been notified or interventions placed to prevent worsening of the area. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 4's Nursing Home Visit Note with Medical Provider (MP)-B from 5/15/2025 revealed Resident 4 had a sacral wound. Facility staff had reported to MP-B the sacral wound was present upon admission,however, MP-B noted the sacral wound was listed as resolved on the documentation from the discharging rehabilitation facility. MP-B placed orders to continue wound care, ensure Resident 4 had appropriate padding in their chair, frequently reposition as Resident 4 allowed, and update MP-B on wound progress every week. A record review of Resident 4's Progress Notes from 5/13/2025-5/27/2025 revealed no evidence of monitoring of Resident 4's pressure ulcer on their coccyx. The Progress Notes did reveal the following: -A note on 5/19/2025 at 3:16 AM revealed the dressing was clean, dry, and intact and staff were assisting Resident 4 with repositioning every 2 hours. -A note on 5/20/2025 at 5:36 AM revealed Resident 4 was being assisted with repositioning every 2-3 hours due to their pressure ulcer on their buttock. The dressing remained clean, dry, and intact. A record review of Resident 4's Weekly Skin Assessments V 2 revealed no evidence a weekly skin assessment had been completed for the week of 5/20/2025 or monitoring of Resident 4's pressure ulcer had been completed. A record review of Resident 4's Weekly Skin Assessment - V 2 with a date of 5/27/2025 revealed Resident 4's pressure ulcer on their sacrum was staged as a Stage 2 (partial-thickness skin loss involving the dermis, or middle layer of skin) with measurements of 1.0 cm x 1.0 cm. Another pressure ulcer was identified on Resident 4's left gluteal fold with measurements of 2.0 cm x 1.8 cm. And two areas of Moisture Associated Skin Damage (MASD) were also identified on both sides of Resident 4's buttocks. There was no evidence MP-B had been notified of the new pressure ulcer area or what interventions had been implemented to prevent worsening of the area. A record review of Resident 4's Progress Notes from 6/1/2025-6/4/2025 revealed the following: -On 6/1/2025 at 5:29 AM, Resident 4's dressing to their buttocks was changed with treatment and cleansing to the wound. There were no signs of infection. -On 6/1/2025 at 10:20 AM revealed Resident 4 had a pressure area that was blanchable that measured 3.5 cm x 4 cm on their right ischial tuberosity area of where the weight of the body rests when sitting, also known as the sit bone.) MP-B was notified via fax. -A late entry for 6/2/2025 at 11:04 AM was placed and revealed Resident 4 had two open wounds. The first wound on Resident 4's sacrum measured 2 cm x 0.5 cm x 1 cm and was staged as a Stage 3 (full-thickness skin loss where fat may be visible) Pressure Ulcer. The second wound on Resident 4's left gluteal area measured 6 cm x 4 cm x 1 cm and was also staged as a Stage 3 Pressure Ulcer. A call had been placed to MP-B's office to confirm the fax from 6/1/2025 had been received. -On 6/4/2025, a verbal reply confirming the fax sent was received by MP-B and approval for a wound clinic evaluation was obtained. A record review of Resident 4's TAR for June 2025 revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Actual harm Residents Affected - Some	-An order to complete a skin assessment and document findings in a 'Weekly Skin Assessment - V 2 every Tuesday for skin integrity with a start date of 6/11/2024 had not been completed on 6/3/2025. -An order for Resident 4's wound dressing change once a day to cover with calmoseptine and ensure the area is not coming in contact with urine with a start date of 5/9/2025 had not completed on 6/2/2025 or 6/3/2025. A record review of an Evaluation of Clinically Unavoidable Pressure Injury with a faxed to the provider date of 6/5/2025, revealed interventions for Resident 4 prior to the development or worsening of a pressure injury included repositioning and pressure redistribution of chair cushion. Additionally, it revealed Resident 4 had clinical conditions or diagnoses that were primary risk factor for the development or worsening of pressure injuries of immobility, refusal of treatments, incontinence of bowel and/or bladder, COPD, Multiple Sclerosis, edema, history of pressure ulcers, and quadriplegia/hemiplegia/hemiparesis. The form was signed by MP-B on 6/5/2025. A follow-up interview on 6/9/2025 at 12:28 PM with the Chief Nursing Officer of the Hospital (CNOH) where Resident 4 received care revealed the CNOH had spoken with MP-B and MP-B had been informed by facility staff that Resident 4 had returned to the facility with the sacral wound, which would have made it unavoidable. MP-B was not aware Resident 4's sacral wound was not present upon re-admission to the facility and then developed within the facility. An interview on 6/4/2025 at 10:55 AM with Registered Nurse (RN) - C confirmed Resident 4 had no pressure ulcer present upon admission, but due to lack of staffing they are unable to keep up with the care and Resident 4 now has two Stage 3 Pressure Ulcers as a result. An interview on 6/4/2025 at 2:30 PM with the Director of Nursing (DON) confirmed Resident 4 had two pressure ulcer, both currently Stage 3, one on their sacrum/coccyx and one on their left gluteal fold/ischial tuberosity and that the facility's documentation confirmed Resident 4's pressure ulcers were not present upon re-admission to the facility, but had developed while in the facility and that the areas had not improved but were worsening. Additionally, the DON confirmed the facility had no evidence Resident 4's sacral wound condition/progress was monitored between 5/14/2025-5/26/2025 (13 days) or that Resident 4's wound dressing was completed on 5/28/2025, 6/2/2025, or 6/3/2025 as ordered at the time of the interview. An interview on 6/4/2025 at 2:33 PM with the facility's Chief Nursing Officer (CNO) revealed the following: -The CNO revealed the facility's process for monitoring wounds is to complete a weekly skin assessment and to notify the provider of any new wounds to obtain a new order. The provider can be notified through fax when initially discovered and staff should follow up by 8:00 AM the following day if no response. If there continues to be no response after 72 hours, management should be notified. At the time of the interview, the CNO confirmed the facility had no evidence MP-B had responded to the facility's fax from 6/1/2025 or follow up had been attempted between 6/2/2025 and 6/4/2025. At this time, the CNO asked the DON to contact the responsible nurse to log on to the electronic health record system remotely and chart a late entry. -At the time of the interview, the facility also had no evidence MP-B had been updated weekly of Resident 4's pressure ulcer progress as ordered on 5/15/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-The CNO confirmed Resident 4's Care Plan had no focus area regarding Resident 4 being at-risk for Pressure Ulcer or interventions to prevent pressure ulcers from developing had been developed or implemented and should have been at the time of the Care Plan development. - The CNO also confirmed Resident 4's Care Plan had not been revised or updated a focus area and interventions after Resident 4's development of Pressure Ulcers and should have been. -Initial interventions that had been put in place prior to the development of Resident 4's pressure ulcers were to place a different cushion in Resident 4's tilt and space wheelchair and heel protectors on their heels when in bed. -The facility's interventions for Resident 4's sacral pressure ulcer included to reposition Resident 4 when in bed and encourage position change when in their wheelchair, as well as a wheelchair cushion. B. A record review of an admission Record indicated the facility admitted Resident 18 on 5/21/2025 with diagnoses of generalized muscle weakness and a pressure ulcer on their sacrum, without a specified stage. A record review of Resident 18's admission MDS with an ARD of 5/28/2025 revealed Resident 18 had a BIMS score of 11/15, which indicated Resident 18 had moderate cognitive impairment. Additionally, it revealed Resident 18 utilized a walker and had no extremity impairment. Resident 18 required partial assistance with bathing and supervision for toileting, bed mobility, and transfers. Under Section H regarding bowel and bladder, the MDS revealed Resident 18 was frequently incontinent of urine and was always continent of bowel. Under Section M regarding skin conditions, the MDS revealed Resident 18 was at-risk for developing pressure ulcers and had one Stage 3 pressure ulcer present. Interventions were a pressure reducing device for chair, repositioning, nutrition and/or hydration intervention, pressure ulcer care, and applications of ointments/medications to affected area. A record review of Resident 18's Care Plan revealed a focus care area regarding pressure injuries with a last reviewed date of 5/23/2025. The area revealed Resident 18 was admitted with a Stage 3 pressure ulcer to their sacrum with the following interventions: -Administer treatments as ordered and monitor for effectiveness. -Assess, record, monitor wound healing with cares weekly. Measure length, width, depth where possible. Assess and document the status of the wound perimeter, wound bed, and healing progress. Report to the physician. -Monitor, document, and report as needed any changes in skin status of appearance, color, wound healing, signs of infection, wound size, and stage. -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, and type of tissue and drainage. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 18's Order Summary Report with an active orders date of 6/10/2025 revealed the following orders: -Complete a skin assessment and document findings in a 'Weekly Skin Assessment - V 2 every Thursday on day shift with a start date of 5/22/2025. -Cleanse sacral pressure ulcer with wound cleaner, apply A&D ointment, and cover with a foam dressing daily for wound care of the sacral pressure ulcer with a start date of 5/22/2025. A record review of Resident 18's Medication Administration Record/Treatment Administration Record (MAR/TAR) from May 2025 revealed Resident 18's order for wound care of the sacral pressure ulcer was not documented as completed on 5/28/2025. A record review of Resident 18's MAR/TAR for June 2025 revealed Resident 18's order for wound care of the sacral pressure ulcer was not documented as completed on 6/2/2025 or 6/3/2025. A record review of Resident 18's Weekly Skin Assessment - V2 from 5/22/2025 - 6/5/2025 revealed the following: -On 5/22/2025, Resident 18's skin was documented as dry and intact except for buttocks. Buttocks have several wounds on gluteal folds and sacrum. There was no evidence measurements of Resident 18's sacral wound had been assessed or the root cause of the wound on Resident 18's gluteal folds had been identified, or interventions had been implemented for these. -There was no evidence an assessment had been completed for 5/29/2025 as ordered. -On 6/5/2025, Resident 18's skin was documented as continuing to have a sacral wound. There was no evidence of monitoring of qualities, measurements, or progress. Additionally, there was no evidence the gluteal fold had resolved or were present. An interview on 6/10/2025 at 2:30 PM with the DON confirmed Resident 18 had a stage 3 pressure ulcer on their sacrum upon admission. The DON also confirmed the facility had no evidence of monitoring the wound's progress, measurements had been obtained, or wound care had been completed on 5/28/2025, 6/2/2025, or 6/3/2025. C. A record review of an admission Record revealed the facility admitted Resident 6 on 1/20/2017. Resident 6 had diagnoses of COPD, generalized muscle weakness,, dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), and Chronic Inflammatory Demyelinating Polyneuritis (CIPD, a rare autoimmune disorder where the body's immune system attacks the myelin sheath, the protective covering of the nerves, primarily in the peripheral nervous system which can lead to progressive weakness and sensory changes in the arms and legs). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 6's quarterly MDS with an ARD of 5/25/2025 revealed Resident 6 had a BIMS score of 10/15, which indicated Resident 6 had moderate cognitive impairment. Additionally, the MDS revealed Resident 6 had unilateral impairment in their upper and lower extremities and utilized a wheelchair. Resident 6 was dependent on staff for toileting, bathing, and dressing. Resident 6 required substantial assistance with bed mobility and transfers. Under Section H regarding Bowel and Bladder, the MDS revealed Resident 6 had an indwelling catheter and was always incontinent of bowel. Under Section M regarding Skin Conditions, the MDS revealed Resident 6 currently had one Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) Pressure Ulcer. Interventions included a pressure reducing device for their chair and bed, repositioning, nutrition and hydration intervention, pressure ulcer care, and application of ointments/medications. A record review of Resident 6's Care Plan revealed a focus area regarding skin integrity, with a last revised date of 4/14/2025, revealed Resident 6 was at-risk for skin integrity compromise due to impaired mobility, incontinence, and occasionally moist skin folds related to obesity. Additionally, it revealed Resident 6 had a Stage 4 Pressure Ulcer to their sacrum with a wound vac (a medical device used to promote wound healing by applying controlled negative pressure to the wound bed) in place. Interventions related to the pressure ulcer included the following: -Assist in staying clean and dry by providing incontinence care as needed. -Follow facility policies/protocols for the prevention/treatment of skin breakdown. -Observe, document, and report as needed to the provider any changes in skin status of appearance, color, wound healing, signs of infection, wound size, and stage. -Weekly skin assessments, notify the provider and initiate intervention for areas of concerns. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, and type of tissue and drainage. -Low air pressure mattress on the bed. -Treatment per wound care orders from wound care provider at the hospital. -Reposition while in bed at lest every 2 hours as tolerated. -Heel protectors to both feet while resting in bed as tolerated. A record review of Resident 6's Order Summary Report with an active orders date of 6/9/2025 revealed the following orders: -Complete a skin assessment and document findings in a 'Weekly Skin Assessment - V 2' every Thursday on day shift for skin integrity with a start date of 6/13/2024. -Ensure wound vac is functioning at 125 millimeters of mercury (mmHG) every shift for wound care with a start date of 6/5/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-Give Arginaid (a supplement designed to support the unique nutritional needs of people with chronic wounds) twice a day for wound healing of the sacral wound with a start date of 2/1/2025. -Low flow air mattress to bed to assist with wound healing of the sacral wound with an order date of 1/31/2025. -Change wound vac dressing every 72 hours and as needed. Cleanse wound with normal saline, prep area around wound with skin prep and drape, pack wound depth with black foam and bridge to lateral trunk, not on a boney prominence, cushion tubing with foam, and anchor in place with drape for Stage 4 sacral pressure ulcer with a start date of 6/5/2025. -Zinc Sulfate 220 milligrams (mg) two times a day for wound healing with a start date of 6/6/2025. A record review of Resident 6's Medication Administration Record/Treatment Administration Record (MAR/TAR) for April 2025 revealed Resident 6's order for Arginiad twice a day for wound healing was documented as not given with a reason of Held/Other/See Progress Note on the following dates: -4/27/2025 PM, -4/28/2025 PM, -4/29/2025 AM, -4/29/2025 PM, - 4/30/2025 AM, -4/30/2025 PM. A record review of Resident 6's Progress Notes for 4/27/2025-4/30/2025 revealed Arginaid order was held or not given due to not being available. A record review of Resident 6's Medication Administration Record/Treatment Administration Record (MAR/TAR) for May 2025 revealed Resident 6's order for Arginiad twice a day for wound healing was documented as not given with a reason of Held/Other/See Progress Note on -5/27/2025 PM, - 5/29/2025 AM, -5/29/2025 PM, -5/30/2025 PM. A record review of Resident 6's Progress Notes for 5/27/2025-5/30/2025 revealed Arginaid order was held or not given due to not being available. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 6's Medication Administration Record/Treatment Administration Record (MAR/TAR) for June 2025 revealed Resident 6's order for Arginiad twice a day for wound healing was documented as not given with a reason of Drug Refused on 6/1/2025 AM, and Held/Other/See Progress Note on the following dates: -6/1/2025 PM, -6/2/2025 PM, -6/3/2025 AM, -6/3/2025 PM, -6/4/2025 AM, -6/4/2025 PM, -6/5/2025 AM, -6/5/2025 PM, -6/6/2025 AM, -6/6/2025 PM, -6/7/2025 AM, -6/7/2025 PM, -6/8/2025 AM, -6/8/2025 PM, -6/9/2025 AM. A record review of Resident 6's Progress Notes for 6/1/2025-6/9/2025 revealed Arginaid order was held or not given due to not being available. The physician was notified of the unavailability of the Arginaid and a new order was provided on 6/6/2025. A record review of Resident 6's Wound Care Visit Notes revealed the following: -On 5/16/2025, the note revealed Resident 6's wound vac was not running when the resident arrived at their appointment. Additionally, Resident 6 was noted to have a red area by the wound opening and was incontinent of bowel on the area around the wound. -On 5/22/2025, the note revealed Resident 6's sacral wound measured 1.6 cm x 1 cm x 2 cm with undermining (a situation where the tissue beneath the skin edges of a wound has broken down, creating a pocket or space) of 1.1 cm with orders to continue with current orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	-On 5/29/2025, the note revealed Resident 6's sacral wound measured 1.3 cm x 1 cm x 1 cm with undermining of 2.1 cm. A wound culture was obtained due to Resident 6 having feces in their wound and odor. Additionally, the note stated to continue with current plan and orders. An interview on 6/9/2025 at 10:50 AM with the DON confirmed the facility did not have Arginaid available on 4/27/2025-4/30/2025 but was ordered on 4/29/2025. Additionally, the DON confirmed the facility has not had Arginaid since 5/27/2025 due to being backordered until 6/16/2025. The provider had not been notified as of the time of the interview and should have been first contacted on 5/28/2025 when first backordered. A follow up interview on 6/9/2025 at 11:20 AM with the DON revealed the order for Arginaid had been placed on hold and would be having a pharmacy delivering the Arginaid this evening.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I) Based on record review and interview the facility failed to prevent the potential for serious harm or injury while performing transfers via Hoyer or sit-to-stand mechanical lifts, this had the potential to affect 11 (Residents 1, 4, 6, 9, 10, 11, 12, 13, 14, 15, and 16) of 11 residents sampled. The facility identified a census of 36. Findings Are: A record review of the facility policy Lifting Machine, Using a Mechanical with revision date of July 2017 revealed in the General Guidelines that at least two nursing assistants are needed to safely move a resident with a mechanical lift. The policy also revealed that the types of lifts that may be available in the facility are a floor-based full body sling lift, an overhead full body sling lift, and a sit to stand lift. A record review of the facility provided Resident List dated 6/7/25 revealed Residents 4, 9, 10, 14, and 16 were marked as utilizing a Hoyer lift. The list also revealed Residents 1, 6, 11, 12, 13, and 15 were marked as utilizing a Sit to Stand Lift. A. A record review of Resident 1's 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 4/9/2025 revealed the resident required substantial/maximal assistance from staff for transfers. A record review of Resident 1's undated Care Plan (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) revealed the resident required two-person assistance with the sit to stand for transfers. If Resident 1 was unable to stand, the care plan stated to use the total lift with two people. This was initiated on 3/10/2025. B. A record review of Resident 4's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 4's undated Care Plan revealed the resident required two-person assistance with the total lift for transfers. This was initiated on 5/1/2025. C. A record review of Resident 6's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 6's undated Care Plan revealed the resident required one-person assistance with the sit-to-stand lift when transferring in/out of bed and to/from the toilet. The care plan stated to use two-person assistance as needed for increased weakness or if the resident was unable to follow instructions. This was initiated on 8/7/2019 and revised on 4/21/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. A record review of Resident 9's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 9's undated Care Plan revealed the resident required two-person assistance with the total lift for transfers. This was initiated on 4/30/2021. E. A record review of Resident 10's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 10's undated Care Plan revealed the resident required a 2-person pivot transfer with gait belt. The care plan also stated to use the total lift with 2 people if the resident was unable to stand, too tired or weak. This was initiated on 1/23/2025. F. A record review of Resident 11's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 11's undated Care Plan revealed the resident required two-person assistance with the sit-to-stand lift for transfers. This was initiated on 5/30/2025. G. A record review of Resident 12's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 12's undated Care Plan revealed the resident required substantial assistance by 2-person pivot transfer with a gait belt. The care plan also stated the resident would occasionally be agreeable to use a sit to stand lift. This was initiated on 10/26/2023 and revised on 1/31/2025. H. A record review of Resident 13's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 13's undated Care Plan revealed the resident required two-person assistance with stand/pivots with a gait belt to move between surfaces and as necessary. This was initiated on 7/15/2024. I. A record review of Resident 14's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 14's undated Care Plan revealed the resident required 2-person assistance with a Hoyer lift for transfers. This was initiated on 10/31/2020 and revised on 4/21/2024. J. A record review of Resident 15's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 15's undated Care Plan revealed the resident required 1-person assistance with transfers PRN (as needed). This was initiated on 7/2/2019 and revised on 5/5/2021. K. A record review of Resident 16's MDS dated [DATE] revealed the resident was dependent on staff for transfers. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 16's undated Care Plan revealed the resident required 2-person assistance for transfers with the use of the total lift. This was initiated on 1/21/2025. An interview on 6/7/25 at 6:30 PM with the Director of Nursing (DON) revealed that one of the Nurse Aides (NA) working that evening was a minor and unable to utilize the mechanical lifts to transfer residents. The DON also revealed that the DON and this minor NA were the only staff scheduled to work the following evening from 2 pm until 10 pm. An interview on 6/7/25 at 6:50 PM with Medication Aide (MA)-H revealed MA-H had worked the past 7 days straight in an attempt to assist with the staffing shortage. MA-H stated that there were 30-some residents in the facility and normally 2-3 staff on duty would be sufficient but there were several residents that were high acuity (requiring significant staff assistance) so the current staffing levels were not enough to provide resident cares. MA-H stated that the evening prior, the staffing was the DON, the MA, and one NA. MA-H stated that there were 3 or 4 residents who required the Hoyer lift for transfers and there were several who utilized the sit-to-stand lift, but some of those residents really needed two staff present due to the residents chicken-winging (a situation where the resident's arms extend out to the side during the transfer, increasing the risk of the resident falling out of the lift sling). MA-H revealed that staff frequently transferred residents with the mechanical lifts alone because otherwise the residents would not get cares due to there not being enough staff on duty. MA-H also revealed that they had recently been told by facility management that it was now okay to use the sit-to-stand lifts alone, although this had not previously been an approved practice. An interview on 6/7/25 at 7:55 PM with Resident 4 revealed there were usually two staff to transfer the resident with the Hoyer lift, but not always. Resident 4 stated that occasionally there was only one staff present during the transfers. Resident 4 stated they felt kind of scared because everyone was leaving and that it was 24 hours a day that there had been less staff on duty than usual. An interview on 6/7/25 at 8:53 PM with MA-H confirmed that the staff had been utilizing the mechanical lifts without a second staff present while transferring the residents and that this had been occurring on a daily basis due to lack of staff on duty. MA-H stated they witnessed a staff completing a resident transfer via a mechanical lift without a second staff in the room the evening prior when MA-H entered the resident room to administer medications to the resident. An interview on 6/9/25 at 10:21 AM with Resident 12 revealed Resident 12 had resided in the facility for almost two years and utilized a sit-to-stand lift for transfers. Resident 12 stated that a lot of the time there was only one staff present in their room during the transfers because they are so short staffed here. An interview on 6/9/25 at 2:25 PM with NA-J revealed they had been working in the facility since about January of this year. NA-J confirmed that staff were supposed to have two staff present when transferring residents with the mechanical lifts. NA-J revealed that they had asked the therapy staff for assistance with transferring a resident with the sit-to-stand lift recently and the therapy staff stated that per state, you don't have to have two staff present, so NA-J did transfer the resident by themself. NA-J stated there have been many shifts with only one or two staff working on the floor and that staff rarely works just 8 hours because there is not enough staff and even after the staff gets off the floor, then they have to go back and do their charting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/11/25 at 9:26 AM with Resident 12 revealed that they had been getting transferred via the sit-to-stand lift with only one staff present for quite a while. Resident 12 stated, It's been so long I really couldn't tell you when it started. An interview on 6/11/25 at 10:57 AM with NA-I revealed the NA had been working in the facility for about 3 years. NA-I stated they were supposed to be on light duty but had been utilizing both the Hoyer and sit-to-stand lifts alone despite being on light duty because there was not ever enough staff on duty to use two people. NA-I stated it had been this way, due to lack of staff availability, since approximately January 2025.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04 Based on observations, record review, and interview; the facility failed to have sufficient staff on duty to prevent the potential for serious harm or injury while performing transfers via Hoyer or sit-to-stand mechanical lifts, this had the potential to affect 11 (Residents 1, 4, 6, 9, 10, 11, 12, 13, 14, 15, and 16) of 11 residents sampled. The facility failed to have sufficient staff on duty to ensure residents receive assistance with their Activities of Daily Living per their plan of care for 6 (Resident 1,2,3,4,12,and 19). The total survey sample was 19. The facility identified a census of 36. The facility administrator was notified on 6/7/2025 at 9:20 PM of an Immediate Jeopardy (IJ) which began on 5/5/2025. The IJ was removed on 6/7/2025, as confirmed by surveyor onsite verification. Findings Are: A record review of a facility provided document SCARAB (Skyview Care and Rehab at Bridgeport) Facility Assessment- 2025 dated 6/4/2025 revealed under the staffing plan section, Our facility houses residents in four different halls (100, 200, 300, and 400 hall). Staffing is based on resident population and the residents' needs for care and support. Our census is reviewed daily with our staff schedule in our morning meeting with management and again in the nursing department morning meeting. We adjust the staffing plan as needed when we have a change in the census or for call-offs or new admissions. We monitor staff hours and census on a daily basis. A. A record review of the facility policy Lifting Machine, Using a Mechanical with revision date of July 2017 revealed in the General Guidelines that at least two nursing assistants are needed to safely move a resident with a mechanical lift. The policy also revealed that the types of lifts that may be available in the facility are a floor-based full body sling lift, an overhead full body sling lift, and a sit to stand lift. A record review of the facility provided Resident List dated 6/7/25 revealed Residents 4, 9, 10, 14, and 16 were marked as utilizing a Hoyer lift. The list also revealed Residents 1, 6, 11, 12, 13, and 15 were marked as utilizing a Sit to Stand Lift. B. A record review of Resident 1's 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 4/9/2025 revealed the resident required substantial/maximal assistance from staff for transfers. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident 1's undated Care Plan (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) revealed the resident required two-person assistance with the sit to stand for transfers. If Resident 1 was unable to stand, the care plan stated to use the total lift with two people. This was initiated on 3/10/2025. C. A record review of Resident 4's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 4's undated Care Plan revealed the resident required two-person assistance with the total lift for transfers. This was initiated on 5/1/2025. D. A record review of Resident 6's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 6's undated Care Plan revealed the resident required one-person assistance with the sit-to-stand lift when transferring in/out of bed and to/from the toilet. The care plan stated to use two-person assistance as needed for increased weakness or if the resident was unable to follow instructions. This was initiated on 8/7/2019 and revised on 4/21/2024. E. A record review of Resident 9's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 9's undated Care Plan revealed the resident required two-person assistance with the total lift for transfers. This was initiated on 4/30/2021. F. A record review of Resident 10's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 10's undated Care Plan revealed the resident required a 2-person pivot transfer with gait belt. The care plan also stated to use the total lift with 2 people if the resident was unable to stand, too tired or weak. This was initiated on 1/23/2025. G. A record review of Resident 11's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 11's undated Care Plan revealed the resident required two-person assistance with the sit-to-stand lift for transfers. This was initiated on 5/30/2025. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	H. A record review of Resident 12's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 12's undated Care Plan revealed the resident required substantial assistance by 2-person pivot transfer with a gait belt. The care plan also stated the resident would occasionally be agreeable to use a sit to stand lift. This was initiated on 10/26/2023 and revised on 1/31/2025. I. A record review of Resident 13's MDS dated [DATE] revealed the resident required substantial/maximal assistance with transfers. A record review of Resident 13's undated Care Plan revealed the resident required two-person assistance with stand/pivots with a gait belt to move between surfaces and as necessary. This was initiated on 7/15/2024. I. A record review of Resident 14's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 14's undated Care Plan revealed the resident required 2-person assistance with a Hoyer lift for transfers. This was initiated on 10/31/2020 and revised on 4/21/2024. J. A record review of Resident 15's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 15's undated Care Plan revealed the resident required 1-person assistance with transfers PRN (as needed). This was initiated on 7/2/2019 and revised on 5/5/2021. K. A record review of Resident 16's MDS dated [DATE] revealed the resident was dependent on staff for transfers. A record review of Resident 16's undated Care Plan revealed the resident required 2-person assistance for transfers with the use of the total lift. This was initiated on 1/21/2025. An interview on 6/7/25 at 6:30 PM with the Director of Nursing (DON) revealed one of the Nurse Aides (NA) working that evening was a minor and unable to utilize the mechanical lifts to transfer residents. The DON further reported the DON and this minor NA were the only staff scheduled to work the following evening from 2 pm until 10 pm. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on 6/7/25 at 6:50 PM with Medication Aide (MA)-H revealed MA-H had worked the past 7 days straight in an attempt to assist with the staffing shortage. MA-H stated that there were 30-some residents in the facility and normally 2-3 staff on duty would be sufficient but there were several residents that were high acuity (requiring significant staff assistance) so the current staffing levels were not enough to provide resident cares. MA-H stated that the evening prior, the staffing was the DON, the MA, and one NA. MA-H stated that there were 3 or 4 residents who required the Hoyer lift for transfers and there were several who utilized the sit-to-stand lift, but some of those residents really needed two staff present due to the residents chicken-winging (a situation where the resident's arms extend out to the side during the transfer, increasing the risk of the resident falling out of the lift sling). MA-H revealed that staff frequently transferred residents with the mechanical lifts alone because otherwise the residents would not get cares due to there not being enough staff on duty. MA-H also revealed that they had recently been told by facility management that it was now okay to use the sit-to-stand lifts alone, although this had not previously been an approved practice. An interview on 6/7/25 at 7:55 PM with Resident 4 revealed there were usually two staff to transfer the resident with the Hoyer lift, but not always. Resident 4 stated that occasionally there was only one staff present during the transfers. Resident 4 stated they felt kind of scared because everyone was leaving and that it was 24 hours a day that there had been less staff on duty than usual. An interview on 6/7/25 at 8:53 PM with MA-H confirmed that the staff had been utilizing the mechanical lifts without a second staff present while transferring the residents and that this had been occurring on a daily basis due to lack of staff on duty. MA-H stated they witnessed a staff completing a resident transfer via a mechanical lift without a second staff in the room the evening prior when MA-H entered the resident room to administer medications to the resident. An interview on 6/9/25 at 10:21 AM with Resident 12 revealed Resident 12 had resided in the facility for almost two years and utilized a sit-to-stand lift for transfers. Resident 12 stated that a lot of the time there was only one staff present in their room during the transfers because they are so short staffed here. An interview on 6/9/25 at 2:25 PM with NA-J revealed they had been working in the facility since about January of this year. NA-J confirmed that staff were supposed to have two staff present when transferring residents with the mechanical lifts. NA-J revealed that they had asked the therapy staff for assistance with transferring a resident with the sit-to-stand lift recently and the therapy staff stated that per state, you don't have to have two staff present, so NA-J did transfer the resident by themself. NA-J stated there have been many shifts with only one or two staff working on the floor and that staff rarely works just 8 hours because there is not enough staff and even after the staff gets off the floor, then they have to go back and do their charting. An interview on 6/11/25 at 9:26 AM with Resident 12 revealed that they had been getting transferred via the sit-to-stand lift with only one staff present for quite a while. Resident 12 stated, It's been so long I really couldn't tell you when it started. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on 6/11/25 at 10:57 AM with NA-I revealed the NA had been working in the facility for about 3 years. NA-I stated they were supposed to be on light duty but had been utilizing both the Hoyer and sit-to-stand lifts alone despite being on light duty because there was not ever enough staff on duty to use two people. NA-I stated it had been this way, due to lack of staff availability, since approximately January 2025. L. A record review of the facility policy Activities of Daily Living (ADL), Supporting with a revision date of March 2018 revealed that residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. An interview on 6/7/25 at 10:14 PM with NA-L and NA-M revealed both NA's worked the night shift. NA-M stated that three nights earlier, it was after midnight before the staff finished getting the residents into bed for the night due to the lack of staff that had been available to provide cares for the residents on the evening shift. A record review of Resident 1's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 4/15, indicating severe cognitive impairment. The MDS also revealed the resident required partial/moderate to substantial/maximal assistance from staff for their oral, toileting, and personal hygiene. The resident also required substantial/maximal assistance for their shower/bathing needs. A record review of Resident 1's undated Care Plan revealed the resident required 1-person staff assistance with their bathing/showering, dressing, personal hygiene, and toilet use. M. A record review of facility provided document for Resident 1 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/14/25, 5/17/25, 5/21/25, 5/28/25, and 5/31/25 Not applicable, and on 5/24/25 Resident Refused. There was no other documentation. A record review of the facility document for Resident 1 titled The Spa at Skyview Bathing Schedule from 5/8/25 through 6/9/25 revealed the resident was scheduled to receive showers every Tuesday, Thursday, and Saturday. The documentation revealed the resident received a shower on 5/8/25, 5/27/25 and 6/3/25. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An observation on 6/7/25 beginning after 6:00 PM revealed Resident 1 sitting in the dining room in their wheelchair asking for assistance as people walk past. Resident 1 remained sitting in their wheelchair and slowly wheeled self from inside the dining room out into the hallway outside the dining room. Resident 1 intermittently asked this surveyor to help them, and stated they wanted to go to bed, surveyor informed resident several times that someone would be along to help them soon. At 7:47 PM Resident 1 was observed telling the administrator that they wanted to go to bed. The administrator told the resident that the next NA they saw, the administrator would have them help the resident. At 8:11 PM, Resident 1 again asked this surveyor to help them to their bed. Administrator heard this and told the resident they would find someone to help. At 8:28 PM, Resident 1 had been taken to their room. Observations conducted on 6/9/25 of Resident 1 revealed the following: -At 9:20 AM Resident 1 was sitting in their wheelchair at a table in the dining room. -At 9:40 AM Resident 1 continued sitting at a table in the dining room but now had food in front of them. -At 10:05 AM Resident 1 remained at the dining room table. The resident had backed their wheelchair about a foot away from the table and they were not eating or drinking. -At 10:52 AM Resident 1 was sitting in the dining room, about 2 feet away from the table. The resident had their eyes closed and their chin was resting on their chest. -At 11:05 AM Resident 1 remained in the same position in the dining room. -At 11:27 AM Resident 1 remained in the same position in the dining room. -At 11:45 AM Resident 1 remained in the same position in the dining room. -At 11:53 AM staff approached Resident 1 and asked the resident if they wanted to scoot closer to the table. Resident 1 declined so then the staff handed the resident a cup of juice, which the resident began drinking. Resident 1 remained in the same position in their wheelchair. -At 11:55 AM the Chief Nursing Officer (CNO) moved Resident 1's wheelchair so the resident was facing their table. -At 12:45 PM Resident 1 remained in the dining room. -At 12:54 PM Resident 1 remained in the dining room. An interview on 6/9/25 at 12:54 PM with the DON confirmed Resident 1 had been in the dining room since the surveyor's arrival just after 9:00 AM. The DON also asked NA-I if anyone had assisted Resident 1 to the toilet during that timeframe and the NA stated, not that I know of. N. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident 2's MDS dated [DATE] revealed the resident had a BIMS score of 14/15 indicating they were cognitively intact. The MDS also revealed the resident required partial/moderate assistance with shower/bathing and with toileting hygiene. A record review of Resident 2's undated Care Plan revealed the resident required the assistance of 1 person with bathing showering and with toileting use. An interview on 6/7/25 at 6:50 PM with MA-H revealed that Resident 2 had reported the evening prior that they were going to wash their hair in the sink because they had not been bathed in two weeks. An interview on 6/7/25 at 7:04 PM with Resident 2 revealed the resident had not been bathed in two weeks. Resident 2 stated there was one day they did not get bathed because there was no hot water, but otherwise it had been due to there not being staff available to complete bathing. Resident 2 also revealed they needed staff assistance with wiping their bottom after they used the toilet, and they sometimes had to wait 30 minutes or more for staff to come assist with this task. An interview on 6/11/25 at 9:52 AM with Resident 2 revealed the resident had been getting bathed routinely prior to the past two weeks when they did not receive any baths. Resident 2 stated they were scheduled to receive their baths every Wednesday and Friday, which they did not like because this meant they had one day between baths and then had to go several days until the next bath. A record review of facility provided document for Resident 2 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/21/25 Shower, and on 5/22/25 and 5/25/25 Not applicable. There was no other documentation. A record review of the facility document for Resident 2 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 2 was scheduled to receive a shower every Wednesday and Friday. The documentation revealed the resident received shower on 5/28/25 and 6/8/25. O. A record review of Resident 3's MDS dated [DATE] revealed the resident had a BIMS score of 14/15 indicating the resident was cognitively intact. The MDS also revealed the resident required partial/moderate assistance from staff for wheeling 150 feet and for shower/bathing. A record review of Resident 3's undated Care Plan revealed staff were to encourage physical activity and daily ambulation, and that resident was to use assistive device if necessary. The care plan also revealed the resident had the potential for ADL self-care performance deficit r/t fatigue, impaired balance, and pain to lower back, right hip, and right knee. The resident required assistance of 1 person for bathing/showering. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on 6/7/25 at 7:12 PM with Resident 3 revealed that the prior week had been their third week living in the facility and that there had been several staff who had resigned since they were admitted to the facility. Resident 3 stated they felt like it's a crisis due to the facility being low on help. The resident also stated it had been about two weeks since they had been assisted with bathing, so they had just been doing sponge baths on their own in their room. Resident 3 stated that they needed assistance wheeling back to their room in their wheelchair after meals due to their arthritis. Resident 3 also stated that the evening prior, they had to wheel back to their room independently because there was no staff available, and the resident had been having pain to their right hip and leg ever since. A record review of facility provided document for Resident 3 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed no showers had been documented for the resident since their admission. A record review of the facility document for Resident 3 titled The Spa at Skyview Bathing Schedule from 5/5 through 6/9 revealed the resident had not been added to the bathing schedule but that the resident had received a shower on 5/17/25 (date of admission), 5/28/25, 5/31/25, and on 6/8/25. P. A record review of Resident 4's MDS dated [DATE] revealed the resident had a BIMS score of 15/15 indicating the resident was cognitively intact. The MDS also revealed the resident was dependent on staff for shower/bathing and toileting. A record review of Resident 4's undated Care Plan revealed the resident required 1-person assistance with bathing/showering and that for toileting, the resident did not have the core strength to sit up on the toilet or commode, so resident needed to be transferred to their bed for peri-cares to be performed. An interview on 6/7/25 at 7:55 PM with Resident 4 revealed that it was either last week or the week before that since their last bath but the facility staff had not shared a reason for this. A record review of facility provided document for Resident 4 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period, revealed that staff had documented on 5/30/25 that the resident had refused their shower that day. There was no other documentation. A record review of the facility document for Resident 4 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 4 was scheduled to receive a shower every Monday and Friday. The documentation revealed that the resident received a shower on 5/12/25 and 6/9/25. Q. A record review of Resident 12's MDS dated [DATE] revealed the resident had a BIMS score of 15/15 indicating the resident was cognitively intact. The MDS also revealed the resident required substantial/maximal assistance with shower/bathing and was dependent on staff for toileting hygiene. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A record review of Resident 12's undated Care Plan revealed the resident required substantial assistance by one staff with bathing schedule and as necessary. The Care Plan also revealed the resident required substantial assistance of two staff with the sit-to-stand for toileting. An interview on 6/9/25 at 10:21 AM with Resident 12 revealed Resident 12 had resided in the facility for almost two years and utilized a sit-to-stand lift for transfers. Resident 12 stated that the prior week they had to wait for two hours before staff was able to take them to the bathroom. Resident 12 also revealed that they were supposed to get three showers a week but that they were lucky if they even got one. The resident stated that 9 days was the longest they have had to go without a shower and that this had happened within the last two months. An interview on 6/11/25 at 9:26 AM with Resident 12 revealed that it was about a month ago when they stopped getting bathed 3 times a week like they preferred. A record review of facility provided document for Resident 12 titled POC Response History Task: ADL-Bathing Schedule and dated 6/10/25 with a 30 day look back period revealed that staff had documented on 5/16/25 and 5/23/25 Not Applicable, and on 5/21/25, 5/26/25, and 5/30/25 Shower. There was no other documentation. A record review of the facility document for Resident 12 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 12 was scheduled to receive a shower every Monday, Wednesday, and Friday. The documentation revealed that the resident received a shower on 5/5/25, 5/9/25, 5/12/25, 5/26/25, 5/28/25, 6/3/25, and 6/9/25. R. A record review of Resident 19's MDS dated [DATE] revealed the resident had a BIMS score of 10/15 indicating the resident had moderate cognitive impairment. The MDS also revealed the resident was dependent on staff for their shower/bathing. A record review of Resident 19's undated Care Plan revealed the resident required 1-person assistance with bathing/showering. An interview on 6/11/25 at 10:18 AM with Resident 19 revealed the resident was supposed to get three baths a week but lately it had been pretty hit and miss. Resident 19 stated that it varied, sometimes they would get one or more baths a week and sometimes it would stretch into two weeks. Resident 19 stated that they couldn't say when this started, it was pretty much when the staff started quitting but the resident stated they could not really say how long ago that was either. A record review of facility provided document for Resident 19 titled POC Response History Task: ADL-Bathing Schedule and dated 6/11/25 with a 30 day look back period revealed that staff had documented on 5/16/25 and 5/19/25 not applicable. Staff had also documented Shower on 5/14/25, 5/23/25, 5/24/25, 5/28/25, 5/30/25, 6/4/25, 6/6/25, and 6/9/25. A record review of the facility document for Resident 19 titled The Spa at Skyview Bathing Schedule from 5/5/25 through 6/9/25 revealed Resident 19 was scheduled to receive a shower every Monday, Wednesday, and Friday. The documentation revealed that the resident received a shower on 5/9/25, 5/14/25, 5/16/25, 5/26/25, 5/30/25, 5/31/25, 6/4/25, and 6/9/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview on 6/11/25 at 11:24 AM with the DON confirmed baths should be given to the residents at least once a week unless the resident wanted them more frequently. The DON revealed that the facility did not currently have a working bathtub and that there had not been a functional bathtub since prior to their date of hire which was 1/6/25, so all of the residents have had to take showers. An interview on 6/11/25 at 11:45 AM with the CNO revealed baths are given per resident preferences, which are established upon admission but were also reestablished as part of the facility's plan of correction following their recent survey. The CNO stated they went around to all residents and asked what they preferred, and the bathing schedule was developed based on this information. S. -Abatement Statement Correction to the resident(s) affected: All residents have been assisted to bed and adequate care provided. Specify how the immediacy of the deficient practice will be corrected for the residents identified and all residents at risk for the deficient practice. Integrated Staffing Solutions (ISS) Staffing will be utilized immediately; and within 24 hours. Staffing with all available personnel will be utilized. System Changes: The facility will have all available certified and licensed staff available, including members of the interdisciplinary team available to respond to residents to ensure needs are met. In-services will be completed by DON/NHA on staffing and resident care for staff present in facility and for remaining staff before their next shift. In-services will be completed by DON/NHA that all mechanical lifts must be operated by two (2) staff members and that staff under age [AGE] cannot operate a mechanical lift independently for staff present in facility and for remaining staff before their next shift. In-services will be completed by DON/NHA that staff should notify the director of nursing (DON) or the nursing home administrator (NHA) for staff present in facility and for remaining staff before their next shift. Monitoring: NHA will monitor pending staffing daily to ensure staffing is adequate for upcoming shifts. If staffing is not adequate, staff will be notified and asked to cover shifts. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	At the time of the survey, the violation was determined to be at the immediate jeopardy level K. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the E level.

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	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-00604(D)Nebraska Revised Statute 71-6018.02(a) Based on record reviews and interviews, the facility failed to maintain acceptable documentation (timecards, time sheets, payroll information) that a Registered Nurse (RN) was on duty for a minimum of 8 consecutive hours a day, 7 days a week, as required. This had the potential to affect all 28 residents by limiting access to RN-level assessment, oversight, and decision-making related to resident care.Findings are: A record review of a facility provided document SCARAB (Skyview Care and Rehab at Bridgeport) Facility Assessment- 2025 dated 6/4/2025 revealed under the staffing type section, nursing services of the Director of Nursing (DON), RN, Licensed Practical Nurse (LPN), Nurse Aides (NA), and Medication Aides (MA) were needed to provide support and care for the facility's residents. Under the staffing plan section, it was revealed that a total of 5 licensed nurses providing direct care were needed. There was no evidence regarding the need for an RN to be on duty for a minimum of 8 consecutive hours a day, 7 days a week. 1.A record review of a facility provided document, Daily Assignment Sheet (dated 6/24/2025), revealed RN-U was listed as the nurse assigned to the 6PM-6AM shift. The same document listed no other RNs, two LPNs and several NAs assigned to resident care throughout the 24-hour period. A record review of the facility provided document Timecard Detail Report for RN-U, covering the date range 6/12/2025 to 8/14/2025, revealed no evidence RN-U had been on duty on either 6/24/2025 or 6/25/2025. A record review of the facility's documentation provided as evidence of RN coverage included the Chief Nursing Officer's (CNO) Vetus Time Study (dated June 2025). For 6/24/2025, the time study listed a task titled DON Coverage - RN Coverage with a total daily hour of 18.5 hours. However, the time study did not include documentation of specific hours worked, nor did it demonstrate that the hours were consecutive. Additionally, the information documented in the time study did not algin with the facility's Daily Assignment Sheet (dated 6/24/2025). 2. A record review of the facility provided document Nursing Coverage (dated 7/8/2025) revealed the CNO had been listed as the 6AM-6PM RN on duty. The same document listed no other RN, two LPNs and several NAs assigned to resident care throughout the 24-hour period. A record review of the facility's documentation provided as evidence of RN coverage included the CNO's Vetus Time Study (dated July 2025). For 7/8/2025, the time study listed a task titled Sky DON Coverage with a total of daily hours of 10 hours. However, the time study did not include documentation of specific hours worked, nor did it demonstrate that the hours were consecutive. Additionally, the information documented in the time study did not algin with the facility's Daily Assignment Sheet (dated 7/8/2025). 3. A record review of the facility provided document Nursing Coverage (dated 7/12/2025) revealed RN-P had been listed as the Registered Nurse for 2:00-10:00 PM and then the RN for 6PM-6AM. The same document listed no additional RNs, one LPN, and several NAs assigned to resident care throughout the 24-hour period. A record review of the facility provided document Timecard Detail Report for RN-P, covering the date range 6/12/2025 to 8/14/2025, revealed RN-P had been on duty on 7/11/2025 at 10:03 PM to 7/12/2025 at 7:28 AM. There was no evidence RN-P had returned for an additional shift at 2:00 PM or later on 7/12/2025 or on 7/13/2025. A record review of the facility provided document Timecard Report, for the Nursing Home Administrator (NHA), covering dates 6/12/2025 to 8/14/2025, revealed the NHA had been on duty on 7/12/2025 from 4:10 PM to 6:00 PM and 7/13/2025 from 6:00 PM to 6:23 AM. A record review of a State of Nebraska - Department of Health and Human Services' License Details revealed the NHA had an active LPN license. Additional record review of the facility's documentation provided as evidence of all nursing staff, including agency/contract and management, who had worked from 6/12/2025-8/14/2025 including Timecard Reports, Timecard Detail Reports, and Vetus Time Studies revealed no evidence of a RN having been on duty of at least 8 consecutive hours for 7/12/2025. An interview on 8/18/2025 at 1:25 PM with the NHA revealed due to a time keeping error/glitch, the NHA's timecard had shown the NHA had worked the night shift on 7/13/2025, however, the NHA had covered the night shift for licensed nurse coverage on 7/12/2025. 4. A record review of the facility provided document Nursing Coverage (dated 7/13/2025) revealed there had been no RN listed on duty for the 24-hour period. The same document listed two LPNs and several NAs assigned to resident care throughout the 24-hour period. Additional record review of the facility's documentation provided as evidence of all nursing staff, including agency/contract and management, who had worked from 6/12/2025-8/14/2025 including Timecard Reports, Timecard Detail Reports, and Vetus Time Studies revealed no evidence of a RN having been on duty of at least 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	06/11/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D) Based on observations, record reviews and interview; the facility staff failed to ensure a medication error rate of less than 5%. Observations of 25 opportunities of medication administration revealed 5 medication errors resulting in a medication error rate of 20%. The medication errors effected 2 (Resident 4 and 17). The survey had a total sample size of 19. The facility identified a census of 36. Findings are: A record review of a facility policy Administering Medications with a last revised date of April 2019 revealed medications are to be administered in accordance with prescriber orders, including any required time frame. The individual administering the medication should check the label three times to verify the right resident, medication, dosage, time, and route prior to administering the medication. A record review of a facility policy, Adverse Consequences and Medication Errors with a last revised date of February 2023 revealed examples of medication errors include omission (when a drug is ordered but not administered), unauthorized drug (when a drug is administered without a physician's order), wrong dose, wrong route, wrong drug, wrong time, or failure to follow manufacturer's instructions and /or accepted professional standards. A. A record review of Novartis' Full Prescribing Information for ondansetron revealed under administration instruction for orally disintegrating tablets (ODT) revealed directions to immediately place the oral disintegrating tablet on top of the tongue where it will dissolve. B. A record review of an admission Record revealed the facility re-admitted Resident 4 back to the facility on 4/23/2025. Resident 4 had diagnoses of schizoaffective disorder (a mental illness that combines symptoms of schizophrenia and mood disorders like bipolar disorder or depression. It's characterized by periods of psychosis (hallucinations, delusions) and mood episodes like mania or depression), anxiety (a feeling of fear, dread, and uneasiness), Multiple Sclerosis (MS, a disease where the body's immune system mistakenly attacks the protective covering of nerve fibers in the brain and spinal cord that can cause muscles weakness, trouble walking, numbness, and difficulty with controlling bowel and bladder), chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung, and legal blindness. A record review of Resident 4's admission 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) 4/30/2025 revealed Resident 4 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15/15, which indicated Resident 4 was cognitively intact. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 4's Order Entries as of 6/10/2025 revealed the following orders: -Ondansetron Oral Disintegrating Tablet (ODT) 4 milligrams (mg) with instructions to administer three times a day, with first administration time between 6 AM and 9 AM, for nausea and vomiting with a start date of 5/15/2025. -Clonazepam (a sedating medication in a class called benzodiazepines) 0.5 mg with instructions to administer three times a day, with first administration time between 6 AM and 9 AM, for schizoaffective disorder and anxiety with a start date of 5/10/2025. -Gabapentin 100 mg with instructions to administer three times a day, with first administration time between 6 AM and 9 AM, for anxiety and irritability with a start date of 4/24/2025. -Lansoprazole (a drug for heartburn) 30 mg with instructions to give one time a day, between 6 AM to 9 AM, for Gastroesophageal Reflux Disease (GERD, a digestive disorder where stomach acid frequently flows back into the esophagus, causing heartburn and potentially damaging the esophageal lining) with a start date of 5/16/2025. An observation on 6/10/2025 at 9:50 AM revealed Medication Aide (MA)-G prepare Resident 4's ondansetron, clonazepam, gabapentin, lansoprazole into one medication cup. An observation on 6/10/2025 at 10:20 AM revealed MA-G took the prepared medications to Resident 4's room. Resident 4 was sitting in their wheelchair at their bedside table resting their head down on the bedside table. A plate of food, sitting on the resident's bedside table from breakfast, had been approximately 25% consumed. MA-G spooned all medication prepared to Resident 4 at once, without separating out Resident 4's ondansetron or instructing to allow to it to dissolve in their mouth. Resident 4 began to make gagging noise. MA-G provided Resident 4 with some water to assist with swallowing the medications down. Resident 4 continued to gag and shake their head, once swallowed Resident 4 stated, Can't drink, I'm gaggy today. An interview on 6/10/2025 at 10:25 AM with MA-G confirmed Resident 4's medications of ondansetron, clonazepam, gabapentin, and lansoprazole were administered late as they were to be administered between 6 AM and 9 AM. MA-G also confirmed the concern Resident 4's second dose of clonazepam was due to be given soon and would be too close to the dose just administered to Resident 4. MA-G also revealed the were unaware Resident 4's ondansetron should be dissolved on their tongue, stating that they only work this medication cart every once in a while, so they were unfamiliar with the medications. An interview on 6/10/2025 at 11:50 AM with the Director of Nursing (DON) revealed the DON had contacted Resident 4's medical provider regarding their clonazepam having been administered late and to obtain an order to hold the next dose. The DON also confirmed Resident 4's medications of ondansetron and lansoprazole were administered late and may have provided Resident 4 relief from their nausea had they been administered timely, as well as the ondansetron have been dissolved on the resident's tongue, provided more immediate relief. C. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of an admission Record indicated the facility admitted Resident 17 on 2/10/2025. Resident 17 had diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior) and restlessness and agitation. A record review of Resident 17's Care Plan with a last revised date of 5/20/2025 revealed a focus area regarding psychotropic medication. This area revealed Resident 17 was ordered venlafaxine for depression with an intervention to administer psychotropic medications as ordered by the physician. A record review of Resident 17's Order Entry revealed the order for venlafaxine extended release (ER) 150 mg with instructions to administer one time a day in the morning with a start date of 5/30/2025. An observation on 6/10/2025 at 10:30 AM revealed Licensed Practical Nurse (LPN) - F prepare Resident 17's venlafaxine to administer. On 6/10/2025 at 10:36 AM, LPN-F administered Resident 17's venlafaxine. An interview on 6/10/2025 at 10:42 with LPN-F confirmed Resident 17's venlafaxine had been administered late as it is to be administered between 6 AM and 9 AM, then it turns red on the EMAR. LPN-F revealed they were behind on medication administration due to being unfamiliar with this medication cart as last time they were on this medication cart was 7 months ago. An interview on 6/10/2025 at 12:40 PM with the Chief Nursing Officer (CNO) confirmed there is a 3-hour medication window from 6 AM to 9 AM for medications ordered for the AM to be administered, after 10 AM, they are considered administered late.

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	285224	A. Building B. Wing	06/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Licensure Reference Number 175 NAC 12-006.10(D) Based on record review and interview, the facility failed to ensure three doses of an intravenous (IV) antibacterial medication were not omitted for 1 (Resident 7) of 1 sampled resident. The facility identified a census of 36. Findings are: A record review of a facility policy, Adverse Consequences and Medication Errors with a last revised date of February 2023 revealed examples of medication errors include omission (when a drug is ordered but not administered), unauthorized drug (when a drug is administered without a physician's order), wrong dose, wrong route, wrong drug, wrong time, or failure to follow manufacturer's instructions and /or accepted professional standards. The policy defined signification medication-related errors as the requirement for the medication to be discontinued or modified, required hospitalization, resulting in disability, requiring treatment with a prescription medication, resulting in cognitive deuteriation, life threatening, or resulting in death. A record review from AstraZeneca Pharmaceuticals (the manufacture) of meropenem: Prescribing Information with a date of 12/2026 revealed skipping doses or not completing the full course of therapy may decrease the effectiveness of immediate treatment and increase the likelihood that bacteria will develop resistance and will not be treatable by meropenem or other antibacterial drugs in the future. A record review of an admission Record indicated the facility re-admitted Resident 7 on 5/27/2025. Resident 7 had diagnoses of Urinary Tract Infection (UTI), Type 1 diabetes, right artificial hip join with surgical aftercare, retention of urine, and neuromuscular dysfunction of the bladder. A record review of Resident 7's Medication Administration Record for June 2025 revealed an order for meropenem (an antibacterial medication) for 1 gram (g) with instructions to use 1g intravenously every 8 hours at 6:00 AM, 2:00 PM, and 10:00 PM for a UTI. The order had a start date of 5/28/2025 and an end date of 6/4/2025. Additionally, the MAR revealed the resident's meropenem had not been documented as administered on 6/1/2025 at 6:00 AM or 6/4/2025 at 2:00 PM. A record review of Resident 7's Progress Notes from 5/27/2025-6/1/2025 revealed the following: -On 5/27/2025 at 7:08 PM, it was documented Resident 7 had returned to the facility via an ambulance. The facility had not received report from the discharging hospital, but a report from the Emergency Medical Services (EMS) was obtained. The writer contacted the discharging hospital and received report. Resident 7 had a urine analysis (UA) during their hospital stay that was positive for pseudomonas (a type of infection). Resident 7 was started on IV meropenem 1 gram IV every 8 hours and had received six doses while in the hospital. Resident 7 was discharged with order to continue the IV meropenem 1 g IV every eight hours through 6/4/2025. At the time of resident's arrival back to the facility, Resident 7 no longer had IV access or the meropenem available. EMS was contacted and Resident 7 was taken to the local hospital. (continued on next page)

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	285224	A. Building B. Wing	06/11/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/27/2025 at 11:08 PM, Resident 7 returned to the facility with a peripheral IV and order to place a midline or peripherally inserted central catheter (PICC line) and to continue the order for meropenem 1 g IV every 8 hours through 6/4/2025. -On 5/28/2025 at 4:58 PM, Resident 7 had a midline access placed. -On 6/1/2025 at 2:48 AM, Resident 7 was discovered to have removed their midline. -On 6/1/2025 at 5:03 AM, Resident 7's meropenem order was held with a note that Resident 7 had remove their midline and there was no IV access at the time. There was no evidence IV access was attempted to be obtained. -On 6/1/2025 at 12:42 PM, Resident 7's medical provider was notified regarding Resident 7 having removed their midline. Resident 7's medical provider provided an order to send back to the hospital for a new line, but no one was available to place the line. EMS was contacted and started a new line and administered the antibiotics. A record review of a Employee Warning Report with a date of 6/2/2025 revealed a warning was given to Licensed Practical Nurse (LPN) - F from the Director of Nursing (DON) for failure to achieve established job standards and a medication error. The report revealed on 5/30/2024 at 2:00 PM, LPN-F failed to administer the prescribed medication at the scheduled time, resulting in a missed dosage that could potentially impact the patient's health. Additionally, the LPN did not inform the DON about the inability to administer the medication, which is a critical breach of protocol. Additionally, it revealed LPN-F was required to notify a Registered Nurse (RN) immediately if LPN-F was unable to administer a medication to ensure that the patient received the required doses without further delay. A record review of a Employee Warning Report with a date of 6/5/2025 revealed a warning was given to Licensed Practical Nurse (LPN) - F from the Director of Nursing for failure to achieve established job standards and a medication error. The report revealed on 6/4/2025 at 2:00 PM, LPN-F failed to administer the prescribed medication at the scheduled time, resulting in a missed dosage that could potentially impact the patient's health. Additionally, the LPN did not inform the DON about the inability to administer the medication, which is a critical breach of protocol. Additionally, it revealed LPN-F was required to notify a Registered Nurse (RN) immediately if LPN-F was unable to administer a medication to ensure that the patient received the required doses without further delay. An interview on 6/10/2025 at 11:50 AM with the DON confirmed Resident 7 had missed a total of 3 antibiotic doses, the first dose and the two doses that were not administered by LPN-F on 5/30/2025 and 6/4/2025, which had the potential to impact Resident 7's health.