STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285225	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage of Webster County	636 North Locust Street Red Cloud, NE 68970

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Licensure Reference Number 175 NAC 12-006.04(A)(iii)(2)(b)(c) Based on observation, record review, and interview; the facility failed to ensure Adult Protective Service (APS)/Child Abuse Neglect (CAN) checks were completed prior to hire as required for 4 of 5 sampled staff. This had the potential for residents to be cared for by staff with adverse findings related to abuse or neglect. The facility census was 28. Findings are:A.Record review of the facility policy titled Abuse, Neglect and Exploitation dated 07/2024 revealed that it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. 1. Screening: Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials' checks shall be conducted on potential employees. The facility will maintain documentation of proof that the screening occurred. Observation on 08/11/2025 at 10:36 AM outside of the room of Resident 3 revealed that Nurse Aide (NA)-E exited the resident's room. Record review of the undated and untitled list of facility employees revealed that NA-E had a hire date of 04/14/2025. Record review of the employee file (a file containing required employee registry and criminal background checks and other facility employee records) for NA-E revealed an Adult Protective Service (APS)/Child Abuse Neglect (CAN) check was labeled as incomplete for NA-E. An interview on 08/12/2025 at 3:18 PM with Human Resources (HR) confirmed that pre-employment background and registry checks for potential employees means the expectation is for the checks to be completed before they start working in the facility. The HR confirmed that this included APS/CAN checks. Interview on 08/12/2025 at 3:15 PM with HR confirmed that APS/CAN checks were run but not reviewed or printed for NA-E. B.Observation on 08/13/2025 at 12:40 PM revealed Dietary Aide (DA) entering and exiting the room for Resident 28 delivering a meal. Record review of the undated and untitled list of facility employees revealed that DA had a hire date of 11/01/2024. Record review of the employee file for DA revealed an APS/CAN check labeled as incomplete. Interview on 08/12/2025 at 3:15 PM with HR confirmed that APS/CAN checks were run but not reviewed or printed for DA. C.Observation on 08/13/2025 at 10:15 AM revealed Housekeeping (HSK) entering and exiting the room for Resident 13 while cleaning. Record review of the employee file for HSK revealed an APS/CAN check labeled as incomplete for HSK. Interview on 08/12/2025 at 3:15 PM with HR confirmed that APS/CAN checks were run but not reviewed or printed for HSK. D.Record review of the undated and untitled list of facility employees revealed that Medication Aide (MA)-G had a hire date of 5/13/2025A review of a nursing schedule (as worked) dated August 2025 revealed that MA-G worked on dates in August 4th,5th,6th, 9th,10th, 12th, and 14th, of 2025.Record review of the employee file for MA-G revealed that APS/CAN checks for MA-F were printed by previous employers prior to being hired on 05/13/2025. APS/CAN checks were not available and/or printed for the date of hire of 5/13/2025. An Interview on 08/12/2025 at 3:15 PM with HR confirmed that APS/CAN checks were run but not printed for MA-G.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Licensure Reference 175 NAC 12-006.04(A)(iii)(2)(a)Based on observation, record review, and interview; the facility failed to ensure that Nurse Aide Registry Checks (a state required record of a successful completion of training and competency to be a nurse aide and any findings of abuse, neglect, or misappropriation of property) were completed prior to hire as required for 3 of 5 sampled staff. This had the potential for residents to be cared for by staff with adverse findings related to abuse or neglect. The facility census was 28. Findings are:A.Record review of the facility policy titled Abuse, Neglect and Exploitation dated 07/2024 revealed that it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. 1. Screening: Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials' checks shall be conducted on potential employees. The facility will maintain documentation of proof that the screening occurred. Observation on 08/11/2025 at 10:36 AM outside of the room of Resident 3 revealed that Nurse Aide (NA)-E exited the resident's room. Record review of the undated and untitled list of facility employees revealed that NA-E had a hire date of 04/14/2025. Record review of the employee file (a file containing required employee registry and criminal background checks and other facility employee records) for NA-E revealed that it contained a Nurse Aide Registry Check for NA-E dated 8/12/2025 (this was almost 4 months after NA-E started working in the facility). An interview on 08/12/2025 at 3:18 PM with Human Resources (HR) confirmed that pre-employment background and registry checks for potential employees means the expectation is for the checks to be completed before they start working in the facility. The HR confirmed that this included Nurse Aide Registry checks. Interview on 08/12/2025 at 3:15 PM with HR confirmed that the nurse aide registry check for NA-E was not completed prior to their hire date as required. B.Observation on 08/13/2025 at 12:40 PM revealed Dietary Aide (DA) entering and exiting the room for Resident 28 delivering a meal. Record review of the undated and untitled list of facility employees revealed that DA had a hire date of 11/01/2024. Record review of the employee file for DA revealed that it did not contain a Nurse Aide Registry Check for DA. Interview on 08/12/2025 at 3:15 PM with HR confirmed that the nurse aide registry check for DA was not complete. C.Observation on 08/13/2025 at 10:15 AM revealed Housekeeping (HSK) entering and exiting the room for Resident 13 while cleaning. Record review of the employee file for HSK revealed that it did not contain a Nurse Aide Registry Check for HSK. Interview on 08/12/2025 at 3:15 PM with HR confirmed that the nurse aide registry check for HSK was not complete.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Licensure Reference Number 175NAC 12-005.06(D)Licensure Reference Number 175NAC 12-006.19(C)Based on observation, record review, and interview, the facility failed to utilize proper hand hygiene during meal preparation and service and failed to transport clean and soiled linens in a manner to prevent cross contamination. This had the potential to affect all residents receiving food and linen supplies in the facility. The facility census was 28. Findings are:B. A review of a facility policy titled Hand Hygiene dated 8/1/2024 revealed all staff will perform proper hand hygiene to prevent the spread of infection. This applies to all staff working in all locations within the facility. Hand hygiene technique when using soap and water instructed to rub hands together vigorously for at least 20 seconds and to use a clean towel to turn off the faucet. The use of gloves does not replace hand hygiene. If your task requires gloves perform hand hygiene prior to donning gloves and immediately after removing gloves. In an observation completed on 8/13/2025 at 9:47 AM the [NAME] picked up a clear plastic tube like package containing raw ground beef with a gloved hand. The [NAME] placed the meat into a clear plastic container sitting on a scale. The [NAME] then removed the glove from their hand that was holding the package of meat then with both hands removed the clear plastic container from the scale and placed it on the counter. The cook did not complete hand hygiene after removing the glove and continuing the with meal prep task. In an observation completed on 8/13/2025 at 10:02 AM the [NAME] completed hand hygiene using soap and water for 12 seconds. The cook did not vigorously rub hands for a minimum of 20 seconds. In an observation completed on 8/13/2025 at 10:05 AM the Dietary Aide (DA) entered the kitchen area. The DA completed 15 second hand hygiene and turned off the sink with the paper towels they used to dry their hands. The DA did not wash hands vigorously for a minimum of 20 seconds and did not use a clean paper towel to turn off the sink. In an observation completed on 8/13/2025 at 10:14 AM the [NAME] used gloved hands to combine/stir a mixture of lettuce, shredded cheese, tomatoes, and onions in a large metal bowl. When completed the [NAME] removed the gloves from both of their hands and walked over to the stove and using a plastic utensil stirred the meat that was cooking in a pot on the stove. The cook then walked back to the table where the bowl containing the lettuce mixture sat and obtained a piece of aluminum foil from a box. The cook placed the aluminum foil over the bowl using a sharpie to label and date the aluminum foil then took the bowl over to the refrigerator and placed the bowl in the refrigerator. The cook then returned to the stove and stirred the meat mixture again. The [NAME] did not complete hand hygiene after removing their gloves. In an observation completed on 8/13/2025 at 10:24 AM the DA performed hand hygiene with soap and water for 16 seconds. The DA then used the paper towels that they dried their hands with to turn off the water. The DA did not rub their hands vigorously for a minim of 20 seconds and use a clean paper towel to shut off the sink. In an observation completed on 8/13/2025 at 10:26 AM the [NAME] completed hand hygiene using soap and water for 10 seconds. The cook did not vigorously rub hands for a minimum of 20 seconds. In an interview completed on 8/13/2025 at 12:41 PM the [NAME] confirmed that hand hygiene should (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be completed after removing gloves and hands should be vigorously for a minimum of 20 seconds. In an interview completed on 8/13/2025 at 12:41 PM the DA confirmed that the water should be shut off with a clean paper towel and not the paper towels they used to dry their hands with. In an interview completed on 8/13/2025 with the Infection Control Coordinator (ICC) the ICC confirmed that hand hygiene should be completed after removing gloves, that hand hygiene with soap and water should be done for a minimum of 20 seconds and that the water should be shut off with a clean paper towel not the paper towel used to dry their hands. B. Observation on 8/11/2025 at 06:10 AM of Medication Aide (MA) D carrying dirty bedding to the laundry area through the hallway in both arms without putting the linens in a bag or in a closed container. The soiled linens were against MA D's clothing which could contribute to cross contamination. Observation on 08/11/2025 at 7:10 AM MA-C who took dirty clothing from a resident's room to the spa room and placed in a dirty linen hamper. Although MA C did not carry the soiled clothes against [gender] clothing, they were not carried in a plastic bag or covered soiled linen container. Interview 08/11/2025 1:30 PM with MA C who confirmed the process is to place all dirty linen in a bag and then take to the dirty /soiled clothing /linens. MA C confirmed the clothes were not placed in a plastic bag prior to carrying them down the hallway to the soiled utility container in the Spa area. Confirmation interview on 08/13/2025 at 11:43 AM with Infection Control Coordinator (ICC) who confirmed that the soiled linens were not in a plastic bag when carried down the hallway by MA C and MA D as is expected by all of the staff carrying soiled items. This is an infection control issue.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09Based on record review, observations, and interviews, the facility failed to ensure that glucometer testing supplies were dated and discarded when expired according to the manufacturer's instructions; and the facility failed to ensure nurses had been trained adequately in the use of the continuous blood glucose monitoring systems. This affected all residents with diabetes, a total of 7 residents (Residents 1, 2, 14, 20, 24, 27, and 28), and the facility failed to ensure insulin (abnormal blood glucose) medication was administered or withheld in accordance with the prescribers' orders for 1 (Resident 1) of 1 sampled resident. The facility census was 28. Findings are: A. Record review of the undated facility policy “Blood Glucose Monitoring” revealed it is the policy of the facility to perform blood glucose monitoring to diabetic residents as per physicians’ orders. The policy explanation and compliance guidelines further stated; 1- The facility will perform blood glucose monitoring as per physician’s orders. 2- The nurse will perform the blood glucose test utilizing the facility’s glucometer as per manufacturer’s instructions. 3- If possible, glucometers should not be shared between residents, but if this is not possible, the nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer’s instructions and in accordance with the facility’s glucometer disinfection policy. 4- Calibration checks on glucometers must be performed ____(Specify frequency/shift) as per manufacturer’s instructions. 8- For residents who have continuous glucose monitoring systems, blood glucose via glucometer for verification of results will be done as per physician order. (See Continuous Glucose Monitors Policy.) Record review of the undated facility policy “Continuous Glucose Monitors” revealed the continuous glucose monitor (CGM) systems are used to increase glycemic time in range and decrease hypo and hyperglycemic episodes (episodes of low or high blood sugars). CGMs may be considered for residents with inconsistent or confounding glycemic control, particularly when insulin is prescribed. It is the policy of this facility to allow diabetic residents access and use of a CGM system when ordered by their physician. Care planning of the CGM use is necessary to meet the needs of each resident and to prevent adverse effects on a resident’s condition. The policy definition of the continuous glucose monitoring system defined the system as the use of a small sensor inserted subcutaneously (sensory needle in the skin) to continuously measure glucose levels in interstitial fluid (the body fluid between blood vessels and cells). Results from the sensor are transmitted to a receiver device, insulin pump, and/or smart phone which displays real time glucose levels and glycemic trends. The policy explanation and compliance guidelines stated 1- Staff and resident training will be provided per facility policy. Consider contacting the device (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manufacturer’s local representative as well as viewing online training videos from the manufacturer. 2- Continuous glucose monitor values will be recorded as part of daily vital signs. 4- The facility will document in the resident’s chart the site, date and time the CGM sensor and or transmitter was applied with a note of when the device will expire. 16- An adequate supply of CGM sensors/transmitters will be kept on hand for a resident with physician orders. CGM sensors/transmitters will be reordered and stored according to facility policy. Record review of the (brand name) glucometer calibration testing solutions on page 23 dated 03/14 from (company name) manufacturing instructions revealed that once glucometer testing solutions are opened, under part B; Storage and Handling, use the control solution within 90 days (3 months) of first opening or discard. It is recommended that the date of opening on the control solution is written as a reminder to dispose of the opened solution after 90 days. Under the testing procedure for the testing solution, the manufacture stated: Step 3 – Mix solution by gently inverting control solution bottles several times. Remove the cap from the control solution bottle. Place cap on flat surface. Squeeze the bottle and discard the first drop. Apply the second drop to the top of the clean cap. Furthermore, on page 21, the manufacturer stated- when you first open the bottle, write the date on the bottle label. Use the test strips within 3 months of first opening the bottle. Step 4 – Bring meter and strip to drop. Test strip will draw up the solution. The meter will show the result. Record review of the (brand name) CGM system user guide revised and published 07/2025 stated on page 37 of the manual that there are only two times that is important to check the CGM with the glucometer You can use your (brand name CGM) to treat. However, there are two situations when you should use your BG meter instead: There is no number and/or no arrow on the monitor where there should be a numerical reading and/or when the resident symptoms don't match sensor readings. Record review of the Midnight Census Report dated [DATE] received from the Director of Nursing who had denoted who was using a continuous blood sugar monitoring device, received insulin, and who received blood glucose monitoring only included the following residents; Resident 1; had a CGM and received insulin injections (medication to control blood sugars) Resident 2; had a CGM and received insulin injections Resident 14; had a CGM and received insulin injections Resident 20; had a CGM and received insulin injections Resident 24; used only glucose monitoring without a CGM and received insulin Resident 27; had a CGM and received insulin injections Resident 28; had only glucose monitoring and no CGM and no insulin injections Record review of the Glucometer Monitoring Record for Resident 11 revealed 1 documented glucometer reading dagted [DATE] using glucometer calibration testing solution Level 1 with the lot (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	number 022224A with a manufacturer expiration date of [DATE] which was not dated with the date opened and a testing solution Level 2 with lot number 0222824A with an expiration date of [DATE] which was not dated when opened. Record review of the Glucometer Monitoring Record for Resident 20 revealed 2 documented glucometer readings dated [DATE] and a second reading of [DATE] was entered after the calibration process with Registered Nurse (RN) A was completed. using glucometer calibration testing solution Level 1 with the lot number 022224A with a manufacturer expiration date of [DATE] which was not dated with the date opened and a testing solution Level 2 with lot number 0222824A with an expiration date of [DATE] which was not dated when opened. Record review of the Glucometer Monitoring Record for Resident 2 revealed 1 documented glucometer reading dated [DATE] using glucometer calibration testing solution Level 1 with the lot number 022224A with a manufacturer expiration date of [DATE] which was not dated with the date opened and a testing solution Level 2 with lot number 0222824A with an expiration date of [DATE] which was not dated when opened. Record review of the Glucometer Monitoring Record for Resident 1 revealed 2 documented glucometer readings dated [DATE] and [DATE] using glucometer calibration testing solution Level 1 with the lot number 022224A with a manufacturer expiration date of [DATE] which was not dated with the date opened and a testing solution Level 2 with lot number 0222824A with an expiration date of [DATE] which was not dated when opened. Record review of the Glucometer Monitoring Record for Resident 24 revealed 2 documented glucometer readings dated [DATE] and [DATE] using glucometer calibration testing solution Level 1 with the lot number 022224A with a manufacturer expiration date of [DATE] which was not dated with the date opened and a testing solution Level 2 with lot number 0222824A with an expiration date of [DATE] which was not dated when opened. Record review of the Glucometer Monitoring Record for Resident 28 revealed no glucometer calibration records were found. Resident 28 had orders for glucometer checks to be completed every Monday. Record review of the Glucometer Monitoring Record for Resident 27 revealed the last glucometer calibration record test found was performed on [DATE] using a different testing solution. Observation on [DATE] at 7:20 AM as RN A checks the CGM system. Reading is 322. RN A then does a glucometer check with a fingerstick glucometer reading of 297. RN A then calibrated the CGM monitoring device to the glucometer reading obtained. Observation on [DATE] at 7:40 AM of the personal blood testing boxes for each diabetic resident in the facility revealed the Test strips for Resident 20 were opened but not dated, the test strips for Resident 27 were opened but not dated, the test strips for Resident 14 were opened but not dated, the test strips for Resident 1 were opened but not dated, and the test strips for Resident 28 were opened but not dated. Observation on [DATE] at 7:45 AM of RN A who calibrated the blood glucometer (blood sugar testing device). RN A did not gently shake either of the testing solutions prior to use. The cap of each solution was removed and wiped with a Kleenex. RN A placed two drops of the testing solution on the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	top of each lid from the testing solutions. RN A then placed a glucose testing strip from the testing supply box of Resident 20 into the glucometer, touched the drop of solution which had been placed on the testing solution cap, and tested the Level 1 calibration solution. This was repeated testing the Level 2 calibration solution in the same way. The blood glucose testing strips had not been dated when opened. The glucometer testing Level 1 solution had an open date of [DATE]. The manufacturer’s expiration date was [DATE]. Lot number 022224A. The glucometer testing Level 2 solution had an open date of [DATE]. The manufacturer’s expiration date was [DATE]. Lot number 0222824A. RN A cleansed the testing space and the top of the testing solutions with a Kleenex and not with a disposable cleansing wipe or any other cleansing solution. When RN A realized the Testing strips were not dated with an open date, RN A wrote [DATE] on the testing strips bottle because “Resident 20 just returned from the hospital and so I think they are new strips.” Interview on [DATE] at 7:40 AM with RN A who revealed all staff use the glucose control solutions until the manufacturer’s date of expiration. The staff do write the date the solutions were opened on the box, but not on the bottles of testing solution. RN A did not know that the testing solution had to be disposed 90 days after opening. RN A did not know the recommended manufacturer’s recommendations stated the solutions had to be discarded 90 days after opening. RN A did know that the testing glucometer strips had to be dated when opened, but did not know that the bottle had to be discarded 90 days after opening. RN A was not able to find any of the calibration and blood glucometer monitoring logs that included the calibration dates, testing solutions and lot numbers with expiration numbers except what RN A found on the clipboard. RN A stated the controls are conducted every ten days for those who wear a CGM, when the new glucose testing strips are opened, and at times when any staff member feels the glucose test needs to be conducted to compare to the CGM results. RN A doesn’t like the CGM very well and does check the glucometer with the CGM readings frequently. RN A does not know how often the other nursing staff do a calibration. Interview on [DATE] at 8:10 AM with the Director of Nursing (DON) who revealed no other documented records could be found for the CGM and blood sugar monitor calibration readings. Interview on [DATE] at 9:00 AM with the DON who confirmed there were no more documents of the glucometer calibrations found other than the ones that had been on the clip board so it looked as if the calibrations were not being completed, confirmed that the staff did not change the glucometer calibration solutions after 90 days, and confirmed that testing strips were not being dated after opening. the DON Confirmed that the calibration testing solution had been open longer than 90 days. DON also confirmed no records of trainings for nursing staff related to insulin injections, the use of insulin pens, the use of CGM systems, or glucometers and calibrations have been found. The DON had only been in the position for the past month and was working with the ICC to do the needed trainings. Interview on [DATE] at 10:40 AM with RN A who stated no formal education was given to staff about using the CGM device. The only training we received was when the last Director of Nursing sat them down and showed them how to use it. That was the only education we received and that training lasted about 10 minutes. The last director of nursing did not review the manufacturer instructions or guidelines. RN A did not remember signing anything confirming education or competency for the use of the CGM. When asked about calibrating education received to know when the glucometer and the CGM had to be calibrated together, RN A stated it seemed to be just common sense – “If you get two different numbers, you calibrate the machine.” RN A stated there were no parameters (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to follow, but felt that any CGM readings over 200 were too high and anything less than 120 was too low and at that point felt there was a need to recalibrate the CGM with a glucometer reading. This is in addition to the recalibration that is completed every 10 days when the new CGM is placed on a resident using the device. RN A did not feel the current system the facility used was very accurate and frequently performed finger stick glucometer checks to check that readings with the CGM. The last DON wanted to use them and RN A simply didn’t trust them. Interview on [DATE] at 2:15 PM with the Infection Control Coordinator (ICC) nurse who stated if we are using the CGM then there is no need to be sticking these residents to do a fingerstick blood sugar check with the glucometer. ICC stated [gender] was unable to find any training or competencies related to insulin injections, insulin pens, or the use of the CGM. B. Record review of a facility policy titled, “Timely Administration of Insulin” undated revealed; It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident’s condition. Explanation and Compliance Guidelines: 1. All insulins will be administered in accordance with physician’s orders. Record review of an admission record for Resident 1 revealed an admission date of [DATE]. Additional reviews revealed Resident 1 relevant diagnosis listed as Type 2 Diabetes Mellitus with Diabetic Neuropathy (diabetes (chronic disease of insufficiency to produce insulin) with nerve damage) Record review of an admission record for Resident 1 revealed an admission date of [DATE]. Additional reviews revealed Resident 1 relevant diagnosis listed as Type 2 Diabetes Mellitus with Diabetic Neuropathy (diabetes (chronic disease of insufficiency to produce insulin) with nerve damage) Record review Resident 1’s physician orders related to insulin, Continuous glucose monitor (CGM) and blood glucose monitoring revealed: -Change CGM every 10 days and as needed (PRN) missing/malfunctioning. every day shift every 10 day(s) -Insulin Lispro Injection Solution 100 UNIT/ milliliter (ML) , Inject 10 unit subcutaneously 0800; 1200; 1700 ***Please hold insulin if blood glucose is less than 110*** -Check blood sugar prior to meals and bedtime four times a day. -May check blood sugar per finger stick glucometer checks PRN if CGM is not available Record review of Resident 1’s blood sugars that are taken four times a day on 0800 (8:00 AM); 1200 (12:00 PM); 1700 (5:00 PM); and 2000 (8:00 PM) from [DATE], [DATE] and [DATE]-12, 2025 (continued on next page)

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Heritage of Webster County	636 North Locust Street Red Cloud, NE 68970

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed several times Resident 1’s blood glucose was listed less than 110 milligrams per deciliter (mg/dL) and insulin was or should have been withheld: 6/3 at 12:00 PM =100mg/dL - Medication date and time on the MAR states HL=(Medication was held). 6/7 at 12:00 PM =101mg/dL - Medication date and time on the MAR states HL. 6/20 at 12:00 PM =97mg/dL - Medication date and time on the MAR states HL. 6/26 at 5:00 PM =96mg/dL - Medication marked as given, Progress Notes for dates [DATE] revealed no notation or explanation. 6/29 at 5:00 PM =107mg/dL - Medication date and time on the MAR states DR=(Drug Refused) notation in Progress Notes on [DATE] Resident 1 refused the medication. 7/3 at 12:00 PM =105mg/dL - Medication marked as given, Progress Notes for dates [DATE] revealed no notation or explanation. 7/3 at 5:00 PM =101mg/dL - Medication date and time on the MAR states OT= (Other Notes); notation in Progress Notes on [DATE] for 1700 revealed the medication was withheld per physician orders. 7/8 at12:00 PM =108mg/dL - Medication marked as given, Progress Notes for dates [DATE] revealed no notation or explanation. 7/28 at 5:00 PM =109mg/dL - Medication date and time on the MAR states HL. An interview on [DATE] at 1:59 PM with the Director of Nursing (DON) agreed that nursing staff should be following physician orders for insulin administration, notifying the physician and documenting a rationale if the medication was given when outside of physician parameters.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure frequency, timeliness, and required physician visits were made by a physician personally. This affected 3 of 5 sampled residents (Resident 5, Resident 6, and Resident 24). The facility census was 28. Findings are:A. Record review of Resident 5's admission Record dated 08/12/2025 revealed an admission date of 02/27/2025. The admission record has a documented attending physician listed as an Advance Practice Registered Nurse (APRN). Record review of a hospital record prior to admission for Resident 5 revealed resident was seen by an APRN, a review of the resident and care coordination was provided including the admission to the Nursing Facility by the APRN. Record review of a Physician Visit/Communication Form dated 3/3/2025 revealed this visit was provided by the APRN. Record review of a Physician Visit/ Communication Form dated 3/31/2025 revealed this visit was provided by the APRN. Record review of a Physician Visit/ Communication Form dated 5/5/2025 revealed this visit was provided by the APRN. Record review of a Physician Visit/ Communication Form dated 6/3/2025 revealed this visit was provided by the APRN. Record review of a Physician Visit/ Communication Form dated 6/16/2025 revealed this visit was provided by the APRN. Record review of a Physician Visit/ Communication Form dated 8/4/2025 revealed this visit was provided by the APRN. B. Record review of Resident 6's admission Record dated 08/12/2025 revealed an admission date of 07/13/2022. The admission record has a documented attending physician listed as an Advance Practice Registered Nurse (APRN). Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 7/1/2024 revealed a 60day visit/recertification was listed and signed as the Primary Care Physician an APRN. Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 10/7/2024 revealed a 60day visit/recertification was listed and signed as the Primary Care Physician an APRN. Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 12/09/2024 revealed a 60day visit/recertification was listed and signed as the Primary Care (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician an APRN. Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 2/10/2025 revealed a 60day visit/recertification was listed and signed as the Primary Care Physician an APRN. Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 4/14/2025 revealed a 60day visit/recertification was listed and signed as the Primary Care Physician an APRN. Record review of Resident 6's Physician Visit/Communication Form and office clinic note dated 6/15/2025 revealed a 60day visit/recertification was listed and signed as the Primary Care Physician an APRN. An interview with the Director of Nursing (DON) on 08/14/2025 at 10:00 AM revealed that Resident 5 and Resident 6 are not under the care of a physician. The APRN listed oversees and conducts care, orders, visits and recertifications for Resident 5 and Resident 6 as the Primary Care Physician even though the APRN is not a licensed Physician. C. Record review of the Resident Clinical Census report revealed that Resident 24 was admitted to the facility on [DATE]. The admitting and the primary physician is listed as an Advanced Practice Registered Nurse (APRN). Record review of the admission History and Physical dated 03/08/2025 was written and signed by the admitting and attending physician who is actually and APRN. There was no admission note from a physician as required. Record review of the Electronic Medical Records (EMR) for Resident 24 did not reveal a 30 day visitation by either a physician or an advanced practice provider. Record review of the Physician Visit Consultation note dated 05/13/2025 for Resident 24's 60 day visit after admission revealed that this resident was seen by an APRN. Record review of the EMR for Resident 24 did not reveal a 90 day visit after admission by either a physician or an advanced practice provider. Record review of the Physician History and Physical dated 07/15/2025 was completed by an APRN. Interview on 08/14/2025 at 10:00 AM with the Infection Control Coordinator (ICC) who confirmed that physicians do not see the residents. All 60 day visits are completed by the APRN, who is not a physician, who oversees this resident for all physician visits and orders, as well as other residents. Confirmation that Resident 24 is under the sole care of an APRN.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(A)(vi) Based on Record reviews and interviews, the facility failed to ensure that Medication Record Reviews (MRRs) were completed by a pharmacist each month for those residents living in the facility. This affected 2 residents (Residents 13, and 24) of 5 residents reviewed. The facility census was 28. Findings are:Record review of the undated policy Medication Regimen Reviews policy statement said the consultant pharmacist reviews the medication regimen of each resident at least monthly. The Policy Interpretation and Implementation revealed- 1. The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility receiving medication.- 2. MRRs are done upon admission or as close to admission as possible and at least monthly thereafter, or more frequently if indicated.- 4. The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.- 5. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems, medication errors, and other irregularities, for example; Medications ordered in excessive doses or without clinical indication Medication regimens that appear inconsistent with the resident's stated preferences Duplicative therapies or omissions of ordered medications Inadequate monitoring for adverse consequences Potentially significant drug-drug or drug food interactions Potentially significant medication related adverse consequences or actual signs and symptoms that could represent adverse consequences Incorrect medication, administration times, or dosage forms, Other medication errors including those related to documentation- 8. Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physician for each resident identified as having a non-life threatening medication irregularity. The report contains; The resident name The name of the medication The identified irregularity The pharmacist's recommendation- 14. The consultant pharmacist provides the Director of Nursing (DON) services and medical director with a written, signed and dated copy of all medication regimen reports.- 15. Copies of the medication regimen review reports, including physician responses, are maintained as a part of the permanent medical record.A.Record review of the Annual 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 07/02/2025 revealed Resident 13 was admitted to the facility on [DATE] and was unable to be scored on the Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) which indicated the resident had severe cognitive impairment. Resident 13 received routine antipsychotic, anti-anxiety, antidepressant, diuretic, antihypertensive, and anticonvulsant medications. Record review of the Medication Administration Record printed and reviewed 08/13/2025 for Resident 13 revealed this resident had been actively taking medications since the admission date of 06/24/2024 and continued to have new medications orders added over time. Resident 13 had orders for the following active medications (as well as others not listed) and their corresponding order and start date:- Acetaminophen - 07/01/2024-Gabapentin - 06/24/2024-Hydrochlorothiazide - 06/24/2024-Lisinopril - 06/24/2025-Olanzapine - 09/04/2024-Senna S - 10/02/2024Record review of the Electronic Medical Record (EMR) for Resident 13 did not reveal monthly MRR data in this resident's permanent EMR.Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed there were no records for the months of August 2024 and September 2024 from the consulting pharmacist.Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 13's chart had not been reviewed during the month of October 2024.Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 13's chart had not been reviewed during the month of January 2025.Record (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 13's chart had not been reviewed during the month of February 2025.Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 13's chart had not been reviewed during the month of March 2025.Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 13's chart had not been reviewed during the month of April 2025.In an interview completed on 8/13/2025 at 3:00 PM with the facility Infection Control Coordinator (ICC) confirmed that the consulting pharmacist should conduct a review of the resident's medication regimen monthly and communicate irregularities and make recommendations to the provider for dosage reductions. The ICC stated that the pharmacist did not do this monthly for Resident 13 and should have.In an interview completed on 8/13/2025 at 3:20 PM with the facility DON, the DON confirmed that the pharmacist did not conduct monthly medication regimen reviews on Resident 13 and should have.B.Record review of the Resident Clinical Census report for Resident 24 revealed this resident was admitted on [DATE] and discharged from the facility on 11/22/2024. Resident 24 was then again admitted on [DATE]. Record review of the Record of Medication Regimen and Chart Review from the consulting pharmacist revealed that Resident 24's chart had an MRR during the month of 11/2024, 12/2024, and 01/2024. Resident 24 did not reside in the facility during the months 12/2024 or 01/2025. In an interview completed on 8/13/2025 at 3:00 PM with the facility Infection Control Coordinator (ICC) confirmed that the consulting pharmacist should conduct a review of the resident's medication regimen monthly and communicate irregularities and make recommendations to the provider for dosage reductions. The ICC stated that the pharmacist did not do this monthly for Resident 24 and should have.In an interview completed on 8/13/2025 at 3:20 PM with the facility DON, the DON confirmed that the pharmacist did not conduct monthly medication regimen reviews on Resident 24 and should have.Interview on 08/14/2025 at 4:05 PM with the Infection Control Coordinator revealed all of the MRRs that the facility had available from the consulting pharmacist had been presented for review. All MRR's given to the facility over the past year had been asked and received from the consulting pharmacist and had been presented for review. The ICC had no knowledge as to why Resident 24 had been listed as a resident who had been reviewed by the consulting pharmacist during the months of 12/2024 and 01/2025.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10DBased on record review, observations, and interviews, the facility failed to have medication error rate less than 5%. There were 5 errors and 27 opportunities with was an actual rate of of 18.5% error rate. The facility census was 28. Findings are:Record review of the manufacturer's directions for the Novo Nordisk Novolog insulin flex pen dated 3/2023 states that when using the pen and after attaching a new needle to the flex pen:1. Turn the dose selector to select 2 units2. Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat, but no more than 6 times. If you still do not see a drop of insulin, change the needle and repeat steps3. Clean your injection site with an alcohol swab. Let your skin dry. Do not touch this area again before injecting. 4. Insert the needle into your skin. Press and hold down the dose button until the dose counter shows 0. Continue to keep the dose button pressed and keep the needle in your skin and slowly count to 6. If the needle is removed before you count to 6, you may see a stream of insulin coming from the needle tip. If you see a stream of insulin coming from the needle tip you will not get your full dose. If this happens you should check your blood sugar levels more often because you may need more insulin.Record review of the manufacturer's directions for Novo Nordisk's Fiasp flexpen dated 07/2023 revealed Fiasp insulin comes in a disposable insulin pen and contains a rapid-acting insulin used to manage blood sugar levels in people with diabetes. It's designed for injection at the start of a meal or within 20 minutes after starting to eat.1. Turn the dose selector to select 2 units2. Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. A drop of insulin should be seen at the needle tip. If you do not see a drop of insulin, repeat, but no more than 6 times. If you still do not see a drop of insulin, change the needle and repeat steps3. Clean your injection site with an alcohol swab. Let your skin dry. Do not touch this area again before injecting. 4. Insert the needle into your skin. Press and hold down the dose button until the dose counter shows 0. Continue to keep the dose button pressed and keep the needle in your skin and slowly count to 6. If the needle is removed before you count to 6, you may see a stream of insulin coming from the needle tip. If you see a stream of insulin coming from the needle tip you will not get your full dose. If this happens you should check your blood sugar levels more often because you may need more insulin.Record review of the manufacturer's instructions for the [NAME] Lilly Humalog Kwikpen insulin dated 07/2023 revealed this is a short acting insulin that is given by an injectable pen. The directions for use stated:1. Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your Pen, turn the Dose Knob to select 2 units. Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. If you do not see insulin, repeat priming steps 6 to 8, no more than 8 times. If you still do not see insulin, change the Needle and repeat priming steps2. Turn the Dose Knob to select the number of units you need to inject. The Dose Indicator should line up with your dose.3. Insert the Needle into your skin. Push the Dose Knob all the way in. Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle.Record review of the [NAME]'s Drug Guide for Nurses revealed that Novolog insulin is a rapid-acting insulin with more rapid onset and shorter duration than human regular insulin; Administer insulin aspart (Novolog) subcutaneously in the abdominal wall, thigh, or upper arm within 5-10 min before a meal. April Hazard Vallerand, PhD, RN, FAAN, [NAME] A. Sanoski, BS, PharmD, FCCP, BCPS, eds. 2025. [NAME]'s Drug Guide for Nurses - 19th Ed. Philadelphia, PA. F. A. [NAME] CompanyRecord review of the undated policy Medication Administration revealed the policy is so medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. This policy explanation and compliance guidelines stated; 10. Ensure that the six rights of medication administration are followed: A. Right resident B. Right drug C. Right dosage D. Right route E. Right time F. Right documentationA.Record review of the Medication Administration Record for Resident 27 revealed an order for Fiasp 14 units insulin pen to be given subcutaneously within 2 minutes prior to the meal or within 20 minutes of the start of the meal. Observation on 8/11/2025 at 7:35 AM of Registered Nurse (RN) A who administered Fiasp 14 units by insulin pen in the room of Resident 27. RN A did not hold the insulin injection pen in place for a total of 6 seconds. Interview on 8/11/2025 at 7:55 AM with RN A who confirmed the insulin was administered without priming the needle and that RN A did not leave the needle and pen in place for a total of 6 seconds.B.Record review of the physician orders printed on 8/11/2025 for Resident 20 revealed an order for HumaLOG KwikPen subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject 9 unit subcutaneously in the morning.Observation on 8/13/2025 at 8:20AM of Registered Nurse (RN) A who did not prime the insulin pen needle and who did not count to 5 seconds when the insulin was administered.Interview on 8/11/2025 at 7:55 AM with RN A who confirmed the insulin was administered without priming the needle and that RN A did not leave the needle and pen in place for a total of 5 seconds.C.Record review of Medication Administration Record dated 8/12/2025 for Resident 2 revealed an order for NovoLOG Injection Solution 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 5; 201 - 250 = 10; 251 - 300 = 15; 301 - 350 = 20; 351+ = 25, subcutaneously as needed for In place of routine insulin when when skipping meal or not eating well at 0800 1200 1700.Observation on 8/12/2025 at 11:37 AM of RN F who administered Novolog Insulin 58 units to Resident 2 at 11:37 AM. At that time no nutritious snack was given to the resident.Observation on 8/12/2025 at 12:20 PM when Resident 2 was served the noon meal in the dining room.Interview on 08/12/2025 at 12:30 PM with RN F; RN F thought that insulins could be given up to one hour prior to a meal. Encouraged to review the inserts for the insulin pens to learn more. RN F did not know about the need for a snack of nutritive value within 10-15 minutes if the meal is not served within that time period.D.Record review of the Medication Administration Record dated 8/12/2025 for Resident 24 which revealed an order for NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 8 unit subcutaneously two times a day. Give before lunch and dinner. Hold if blood sugar is less than 120.Observation of RN F who gave insulin to Resident 24 but did not prime the insulin needle and held the needle in place for only one second.Interview on 08/12/2025 at 11:45 AM with RN F who confirmed RN F did not hold the needle in place for 6 seconds or prime the pen.E.Record review of the Medication Administration Record dated 8/12/2025 for Resident 27 which revealed an order for Fiasp 14 units insulin pen to be given subcutaneously within 2 minutes prior to the meal or within 20 minutes of the start of the meal. Observation on 8/12/2025 at 11:21 AM of RN F who held the insulin pen, primed the pen, and held the pen in place for a total 1.5 seconds instead of 6 seconds or more during administration of the Fiasp in the room of Resident 27. Did not offer the resident a nutritious snack prior to leaving the room.Interview on 08/12/2025 at 11:45 AM with RN F who confirmed RN F did not hold the needle in place for 6 seconds when administering the medication to Resident 27.Observation on 08/12/2025 at 11:50 AM of Resident 27 seated in the dining room and had not been served the meal. Only a glass of water and a glass of tea were in front of Resident 27 while seated at the dining table. Observation on 08/12/2025 at 12:04 PM of Resident 27's yawning at the dining table. Resident 27 still had not been served a meal and had only water and tea in front of Resident 27. Observation at 08/12/2025 on 12:11 PM Resident 27 was served the noon meal. Interview on 08/12/2025 at 12:30 PM with RN F; RN F thought that insulins could be given up to one hour prior to a meal. Encouraged to review the inserts for the insulin pens to learn more. RN F did not know about the need for a snack of nutritive value within 10-15 minutes if the meal is not served within that time period.F.Interview on 8/12/2025 at 10:50 AM with the Infection Control Coordinator (ICC) revealed that they are not aware of any insulin training that has been completed or any (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	competencies that have been completed with staff about the use of insulin pens and how long the pens must be held in place prior to removing the insulin needle. The ICC also stated that insulin could be given up to 30 minutes prior to any meal. The ICC admitted to not knowing the FIASP had to be administered within 2 minutes of the start of any meal per the physician orders and per the manufacturer's directions. Interview on 8/12/2025 at 10:50 AM with the Director of Nursing (DON) revealed that insulin could be given up to 15 minutes prior to a meal. The DON was not 100% certain how long the insulin pen needles needed to stay in place when administering the insulin. Confirmed that giving insulin without priming the needles is not an accurate method of giving insulin when using insulin pens. The DON also confirmed that there should have been a snack given prior to the meal if the meal wasn't going to be served immediately. The DON admitted to not knowing the FIASP had to be administered within 2 minutes of the start of any meal per the physician orders and per the manufacturer's directions.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Licensure Reference Number 175 NAC 12-006.05(G) Based on record reviews and interviews, the facility failed to provide a rationale for not conducting a Gradual Dose Reduction (GDR, Stepwise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued) for 1 (Resident 23) of 5 residents sampled. The facility census was 28. Findings are:Record review of a policy titled, Use of Psychotropic Medication(s) undated revealed:7. The resident's medical record shall include documentation of this evaluation and the rationale for chosen treatment options. This includes any indicated documentation of rationale for prescribing multiple psychotropic medications or switching from one type of psychotropic medication, specifically an antipsychotic medication, to another category of psychotropic medication.16. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted: a. PRN orders for psychotropic medication, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. b. PRN orders for antipsychotic medications only, shall be limited to 14 days with no exceptions. If the attending physician or prescribing practitioner believes it is appropriate to write a new order for the PRN antipsychotic, they must first evaluate the resident to determine if the new order for the PRN antipsychotic is appropriate.Record review of Resident 23's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 7/16/2025 revealed Resident 23 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 1/15. The MDS manual identified a score of 1 as a severe impairment. Record review of Resident 23's medication order summary revealed Quetiapine Fumarate Oral Tablet 25 milligram (mg) was ordered and the amount to be administered was 25 mg to be taken 1 time per day for vascular dementia, unspecified severity, with other behavioral disturbance. A pharmacy review of the medication was conducted by a pharmacist on 07/02/2025 with a recommendation to gradually reduce the amount to be administered. The primary physician disagreed with the recommendation for a dose reduction and did not provide a rationale for disagreement. An interview with the Director of Nursing (DON) on 08/14/25 at 9:16 AM confirmed there was no rationale provided by the doctor regarding not conducting the GDR of Quetiapine for Resident 23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285225	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage of Webster County	636 North Locust Street Red Cloud, NE 68970

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Licensure Reference Number 175NAC 12-00.02(H)Based on record review and interview, the facility failed to submit a written investigation of a possible instance of abuse or neglect to the state agency within 5 working days for 1 (Resident 29) of 1 sampled residents. The facility census was 28.Findings are:A review of a facility policy titled Abuse, Neglect and Exploitation dated 07/2024 revealed the facility will report all alleged violations of abuse or neglect no later then 24 hours after the event if the event does not result in serious bodily injury. The facility will report the results of an investigation of allegations within 5 working days of the incident, as required by the state agency. A review of an admission Record revealed the facility admitted Resident 29 on 3/21/2024 with 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).The 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 6/18/2025 revealed Resident 29 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 2 indicating the resident had severe cognitive impairment. did not have impairment to the function of their upper or lower extremities, and required staff set up or clean up assistance with eating.A record review of a facility document titled Hot Liquids Risk Assessment revealed the resident exhibited risk factors of impaired cognition, confusion, and dementia placing them at risk for hot liquid accidents.A record review of Resident 29's Progress Notes revealed on 7/30/2025 documentation stating that the resident spilled coffee on themselves while sitting at the dinning room table. The resident was taken to their room and was observed to have a light pink area to their skin on the left side of their abdomen.A record review of an Incident Investigation dated 7/30/2025 revealed an order was placed to monitor Resident 29's burn to their abdomen.In an interview completed on 8/12/2025 at 3:30 PM with the facility Director of Nursing (DON), the DON confirmed that they did not submit the investigation into Resident 29's burn received due to a hot coffee spill to the state agency and should have.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175NAC 12-00.09 (I)Based on observation, record review, and interview the facility failed to protect residents from accidents and or incidents for 2 residents (Resident 6 and Resident 29) of 2 sampled residents. The facility census was 28.Findings are:A.A review of an admission Record revealed that the facility admitted Resident 6 on 7/13/2020 with 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).The Comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 6/17/2025 revealed Resident 6 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 1 indicating the resident had severe cognitive impairment, the resident required substantial or maximal assistance with bed mobility, transfers, and toilet use, and the resident had 3 falls since the prior assessment (in the last 90 days).Review of Resident 6's 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) on 8/12/2025 revealed a focus of the resident had a history and the potential for falls with date initiated of 7/14/2020. Interventions were listed that the resident was to have a pressure alarm while in wheelchair and bed dated 6/19/2023 and to ensure the fall alarm was out of the residents reach but still audible dated 11/5/2023.In an observation completed on 8/13/2025 at 2:05 PM Resident 6 was self-propelling their wheelchair down the 200 hallway. The resident stopped in front of the couch located at the end of the hall. The resident transferred independently from their wheelchair onto the couch. No alarm was heard to be sounding. There was a white box with a cord coming out of it attached to the back of the resident's wheelchair. The Director of Nursing (DON) came down the hall witnessed the resident sitting on the couch and assisted the resident back into their wheelchair. The DON then reached for the bottom of the white box and turned on the resident's alarm.In an interview completed on 8/13/2025 at 2:08 PM with the facility DON, the DON confirmed that Resident 6's alarm was not turned on allowing the resident to self-transfer from their wheelchair to the couch without staff assistance. The DON confirmed that Resident 6's alarm is to always be on when in their wheelchair.In an interview completed on 8/13/2025 at 2:14 PM with Medication Aide C (MA-C), MA-C confirmed that Resident 6 had a history of falls and was to have their alarm on at all times to alert staff to when the resident was attempting to self-transfer so staff could intervene and assist the resident to prevent the resident from falling.In an interview completed on 8/13/2025 at 2:15 PM with Medication Aide D (MA-D), MA-D confirmed that Resident 6 had a history of falls and was to have their alarm on at all times to alert staff to when the resident was attempting to self-transfer so staff could intervene and assist the resident to prevent the resident from falling.In an observation completed on 8/14/2025 at 8:43 AM Resident 6 was observed to be sitting at the table in the dining area in their wheelchair. The residents' white alarm box or alarm cord was not visible, indicating the residents' alarm was attached or on while the resident was sitting in their wheelchair.In an observation completed on 8/14/2025 at 9:17 AM Medication Aide G (MA-G) was observed to be assisting Resident 6 to their room via their wheelchair. When in the residents' room MA-G removed the white alarm box from the residents' bedside table and connected it to the resident and placed it on the back of the resident's wheelchair.In an interview completed on 8/14/2025 at 9:17 AM with MA-G, MA-G confirmed that Resident 6 is to always have their alarm on to alert staff to when the resident was attempting to self-transfer for staff to intervene and prevent the resident from falling. The MA confirmed they had just placed the alarm to the resident and the alarm should have been on while the resident was in their wheelchair and was not.In an interview completed on 8/14/2025 at 9:18 AM with the DON, the DON confirmed that Resident 6 was (continued on next page)

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	285225	A. Building B. Wing	08/14/2025

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Heritage of Webster County	636 North Locust Street Red Cloud, NE 68970

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to always have the alarm on.B.A review of an admission Record revealed the facility admitted Resident 29 on 3/21/2024 with 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).The 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 6/18/2025 revealed Resident 29 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 2 indicating the resident had severe cognitive impairment. did not have impairment to the function of their upper or lower extremities, and required staff set up or clean up assistance with eating.A record review of a facility document titled Hot Liquids Risk Assessment and dated 3/24/2025 revealed the resident exhibited risk factors of impaired cognition, confusion, and dementia placing them at risk for hot liquid accidents. The document stated the resident was to be evaluated by therapy and staff were to provide supervision with meals until evaluation was completed.A record review of Resident 29's Progress Notes revealed on 7/30/2025 documentation stating that the resident spilled coffee on themselves while sitting at the dining room table. The resident was taken to their room and was observed to have a light pink area to their skin on the left side of their abdomen.A record review of an Incident Investigation dated 7/30/2025 revealed on order was placed to monitor Resident 29's burn to their abdomen.In an interview completed on 8/12/2025 at 3:30 PM with the facility Director of Nursing (DON), the DON confirmed that Resident 29 was not evaluated by therapy and supervised during meals until evaluated by therapy as directed on the 3/24/2025 Hot Liquid Risk Assessment. The DON confirmed that Resident 29 did have a burn due to a hot liquid spill on 7/30/2025