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	06/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Skyview	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 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. Licensure Reference Number 175 NAC 12-006.04(D)(i)Based on record review and interview, the facility failed to submit a director of nursing continuous coverage notification to the state agency as required. This had the potential to affect all residents.Findings are: Record review of the Change of Director of Nursing Notification Form submitted to the Department of Health and Human Services by the facility revealed no Director of Nursing (DON) coverage between the dates of 4/29/2026 and 5/4/2026. Interview with Regional Nurse Consultant (RNC) at 6/16/2026 at 11:35 AM revealed that RNC was the DON during the gap stated above, but it was not recorded on paper to confirm. Interview with Administrator (ADM) at 6/16/2026 at 11:35 AM confirmed that the Change of Director of Nursing Notification Form does show a gap of DON coverage between 4/29/2026 and 5/4/2026. ADM confirmed the facility does not have written proof of DON coverage in that time frame.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 175 NAC 12-006.11(E)Based on observations and record reviews, the facility failed to perform hand hygiene with soap and water for a minimum of 20 seconds. The facility failed to ensure cleanliness of the kitchen to prevent the potential for cross contamination. The facility also failed to label and seal stored foods. This had the potential to affect all residents. The facility showed a census of 25.Findings are: Observations made beginning at 8:20 AM on 6/11/2026 revealed in the dry storage area, there were 4 boxes of baking soda on the shelf, each with an expiration date of July 2024. Also, in the dry storage there was 1 large bag of macaroni noodles that were open and unsealed with no open date on the packaging. Inside the storage area there were 3 separate freezers. Inside one of the freezers there was 1 bag of hashbrowns that were not sealed and did not have an open date listed on the packaging. That same freezer also had a package of frozen corn tortillas that did not have an expiration or best by date. Inside another freezer there was one more bag of hashbrowns that were unsealed and undated. Inside 2 of the 3 freezers there were multiple bags of frozen peas that did not have expiration date or best by date. Inside one freezer was a bag of cinnamon rolls in a plastic bag tied, with no open date. There was also a large blue bag filled with chopped carrots that was not sealed and did not have an open date on it. Inside a freezer there was a plastic Ziploc bag with fish fillets inside them that did not have an open date marked. There was one bag of ground sausage in a Ziploc bag with a date of 5/21 and was not sealed. There was one bag of frozen waffles that did not have an expiration or best by date as well as a large plastic bag of frozen bread that was not sealed and did not have an open date. Additional observations inside the kitchen revealed there was a grey fuzzy substance on the chains holding up the hood vent above the stove/oven. The ice machine lid was covered in a dry white substance and appeared to have a slow water drip coming from the top portion of the machine that ran down the lid of where the ice was held.An interview with the Dietary Manager (DM) at 8:30 AM on 6/11/26 confirmed the expiration dates on the 4 boxes of baking soda.Observations that began at 10:40 AM on 6/11/26 of meal preparation revealed DM performed hand hygiene via soap and water for 10 seconds and donned (put on) new gloves and then began to prepare fruit cups for residents. At 10:55 AM the DM removed their gloves and then performed hand hygiene with soap and water for 7 seconds. The DM then donned new gloves, touched a paper on the prep counter then put on oven mitts and removed the chicken from the oven. The DM then removed the left oven mitt from their hand, then closed and locked the oven door. The DM removed the tin foil from the chicken and then grabbed a thermometer and cleaned it with appropriate wipe. The DM put the thermometer into a piece of chicken to check the temperature and then put thermometer down on top of stove and stepped away to help the Cook-D. When the DM returned, they used the thermometer-without recleaning it- to temp the chicken again at 10:57 AM and the chicken was temping at 96F (Fahrenheit). The DM removed their gloves and put the thermometer on counter, put on oven mitts and placed chicken back in oven. At this time the DM demonstrated that if the lock on the oven door is not latched, the door does fall open and stated, The oven stops working randomly. food always takes longer to cook than it should. Cook-D was attempting to seal and store a bag of salad and discovered there was a hole in the back of the bag causing food to fall out so the cook placed a piece of clear tape over the hole and placed bag of salad back in the fridge. The DM was then preparing salad dressing cups for the residents and touched a piece of paper that was on the prep counter with their gloved hands and then continued to prepare the salad dressing cups. At 11:49 AM Cook-D came back into the kitchen from an unknown location, did not perform hand hygiene and donned new gloves. At this time the DM took a cleaning rag from a red bucket and used it to wipe down the preparation counter. Cook-D then removed his gloves, performed hand hygiene with soap and water for 10 seconds, donned new gloves and then grabbed a loaf of bread and removed several pieces of bread from the bag. Cook-D was then called out of the kitchen by another staff member and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	kept their gloves on. At this time the DM removed a container of cottage cheese from the fridge with their gloves hands and then put cottage cheese into individual cups. The DM then put the trays with the cottage cheese cups into the refrigerator and then removed a silver bin full of broccoli. The DM then removed the plastic wrap from the broccoli, then removed gloves and walked out of kitchen. The DM came back into the kitchen with a box of aluminum foil, tore off a section and then placed it over the broccoli. The DM then put water into the broccoli and placed the silver bin of broccoli and water in oven. The DM then removed their gloves and used a rag from red bucket to wipe down counter. The DM then performed hand hygiene with soap and water for 6 seconds. At this time Cook-D was making sandwiches with gloved hands by putting peanut butter on 4 pieces of bread, but then stopped, removed their gloves, left the kitchen at 11:41 AM, and then came back at 11:42 AM with a box full of individual jelly packets, did not perform hand hygiene, and donned new gloves. Cook-D then proceeds to put jelly on 4 different pieces of bread. At 11:45 AM the DM donned gloves and then put on oven mitts and took the chicken out of the oven, then removed the aluminum foil from the silver pan. The DM then grabbed the thermometer and placed the thermometer into chicken which temped at 205F. The DM then transferred all the chicken to another silver pan from the steam holding tray. The DM then manually shredded the chicken and stated there were no pureed diets for residents, only mechanical soft. At this time Cook-D removed their old gloves and used hand sanitizer to perform hand hygiene, then donned new gloves and put away a box of plastic wrap. Cook-D then used the same gloved hands to touch the paper that had been sitting on the prep counter and then wrote down the temperature of the chicken on a white board on the side of the steam holding tray. The DM then removed the broccoli from the oven using the oven mitts and added more water to it. The DM then removed their gloves and walked out of the kitchen in search of a pen. The DM walked back into the kitchen at 11:59 AM, did not perform hand hygiene and donned a new pair of gloves. The DM then opened the fridge door with their gloved hands and removed the sauce for the chicken and placed the sauce in a pot on the stove and heated it while stirring it with a whisk. At this time the DM began preparing mechanical soft broccoli for residents and preparing the steam holding tray for foods. The ND advised staff to rewash their hands with soap and water- which they did for over 2 seconds each and then continued training Cook-D on serving residents.Record review of an undated facility policy labeled ?Food Storage' revealed the following statements:-It is recommended that food items are to be dated upon receipt with the month, day and year (00/00/00).-All opened and partially used foods shall be dated, labeled and sealed before being returned to the storage area.This policy has a separate section on page 23, labeled ?Frozen' with the following statements:-Cover all food containers-Wrap all food well to prevent freezer burn, label if product is not identifiable, and date of entry to freezer.-Opened boxes of food must be securely closed to preserve quality.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure number 175 NAC 12-006.05Based on record review and interviews, the facility failed to ensure residents and/or resident representatives were informed of and consented to treatment prior to the administration of psychotropic medications for 2 (Resident 4 and Resident 21) of 5 sampled residents. The facility identified a census of 25 residents.Findings include: A. Record review of Resident 4's admission Record dated June 10, 2026 revealed Resident 4 admitted to the facility on [DATE] with a diagnosis of major depressive disorder. Record review conducted on June 10, 2026, of Resident 4's Doctor's Progress Note dated December 5, 2025, revealed Resident 4 was prescribed Seroquel (an antipsychotic medication used to treat major depressive disorder). Record review of Resident 4's medical record revealed no evidence of informed consent being obtained prior to the first dose of their Seroquel being administered. B. Record review of Resident 21's admission Record dated June 10, 2026 revealed Resident 21 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder, post-traumatic stress disorder and irritability and anger. Record review conducted on June 10, 2026, of faxed order from provider dated March 12, 2026 revealed Resident 21 was prescribed Risperdal (an antipsychotic medication used to treat several mental health disorders) for inappropriate sexual behavior. Record review of Resident 21's medical records revealed no evidence of informed consent being obtained prior to the first dose of their Risperdal being administered. Record review of Nursing Note with verbal order from provider dated March 11, 2026 revealed Resident 21 was prescribed Olanzapine (an atypical antipsychotic medication used to treat mental health issues) was prescribed for mood disorder unspecified with hypersexuality. Record review of Resident 21's medical records revealed no evidence of informed consent being obtained prior to the first dose of their Olanzapine being administered. Interview with the Director of Nursing (DON) on June 10, 2026 at 10:23 AM, revealed residents admitted to the facility on psychotropic medications should have informed consent completed upon admission. The DON stated informed consent should also be obtained when new psychotropic medications are initiated. The DON confirmed informed consent may be obtained in person or through documented telephone consent with the resident representative. The DON confirmed there was no informed consent obtained for Resident 4 and Resident 21 prior to starting these antipsychotic medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review, observation, and interview, the facility failed to ensure the MDS was coded accurately to reflect wandering behavior for one (Resident 16) of twelve sampled residents. The facility identified a census of 25.Findings are: Record review of Resident 16's admission Record dated 6/15/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 16's Diagnosis Information dated 6/15/2026 revealed a diagnosis 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]) was added on 2/10/2025. A diagnosis of Metabolic Encephalopathy (when the brain has trouble working because of a chemical, or metabolic, problem in the body which can cause confusion and memory loss) was added on 2/10/2025. A diagnosis of Restlessness and Agitation (involve feelings of inner tension, mental distress, and an inability to sit still; that can manifest as pacing, wandering, repetitive actions, or verbal outbursts) was added on 2/10/2025. Record review of Resident 16's Order Recap Report dated 6/15/2026 revealed the resident had an order for a Wanderguard (patient-safety technology used to keep residents with cognitive impairments [such as dementia] safe while promoting freedom of movement within a facility) with a start date of 6/9/2025. The order was revised on 7/19/2025, 3/24/2026, and 4/9/2026. Record review of Resident 16's undated Care Plan revealed the resident is an elopement risk/wanderer which was initiated on 6/9/2025 and revised on 2/6/2026. An observation on 6/10/2026 at 8:14 AM revealed Resident 16 walking to the door at the end of the 100 hallway. An alarm was set off, and a staff member went out to get the resident who had gone approximately 15 steps out the door. Observation revealed Resident 16 holding hands with a staff member walking through the halls on:6/11/2026 at 10:44 AM6/15/2026 at 8:19 AM6/16/2026 at 8:40 AM Observation on 6/15/2026 at 1:52 PM revealed Resident 16 walking down the 100 hallway telling a surveyor they need to use the bathroom while walking towards the exit door at the end of the hall. A dietary aide stopped the resident from exiting and helped the resident walk to the 400 hallway to get a nurse aide to help the resident. Resident 16 had a wanderguard on their left ankle. Observation on 6/15/2026 at 2:34 PM revealed Resident 16 wandering the 400 hallway alone. Observation on 6/16/2026 at 8:54 AM revealed Resident 16 walking the halls following a surveyor. Observation on 6/16/2026 at 11:26 AM revealed Resident 16 wandering the 200 hallway alone then Administrator (ADM) came over and guided the resident to the dining room. Observation on 6/16/2026 at 4:00 PM revealed Resident wandering 100 hall towards the exit door. MDS Coordinator (MDS-C) caught up to the resident to stop Resident 16 from opening the exit door. An interview on 6/15/2026 at 2:52 PM with Registered Nurse (RN)-A confirmed that Resident 16 had been wandering since the day Resident 16 was admitted to the facility. Wandering was nothing new for the resident. RN-A confirmed that because the resident wandered everyday, the nurses did not chart the behavior. The nurses would only chart when Resident 16 was exit seeking. RN-A confirmed that Resident 16 was care-planned for wandering. An interview with the Regional Nurse Consultant (RNC) on 6/16/2026 at 9:00 AM revealed the facility does not have an 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) policy as they follow the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services [CMS] to facilitate accurate and effective resident assessment practices in long-term care facilities) to complete the MDS's. A record review of the RAI Manual dated October 2025 revealed that on page E-18 to E-19 in Chapter 3, Section E that the line E0900: Wandering - Presence & Frequency requires assessing the medical record and interviewing staff to determine whether wandering occurred during the 7-day look-back period. Wandering is defined as the act of moving (walking or locomotion in a wheelchair) from place to place with or (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a specified course or known direction. Wandering may or may not be aimless. E0900 should be coded as 0 if the behavior was not exhibited. E0900 should be coded as 1 if wandering occurred 1-3 days during the 7-day look-back period, 2 if it occurred 4-6 days, or 3 if it occurred daily. Coding 1-3 would trigger E1000: Wandering - Impact, which assesses if the wandering places the resident at significant risk of getting to a potentially dangerous place or if the wandering significantly intrudes the privacy or activities of others. A. Record review of Resident 16's Progress Notes revealed a nursing note from 8/8/2025 at 3:06 PM that Resident 16 had been wandering more that day than their normal. Record review of Resident 16's Quarterly MDS dated [DATE] revealed that section E0900 was coded as 1 indicating that wandering behavior occurred 1-3 days. Record review of Resident 16's Modified Quarterly MDS dated [DATE] revealed that section E0900 was coded as 0 indicating that wandering behavior was not exhibited. Interview with MDS-C on 6/15/2026 at 3:58 PM confirmed that the Progress Note dated 8/8/2025 reflected Resident 16 wandering and that the MDS should have been coded as 1. B. Record review of a Resident 16's Progress Notes revealed a Provider Visit Note dated 11/8/2025; the resident was being seen for a follow up on Resident 16's depression, anxiety, and wandering. Record review of Resident 16's Quarterly MDS dated [DATE] revealed that section E0900 was coded as 0 indicating that wandering behavior was not exhibited. C. Record review of Resident 16's Progress Notes revealed a nursing note from 2/1/2026 at 5:41 PM that Resident 16 was ambulating around the facility independently per ?gender' norm, exit seeking. Record review of Resident 16's Progress Notes revealed a nursing note from 2/2/2026 at 5:51 AM that Resident 16 was ambulating independently before going to bed and was given Tylenol for restlessness. Record review of Resident 16's Significant Change MDS dated [DATE] revealed that section E0900 was coded as 0 indicating that wandering behavior was not exhibited. Interview with MDS-C on 6/15/2026 at 3:58 PM confirmed that the note on 2/1/2026 and 2/2/2026 reflected Resident 16 wandering and that the MDS should have been coded as 1. D. Record review of Resident 16's Quarterly MDS dated [DATE] revealed that section E0900 was coded as 0 indicating that wandering behavior was not exhibited. Record review of the Elopement Risk Scale dated 4/18/2026 revealed Resident 16 was at risk for elopement/wandering. Interview with MDS-C on 6/15/2026 at 3:58 PM confirmed that because Resident 16's Care Plan said the resident was a wanderer that the MDS should match that focus and code the resident for wandering.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide behavioral health care and services to one sampled resident (Resident 5). The facility identified a census of 25 residents. Findings are:Record review of a facility document titled, admission record, revealed Resident 5 was admitted on [DATE] with diagnoses of arthropathy (arthritis) in their left shoulder, chronic bronchitis, protein-calorie malnutrition, obstructive bladder dysfunction, history of falling, and depression. Record review of Resident 5's comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) dated 3/4/26 revealed the following:Section C revealed Resident 5 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score 15 of a possible 15 points, indicating they were cognitively intact.Section I (Active diagnoses) revealed Resident 5 had an active diagnosis of depression within the last 7 days.Section N (Medications) revealed Resident 5 was taking an antidepressant in the last 7 days.Record review of Resident 5's undated care plan revealed:Resident 5 was determined not to be able to make informed decision by the provider on 1/7/26. Date initiated was 2/6/26.Resident 5 had a diagnosis of depression, and documented goal was to remain free of symptoms of distress, depression, anxiety, and sad mood. The date the goal was initiated was 12/10/25.An intervention in Mood/Behavior, dated 12/10/25 stated the facility would arrange for a psych consult for Resident 5.Other interventions for Resident 5's in the mood and behavior section were to monitor, document, and report any emotional distress, offer reassurance of a safe environment, and assess for unmet needs, all dated 12/10/25. A record review of Resident 5's progress notes in the electronic medical record (EMR) revealed the following:-On 9/18/25, the Social Services Director (SSD) completed measured Resident 5's BIMS score at 11/15 which indicated moderate impaired cognition, with no concerns found regarding the resident's mood or behavior.-On 9/19/25, at 8:10 PM, a nursing note revealed that Resident 5 left a note at their table in the dining room that stated the government wanted them dead. A staff member then found Resident 5 in the courtyard with a fork held to their abdomen and told the staff member the government was trying to take all their belongings. Resident 5 had learned earlier in the day they would need to make a list of their assets as part of the Medicaid application before it could be approved. Resident 5 was taken to the hospital for evaluation after the fork incident and comments.-On 9/20/25, at 3:00 AM, a nursing note revealed the facility had received information from the hospital that the resident was no longer suicidal and would be returning to the facility.-On 9/20/25, at 3:30 AM, a nursing note revealed the Resident 5 returned to the facility and stated, I did a foolish thing, and was apologetic and emotional. The note stated Resident 5 would be monitored every 15 minutes.-On 9/22/25, a nursing note revealed the 15-minute checks were discontinued following a visit by a provider, and Resident 5's requested that all their mail be screened so any financial or insurance matters could be handled by SSD. Record review of an untitled facility document dated 2/27/26 revealed a letter on facility letterhead that notified Resident 5 and their representative that the resident would be discharged 30 days after receipt of the letter, as well as pursue legal recourse to recover a past due balance. A record review of Resident 5's progress notes in the electronic medical record (EMR) revealed the following:-On 3/3/26, the SSD scheduled a care conference with Resident 5's representative for 3/12/26.-On 3/13/26, SSD informed Resident 5 that their Medicaid application was denied, the facility would look for placement in a different facility for the resident and asked for Resident 5's input on a location.-On 3/16/26, Resident 5 reported to nursing staff that they were suicidal, discussed feelings of helplessness with staff, and denied having a specific plan or time frame. Resident 5 reported that the facility was going to put them out on the street.-On 3/25/26, Resident 5 stated they wished to appeal their Medicaid application denial, and SSD communicated with State (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resources and the ombudsman on the resident's behalf.-On 3/26/26, Resident 5's family member called the facility to check on Resident 5's emotional well-being since their house had been sold, then the family member spoke to the resident on the phone.-On 4/4/26, a nurse received new orders to discontinue several medications including escitalopram, an antidepressant. Another note on 4/7/26 revealed the same information.No additional information about Resident 5's psychological care was included in the progress notes after that date. A review of the Medication Administration Record for April 2026 revealed the order for Resident 5's escitalopram 20 mg daily at bedtime started on 7/29/25.A record review of Resident 5's physician orders on 6/16/26 revealed no orders for any psychotropic medications, and no orders to monitor or document any behaviors related to depression or other mental illness.An interview on 6/16/26 at 1:27 PM with the Social Service Director (SSD) revealed Resident 5's suicidal ideation was due to finances, so the resident is no longer managing their own finances. SSD assisted Resident 5 with the Medicaid application process, and it was more complex and lengthier than usual in this case. SSD was not aware of any additional interventions for mental health, behavioral assistance, or related services that were completed with Resident 5 following their expressions of depressive and suicidal thoughts.An interview on 6/16/26 at 2:00 PM with the MDS Coordinator confirmed there was no documentation that the psychiatric or psychological evaluation recorded on the care plan had been completed.An interview on 6/16/26 at 2:20 PM with the Regional Nurse Consultant (RNC) revealed the psych consult was not completed for Resident 5 as stated on the care plan and it should have been. The interview also confirmed that there should have been more monitoring by staff with Resident 5 after they verbalized/exhibited suicidal behavior in September 2025 and March 2026.