

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Nye Pointe Health & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 Laverna Street Fremont, NE 68025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H). Based on record review and interview the facility failed to ensure daily weights were obtained for 1 (Resident 1) of 1 sampled resident and failed to implement neurological evaluations after an unwitnessed fall for 1 (Resident 3) of 4 sampled residents. The facility staff identified a census of 40. The findings are: A. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 07-28-2025 revealed the facility staff assessed the following about the resident:-admission date of 07-22-2025.-Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13 to 15 indicates a person is cognitively intact.-had a diagnosis of Heart Failure.-required moderate assistance with hygiene, and transfers.-required substantial assistance with upper body dressing.-required total assistance with lower body dressing, toileting and bathing. Record review of Resident 1's Medication Administration Record (MAR) for July of 2025 revealed an order for daily weights and to notify the physician if the resident gains greater than 3 pounds in a day or greater than 5 pounds in a week. Further review of Resident 1's MAR revealed there were no weight listed for 07-25-2025 or 07-28-2025. Record review of Resident 1's MAR for August of 2025 revealed an order for daily weights and to notify the physician if the resident gains greater than 3 pounds in a day or greater than 5 pounds in a week. Further review of Residents 1's MAR for August 2025 revealed no weight were listed on 08-03-2025, 08-04-2025, 08-05-2025, 08-07-2025, 08-08-2025, 08-09-2025, 08-10-2025, 08-14-2025 and 08-16-2025. An interview with the Corporate Nurse (CN) on 08-20-2025 at 10:30 AM confirmed daily weights were not conducted daily and should have been for Resident 1. B. Record review of Resident 3's MDS dated [DATE] revealed the facility staff assessed the following about the resident:-BIMS was scored at a 9. According to the MDS Manual a score of 08-12 indicates moderate cognitive impairment.-required substantial assistance with bed mobility and hygiene.-required total assistance with toileting, dressing and transfers. Record review of Resident 3's Comprehensive Care Plan (CCP) dated 08-01-2025 revealed Resident 3 had an unwitnessed fall on 08-07-2025. Record review of Resident 3's Electronic Health Record revealed no neurological evaluations (an assessment for identifying potential head trauma) following the unwitnessed fall on 08-07-2025. An interview with the CN on 08-21-2025 at 11:00 AM confirmed the neurological evaluations were not done after the unwitnessed fall on 08-07-2025 and should have been done for Resident 3. Record review of the facility's undated policy titled Falls revealed a possible head injury includes visible head trauma, unwitnessed fall where resident is unable to deny a head injury or a witnessed fall with resident hitting their head. When a head injury is noted or suspected, neurological checks will be initiated and any adverse findings will be reported to the resident's physician.		

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Licensure Reference Number 175 NAC 12-006.09(H)(iv)(4) Based on observation, interview and record review the facility failed to secure a catheter in a manner to prevent skin trauma for 1 (Resident 29) of 1 residents sampled. The facility census was 40. The findings are:Record review of Resident 29's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) revealed the facility staff assessed the following about the resident:-Brief Interview of Mental Status (BIMS) was scored at 12. According to the MDS Manual a score of 8-12 indicates moderate cognitive impairment.-had a life expectancy of 6 months or less.-had an indwelling urinary catheter.-had a stage 4 pressure ulcer.-required moderate assistance with upper body dressing.-required total assistance with toileting, bathing, lower body dressing, bed mobility and transfers. Record review of Resident 29's Treatment Administration Record for August 2025 revealed an order for a foley catheter for continuous drainage. Secure tubing to thigh area to avoid pulling. An observation on 08-19-2025 at 12:01 PM of Resident 29 lying in bed being repositioned by the hospice Nursing Assistant revealed the urinary catheter was not secured to Resident 29's thigh with the urinary catheter tubing was laying across the right thigh. An observation on 08-20-2025 at 10:17 AM with the Assistant Director of Nursing (ADON) revealed Resident 29 was lying in bed and the urinary catheter tubing was not secured to the resident's thigh. An interview with the ADON on 08-20-2025 at 10:25 AM confirmed Resident 29's catheter tubing was not secured to the resident's thigh and should have been.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10DBased on observation, interview and record review the facility failed to ensure a medication error rate of 5% of less, as evidenced by 3 errors out of 25 opportunities for error resulting in a 12% medication error rate. The facility census was 40. The findings are:A.Record review of Resident 10's Order Summary (OS) printed on 08-20-2025 revealed the following orders:-ondansetron 4 milligram (mg) take 1 tablet by mouth every morning before breakfast.-pantoprazole 40 mg take 1 table by mouth daily, do not crush or chew, take 30 to 60 minutes prior to eating. An observation on 08-20-2025 at 8:20 AM of Medication Aide (MA) A administering medications to Resident 10 revealed the following medications were administered while eating breakfast:-pantoprazole 20 mg tablet give 1 tablet by mouth-ondansetron 4mg tablet give 1 tablet by mouth An interview conducted on 08-20-2025 at 12:47 PM with MA A confirmed pantoprazole and ondansetron were given while Resident 10 was eating breakfast and should have been given prior to eating. B. Record review of Resident 2's Medication Administration Record (MAR) printed on 8-19-2025 revealed an order for aspirin enteric coated 81mg take 1 tablet by mouth daily take with food and do not crush. An observation on 08-20-2025 at 8:25 AM of MA A administering medications to Resident 2 revealed Aspirin 81mg chewable tablet was administered to Resident 2. An interview with MA A on 08-20-2025 at 12:19 PM confirmed Resident 2 received Aspirin 81mg chewable tablet and Aspirin 81mg enteric coated tablet should have been administered. Record review of the facility policy titled Medication Administration Guideline dated 2023 revealed medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.		