STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I) and 12-006.09(I)(i)(1,2,3 and 4). Based on observation, record reviews and interviews; the facility failed to ensure residents that were identified as an elopement risk were supervised when leaving the facility for 1 (Resident 1) of 3 residents sampled, failed to ensure prompt follow-up after a resident's whereabouts were unknown for 1 (Resident 2) of 3 residents sampled, failed to identify and implement interventions to prevent elopements and falls and failed to monitor for neurological changes after unwitnessed falls or falls with head injuries for 1 (Resident 1) of 3 residents on sample. The facility staff identified a census of 65.The facility Administrator (ADM) was notified on 6/8/26 at 5:25 PM of an Immediate Jeopardy (IJ) which began on 6/8/26. The IJ was removed on 6/8/26, as confirmed by surveyor onsite verification. The findings are: A. Record review of the facility's policy titled Elopement, Risk reduction strategies and management of missing residents and wandering missing residents dated 01-2024 revealed the facility maintains a process to assess all residents for risk of elopement, implement measures for resident identification at the time of admission, and conduct a coordinated resident search in the event of a missing resident. The policy defines elopement as the ability of a cognitively impaired resident, who in not capable of protecting themselves, to successfully leave the facility unsupervised and unnoticed, potentially coming to harm. Under the section titled Assessment revealed the facility preadmission process referral process includes wandering and elopement history, and whether the resident can be safely cared for at the facility. An elopement risk data collection is completed by the nursing staff on all residents at admission, readmission, quarterly and after an elopement event. The initial resident assessment is conducted at admission if possible and no later than 8 hours after admission. The risk data collection addresses the resident's mobility, psychological, behavioral, physical, and cognitive functions. Specific risk factors included: -an involuntary admission. -a history of wandering prior to admission or details of the wandering history such as when wandering is most common, or activities that trigger exit seeking. -problems noted in the resident's adjustment to the facility. -any cognitive impairment which results in an inability of the resident to appreciate safety risks and an inability to protect himself or herself. -a change in the resident's mental status (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-interference with risk reduction strategies, including an expressed displeasure with an electronic monitoring bracelet or an attempt to remove it. -behavior problems, including those where the resident is not easily redirected or managed when he or she is agitated or aggressive. Further review of the policy revealed under section Risk Reduction Measures revealed interventions that may be used for residents identified at high risk for elopement include: -frequent observation of the resident's whereabouts to assure he or she remains in the facility. -room placement close to common areas such as the nurse's station and away from exits. -promoting activities that are in full view of staff members -alternative activities to maintain the interest level of the wanderer. -implementation of a wander bracelet -transfer to a more suitable or more secured facility if necessary -notification of physician for changes in behavior, such as increased insistence or attempts to leave. -environmental controls such as functional alarm system for egresses and stairwells, interior courtyards, restricted window openings to six inches to allow ventilation but prevent resident exit and fenced perimeters, additional resident and family involvement and education. A sign-in-and-out system is implemented, which requires responsible parties to sign the resident out when leaving and note an expected return time. B.Record review of the facility policy titled Fall Management dated 01-2024 revealed a risk reduction, falls and injury program will be used to assess residents/patients to determine fall risk factors. The interdisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Under the section procedure revealed: - the staff are to assess and review resident risk factors for falls and injuries upon admission, quarterly, with a significant change or after a fall. -implement goals and interventions with the resident/family for inclusion in the interdisciplinary plan of care based on individual needs. -communicate interventions to the care giving teams. -provide training to staff as needed and document. -review and revise the interdisciplinary plan of care at subsequent care plan meetings -educate resident and family as indicated. In the event the resident has fallen and/or is found on the ground, a complete head-to-toe assessment (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	must be performed prior to moving the resident unless life-threatening safety concerns are present. Upon arrival of the nurse, a quick head-to-toe scan will be performed without unnecessary movement, palpating and examining all areas for breaks in the skin and/or other abnormal findings. Obtain neurological checks (Neuro Checks) per policy for any unwitnessed fall or any fall with evidence of injury to the head. C.Record review of the facility's policy titled Accidents/Neuro Checks dated 01-2024 revealed the purpose of this procedure is to provide guidelines for a neurological assessment. Neurological assessments are indicated: -upon physician order -following an unwitnessed fall -following a fall or other accident/injury involving head trauma - when indicated by resident's condition. When assessing neurological status always include frequent vital signs. Particular attention should be paid to widening pulse pressure (the difference between the top and bottom blood pressure numbers), this may be indicative of increasing intracranial pressure. Any change in vital signs or neurological status in a previously stable resident should be reported to the physician immediately. D. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 02-17-2026 revealed the facility staff assessed the following about the resident: -admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored as an 8. According to the MDS Manual a score of 8 to 12 indicates moderate cognitive impairment. -had diagnosis of malnutrition, seizure disorder, depression and anxiety disorder. -had a history of falls -had delusions (a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary). -had fluctuating inattention (reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. A person seems unaware or out of touch with the environment) -had fluctuating disorganized thinking (evidenced by rambling, irrelevant, or incoherent speech). -required set-up or clean up assistance with eating and dressing. -required supervision or touching assistance with toileting, personal hygiene and toilet transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-required supervision or touching assistance with ambulation of 10 to 150 feet, and on uneven surfaces up to 10 feet and when bending over to pick up objects. -required the use of a walker (mobility device). Record review of Resident 1's Nursing admission Data Collection (NADC) dated 02-11-2026 under the section Elopement/Wandering Risk revealed Resident 1 had a history of exit seeking, wandering away or getting lost and had a pertinent diagnosis of anxiety disorder and was capable of independent mobility. Further review of the NADC revealed Resident 1 was a potential elopement risk and directed the staff to initiate elopement risk interventions and document on the care plan. Record review of Resident 1's Comprehensive Care Plan (CCP) printed on 06-08-2026 revealed no interventions for Resident 1's risk for elopement. Record review of the facility's Release of Responsibility for Leave of Absence Sheet (RRLAS) with a date of 02-16-2026 at the top of page revealed Resident 1 signed out of the facility without supervision 234 times between the dates of 02-16-2026 and 05-19-2026. Record review of Resident 1's Progress Notes (PN) dated 03-25-2026 at 12:43 AM revealed a staff member had brought Resident 1 from the parking lot into the facility and stated Resident 1 fell in the parking lot. Further review of the progress notes revealed Resident 1 reported having hit (gender) head. Record review of Resident 1's PN dated 03-25-2026 at 11:06 AM revealed Resident 1 was outside of the facility and noted to be on the ground with a trickle of blood running down the face. Resident 1 was sent to the emergency room (ER) for treatment. Record review of Resident 1's PN dated 03-25-2026 at 4:18 PM revealed Resident 1 returned from the hospital with an update that Resident 1 refused treatment. Record review of Resident 1's CCP revealed no additional interventions were added to prevent further elopements or injuries from falls dated 03-25-2026. Record review of Resident 1's PN dated 04-10-2026 revealed a staff member was driving from the facility and noted Resident 1 was lying on the ground with blood to the side of the head. Resident 1 was sent to the ER for treatment. Record review of Resident 1's PN dated 04-10-2026 at 9:41 PM revealed Resident 1 had returned from the hospital with an abrasion to the left outer eyebrow. Record review of Resident 1's RRLAS dated 04-10-2026 revealed Resident 1 had signed out at 1:55 PM. Record review of Resident 1's CCP revealed no additional interventions were added to prevent further elopements or injuries from falls dated 04-10-2026. Record review of Resident 1's PN dated 05-19-2026 revealed Resident 1 was lying on the ground in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the parking lot with a significant amount of blood effusing from the scalp. Resident 1 was sent to the ER. Record review of Resident 1's Emergency Department Notes dated 05-19-2026 revealed Resident 1 had a head Computed Tomography (CT: an advanced imaging test that combines X-rays with computer processing to create detailed, cross-sectional slices of your bones, organs, and soft tissues) with the following findings: -Subdural hematoma on the right side with subarachnoid hemorrhage and midline shift. -scattered small volume subarachnoid hemorrhage -suspected subdural hemorrhage along the left posterior occipital convexity. -mild hypoattenuation along the temporal, parietal, and occipital lobes suspicious of parenchymal hemorrhage. -mass effect results in a right to left midline shift at the septum pellucidum. -prominent hematoma along the right posterior scalp. Record review of Resident 1's PN dated 05-22-2026 revealed Resident 1 returned from the hospital. Record review of Resident 1's PN dated 05-23-2026 at about 2:20 AM revealed Resident 1 left the facility. Record review of Resident 1's PN dated 05-23-2026 at 7:45 AM revealed Resident 1 was found lying on the street, unable to get up and had hit the head. Resident 1 was sent to the ER for treatment. Record review of Resident 1's RRLAS revealed Resident 1 signed out of the facility on 05-23-2026 at 2:20 AM and returned at 3:40 AM. Further review of the RRLAS revealed Resident 1 also signed out of the facility at 10:00 AM on 05-23-2026. Record review of Resident 1's PN dated 05-24-2026 revealed Resident 1 returned from the hospital. Record review of Resident 1's CCP revealed no additional interventions to prevent further elopements or injuries from falls for 05-23-2026. Record review of Resident 1's PN dated 05-31-2026 revealed at 10:00PM the night before a staff member found Resident 1 on the ground behind their car in the parking lot. Record review of Resident 1's RRLAS revealed no documentation Resident 1 had signed out on 05-30-2026 or 05-31-2026. Record review of Resident 1's PN dated 06-01-2026 revealed Resident 1 had fallen in the road and Resident 1 stated I hit my head and I'm hurt. Resident 1 was sent to the ER for treatment. Record review of Resident 1's RRLAS dated 06-01-2026 revealed Resident 1 had signed out and the time of the sign out was illegible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview conducted with the facility Administrator (ADM) on 06-08-2026 at 11:47 AM confirmed residents leaving the facility were to sign out on the RRLAS and for residents with a low BIMS score the Power of Attorney (POA) or guardian would have to sign the resident out. An interview conducted with the Director of Nursing (DON) on 06-08-2026 at 4:15 PM confirmed Resident 1 was identified on admission as a potential elopement risk, Resident 1's BIMS on admission was scored as an 8, a care plan for elopement was not implemented and confirmed Resident 1 had been signing out of the facility without supervision. E. Record review of the facility's accident log printed on 06-08-2026 revealed Resident 1 had: -an unwitnessed fall on 04-05-2026, -2 unwitnessed falls on 05-19-2026, -witnessed fall on 05-02-2026. Record review of Resident 1's Progress Notes (PN) revealed from 02-11-2026 to 05-19-2026 Resident 1 had: -an unwitnessed fall on 02-27-2026, -2 unwitnessed falls on 03-25-2026, -an unwitnessed fall 03-26-2026, -an unwitnessed fall on 04-05-2026, -an unwitnessed fall on 04-10-2026. Record review of Resident 1's CCP dated 02-11-2026 revealed Resident 1 was at risk for falls related to diagnosis of convulsions and high-risk medications and a history of falls prior to admission. The goal was Resident 1 would not sustain serious injury through the review date. Interventions listed were: -Physical and Occupational Therapy to evaluate and treat if indicated dated 02-20-2026. -education to ask staff for assistance dated 02-27-2026 -gripper strips placed in room next to the bed dated 04-05-2026. -walker replaced 05-02-2026. -placed in bed, education to not ambulate on (gender) own dated 05-19-2026. -sent to emergency room (ER), will evaluate interventions upon return dated 05-19-2026. -encourage resident to abstain from drinking alcohol for fall on 05-19-2026 dated 05-23-2026. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the CCP revealed no new interventions for the falls on 03-25-2026, 03-26-2026, and 04-10-2026. Record review of Resident 1's Electronic Medical Record (EMR) revealed neurological checks for the following unwitnessed falls: -02-27-2026 no neurological checks present in the EMR. -03-25-2026 at 12:43 AM no neurological checks present in the EMR. -03-25-2026 at 11:06 AM sent to the ER for treatment. -03-26-2025 neurological checks were incomplete. -04-05-2026 neurological checks were incomplete. Record review of Resident 1's PN dated 05-19-2026 at 12:57 PM revealed Resident 1was observed by the ADM sitting on buttocks in the front door corridor area. Resident said Yes I hit my head on the door. Resident 1 was assisted to the room on a wheeled walker as the resident was unsteady to ambulate to the room. Resident 1 was left in room with call light in reach. Record review of Resident 1's neurological checks dated 05-19-2026 revealed Resident 1 was outside, and neurological checks were not done on 05-19-2026 at 2:00 PM, 4:30 PM, 5:30 PM, and the section for 6:30 PM was left blank. Record review of Resident 1's PN dated 05-19-2026 at 7:35 PM revealed Resident 1 was lying on his back in the parking lot, with a significant amount of blood effusing from the scalp. Resident 1 was sent to the ER for treatment. Record review of Resident 1's Emergency Department Notes dated 05-19-2026 revealed Resident 1 had a head Computed Tomography (CT: an advanced imaging test that combines X-rays with computer processing to create detailed, cross-sectional slices of your bones, organs, and soft tissues) with the following findings: -Subdural hematoma (a life-threatening type of bleeding where blood collects between the brain and the dura mater, its outermost protective layer) on the right side with subarachnoid hemorrhage and midline shift. -scattered small volume subarachnoid hemorrhage -suspected subdural hemorrhage along the left posterior occipital convexity. -mild hypoattenuation along the temporal, parietal, and occipital lobes suspicious of parenchymal hemorrhage. -mass effect results in a right to left midline shift at the septum pellucidum. -prominent hematoma along the right posterior scalp. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident 1's PN dated 05-22-2026 revealed Resident 1 had readmitted to the facility. Record review of Resident 1's PN dated 05-23-2026 revealed at 2:20 AM Resident 1 left the facility. Record review of Resident 1's PN dated 05-23-2026 at 7:45 AM Resident 1 was found lying on the street, unable to get up and had hit the head. Resident 1 was sent to the ER for treatment. Record review of Resident 1's PN dated 05-24-2026 revealed Resident 1 was readmitted to the facility. Record review of Resident 1's PN dated 05-31-2026 revealed at 10:00PM the night before a staff member found Resident 1 on the ground behind their car in the parking lot. Record review of Resident 1's PN dated 06-01-2026 revealed Resident 1 had fallen in the road and couldn't get up. Resident 1 stated I hit my head and I'm hurt, Resident 1 was sent to the ER for treatment. Record review of Resident 1's Trauma Surgery History and Physical dated 06-02-2026 revealed Resident 1 had been evaluated and found to have a large Subdural Hematoma with a mass effect of 6 millimeters of right to left midline shift. Record review of Resident 1's CCP printed on 06-08-2026 revealed no new interventions for the falls on 05-23-2026, 05-31-2026 and 06-01-2026. An interview conducted with the ADM on 06-09-2026 at 3:20 PM confirmed when Resident 1 fell on [DATE] at 12:45 PM the facility did not implement an intervention to prevent further falls other than assisting the resident into bed, and Resident 1 fell again later that day and sustained a brain hemorrhage. An interview with the DON on 06-09-2026 confirmed neurological checks were incomplete or not conducted for all of Resident 1's unwitnessed falls and confirmed not all of Resident 1's falls were investigated for causal factors with new interventions implemented. The facility was informed to the Immediate Jeopardy status on 06/08/26. The facility abatement plan was implemented on 06-08-26. The specific requirements that were violated were F689 and 175 NAC 12-006.09(I) and 12-006.09 (I)(i) for failure to ensure prompt follow up when a missing person was identified and for failure to ensure adequate supervision for residents identified as a potential elopement risk and residents identified as cognitively impaired. The facility implemented the following actions on 06-08-26 to remove the immediacy of the situation and to protect the residents: -the facility posted a sign at the front desk for residents to go to the [NAME] Side Nurses Station to sign out. -Residents with a BIMS score of 12 or more will be allowed to continue to sign out and go out of the facility unassisted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Residents in the Secure Dementia Unit will not be allowed to sign out and leave the facility unassisted. -Current facility residents who leave the unassisted had an Elopement Risk Assessment (ERA) reviewed and Care Plans were reviewed and updated and interventions were implemented as appropriate. -The Clinical Interdisciplinary Team (CIT) will review new admit's ERA and the Care Plan during the Daily Clinical Meeting to ensure the ERA had been completed accurately and the Care Plan has been updated with appropriate interventions to prevent an Elopement. This will occur during the Morning Clinical Meeting 3 to 5 times a week and this review will occur indefinitely. -The CIT will review current facility residents' ERA and Care Plan quarterly and with a significant change to ensure the ERA has been completed accurately and Care Plan has been updated with the appropriate interventions to prevent an Elopement. This review will occur during the Morning Clinical Meeting 3 to 5 times a week and this review will occur indefinitely. -When a resident signs out (not an elopement) the resident will be asked the approximate time of return and will be educated if they do not return at the time the facility will do the following: a.Attempt to call the resident if not able to reach the resident b.Notify the ADM and/or DON c. Notify the resident's Emergency Contact/Family d.Document attempts e.Adult Protective Services (APS) will be notified f. Police will be notified. g. Physician and/or Nurse Practitioner will be notified. -Education: The current facility staff were educated via Empeon (facility staffing platform) that residents profiles were updated to show if the resident is not able to sign out or leave the facility unassisted. Agency staff will be notified via the [NAME] App that is visible when the Agency Staff signs up for a shift. The ADM receives Email and App notifications when staff read the education. The facility staff have to read the education to access their schedules. Education was also posted at each Nurses Station. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	F. Record review of Resident 2's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 5/11/26 identified the facility admitted the resident on 5/5/26 with diagnoses of acute post hemorrhagic anemia, End Stage Renal Disease (ESRD) receiving dialysis, diabetes mellitus, hypertension (HTN), congestive heart failure (CHF), and seizure disorder with severely impaired vision. Further review of the MDS revealed the resident required set up/clean up assistance for upper body dressing, supervision or touching assistance for oral hygiene, lower body assistance, sit to stand transfer and chair to bed to chair transfers and partial/moderate assistance for eating, toileting hygiene, shower/bathe self, and putting on and taking off shoes. Review of brief interview for mental status (BIMS, a cognitive screening test used in nursing homes to evaluate orientation) revealed a score of zero. According to the MDS manual a score of zero indicates severe impairment. Further review of the residents MDS section signs and symptoms of delirium revealed Resident 2 was identified with behaviors of inattention and disorganized thinking noted to be present, fluctuated. In an interview with the Social Service Director (SSD) on 6/8/26 at 11:40 AM, it was revealed Resident 2 was not answering the questions for the BIMS when they conducted the interview. According to the MDS manual, if the resident chooses not to participate in the BIMS or if four or more items were coded zero because the resident chose not to answer or gave nonsensical response. Continue to perform the Staff Assessment for Mental Status. The staff assessment for mental status was not completed on the MDS dated [DATE]. Record review of an undated document titled Consent to admission and Treatment scanned into the EMR on 6/9/26 was signed by Resident 2 Record review of a document titled Release of responsibility for leave of absence revealed Resident 2 signed out of the facility on 6/1/26 at 11:05 AM. Record review of a progress note in Resident 2's Electronic Medical Record (EMR) on 6/1/26 at 5:46 PM revealed Resident 2 went out on pass and had not returned at that time. Record review of a progress note in Resident 2's EMR on 6/1/26 at 6:00 PM revealed the facility staff had spoken to both of Resident 2's emergency contacts (daughters) and they were not aware of the residents whereabouts. Record review of a progress note in Resident 2's EMR on 6/2/26 at 1:18 AM revealed the resident was still out of the facility, call was placed to the resident's cell phone without answer. Call was placed to the resident's daughter, who stated the resident was not with the daughter. Record review of a progress note in Resident 2's EMR on 6/5/26 at 8:32 PM revealed a representative from University of Nebraska Medical Center (UNMC) called the facility requesting physician orders on Resident 2. In an interview with the Administrator on 6/8/26 at 11:47 AM it was revealed Resident 2 informed the facility staff [gender] was going to an appointment at the Social Security office on 6/1/26. Resident 2 arranged their own transportation for the appointment and signed out on the facility sign out form. The administrator stated the facility had made attempts to contact the Resident 2 on 6/2/26 and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6/3/26 without success. The administrator spoke with Resident 2's daughters on 6/2/26 and they were unaware of Resident 2's location but were going to check places they thought the resident may have gone. The Administrator spoke with Resident 2's daughters again on 6/3/26 and they had not located the resident. The administrator contacted APS and law enforcement on 6/3/26 at approximately 3:00 PM, 2 days after the resident left the facility for an appointment and their whereabouts were unknown. In an interview with the administrator on 6/8/26 at 4:40 PM it was confirmed the facility did not report the resident was missing to APS or the police until 52 hours after the resident left.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285239	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Legacy Pointe LLC	3110 Scott Circle Omaha, NE 68112

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Licensure Reference Number 175 NAC 12-006.04(B)(ii)Based on record review and interview, the facility failed to ensure competencies were completed on 12 (Nurse Aide(NA) A,NA B, NA C, NA D, NA E ,Medication Aide (MA F, MA G, MA H, MA I, MA J), Licensed Practical Nurse (LPN) K and Registered Nurse (RN) L) of 12 staff reviewed. The facility identified a census of 65.Findings are:Record review of Nurse A (NA) revealed a hire date of 2/24/2026, further review revealed they had not had competencies completed since the hire date.Record review of NA B revealed a hire date of 3/18/2026 further review revealed they had not had competencies completed since the hire date.Record review of NA C revealed a hire date of 1/13/2026 further review revealed they had not had competencies completed since the hire date.Record review of NA D revealed a hire date of 4/15/2026 further review revealed they had not had competencies completed since the hire date.Record review of NA E revealed a hire date of 4/7/2026 further review revealed they had not had competencies completed since the hire date.Record review of Medication Aid (MA) F revealed a hire date of 7/30/2020, further review revealed they had not had competencies completed in the last year.Record review of MA G revealed a hire date of 3/24/2021 further review revealed they had not had competencies completed in the last year.Record review of MA H revealed a hire date of 11/16/2021 further review revealed they had not had competencies completed in the last year.Record review of MA I revealed a hire date of 4/22/2025 further review revealed they had not had competencies completed in the last year.Record review of MA J revealed a hire date of 3/24/2021 further review revealed they had not had competencies completed in the last year.Record review of Licensed Practical Nurse (LPN) K revealed a hire date of 1/20/2020 further review revealed they had not had competencies completed in the last year.Record review of Registered Nurse (RN) L revealed a hire date of 3/6/2023 further review revealed they had not had competencies completed in the last year. In an interview with the Director of Nursing (DON) on 6/9/26 at 2:30 PM it was revealed no competencies had been completed in the last year, and competencies were not being completed on new hires.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Licensure Reference Number 175 NAC 12-006.02 Based on observations, record reviews and interviews; the facility management failed to utilize its resources to attain or maintain the highest practicable physical and psychosocial well-being of each resident as identified by the deficient practices cited. The facility staff identified a census of 65. Findings are: -F689: The facility failed to ensure residents that were identified as an elopement risk were supervised when leaving the facility, failed to ensure prompt follow-up after a resident's whereabouts were unknown, failed to identify and implement interventions to prevent elopements and falls and failed to monitor for neurological changes after unwitnessed falls or falls with head injuries. These findings placed the facility in a substandard level of care requiring an extended survey. -F725: The facility failed to ensure competency testing for 12 of 12 employees sampled. -843: The facility failed to obtain a transfer agreement with a local hospital.-867: The facility failed to ensure the QAPI program identified and addressed concerns related to deficient practice for elopement and falls prior to a complaint survey.-947: The facility failed to ensure 12 hours of yearly training for 5 of 5 nurse aide/medication aids sampled and failed to ensure 5 of 5 medication aides had the required number of hours for dementia training.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on record review and interview; the facility staff failed to have a transfer agreement between the facility and hospital. This had the potential to effect all residents in the facility. The facility staff identified a census of 65. Findings are: Record review of the facility agreements revealed there was no evidence of a transfer agreement between the facility and the hospital.Interview on 06/09/2026 at 1:50 PM with the Administrator (ADM) revealed the facility did not have a hospital transfer agreement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Licensure reference Number 175 NAC 12-006.07(C)Based on observation, interview, and record review, the facility failed to ensure the QAPI program identified and addressed concerns related to deficient practice for elopement and falls prior to a complaint survey. This had the potential to affect all residents in the facility. The facility identified a census of 65.Findings are:A.Record review of a facility policy titled Quality Assurance and Performance Improvement (QAPI) Program-Governance and Leadership with a revision date of 1/2024 revealed the following:Policy: the Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI committee, which reports its findings, actions and results to the Administrator and the governing body.Policy Interpretation and Implementation1. The Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI Program, and for interpreting its results and findings to the governing body.2. The governing body is responsible for ensuring that the QAPI Program:a. Is implemented and maintained to address identified priorities;d. Is based on data, residents and staff input, and other information that measures performances; and e. Focuses on problems and opportunities that reflect processes, functions and services provided to the residents.4. The responsibilities of the QAPI Committee are to:a. Collect and analyze performance indicator data and other information;b. Identify, evaluate, monitor and improve facility systems and processes that support the delivery and care of services;c. Identify and help resolve negative outcomes and/or care quality problems identified during the QAPI process;d. Utilize root cause analysis to help identify where identified problems point to underlying systematic problems;e. Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality care;f. Establish benchmarks and goals by which t measure performance improvement;g. Coordinate development, implementation, monitoring and evaluation of performance improvement projects to achieve specific goals; Record review of the facility QAPI minutes and Performance Improvement Plans revealed the facility had not identified the areas of deficient practice. During the recent survey with an exit date of 6/9/26 the following deficiencies were identified:F684-The facility failed to conduct neurological evaluations after unwitnessed falls for Resident 1. F689- The facility failed to ensure prompt follow up after a resident did not return to the facility and their whereabouts were unknown for 1Resident (2) and failed to implement interventions for potential elopement and falls for 1 resident 1.F725- The facility failed to ensure competencies for nursing staff at hire and annually.F835- The facility management failed to utilize its resources to attain and maintain the highest practicable physical and psychosocial well-being of each resident as identified in the deficient practices cited. F843- The facility failed to obtain a transfer agreement with a local hospital. F947-The facility failed to ensure 12 hours of yearly training for 5 of 5 nurse aides/medication aids sampled and failed to ensure 5(MA F, MA G, MA H, MA I, MA J) of 5 medication aides had the required number of hours for dementia training. In an interview with the Administrator on 6/9/26 at 3:30 PM the administrator confirmed the areas of deficient practice had not been identified with a Performance Improvement Plan for QAPI prior to the survey.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12.006.04(B)(ii)(1), Licensure Reference Number 175 NAC 12.006.04 (B)(iii) Based on record review and interview, the facility failed to ensure 12 hours of yearly training for 5 of 5 nurse aide/medication aids sampled and failed to ensure 5(MA F, MA G, MA H, MA I, MA J) of 5 medication aides had the required number of hours for dementia training. The facility identified a census of 65.Findings are:Record review of Medication Aid F revealed a hire date of 7/30/2020 revealed they did not have 12 hours of training in the last year. Further review of Medication Aid F revealed they had attended dementia training with no amount of time specified.Record review of Medication Aid G revealed a hire date of 3/24/2021 revealed they did not have 12 hours of training in the last year. Further review of Medication Aid G revealed they had attended dementia training with no amount of time specified.Record review of Medication Aid H revealed a hire date of 11/16/2021 revealed they did not have 12 hours of training in the last year. Further review of Medication Aid H revealed they had no dementia training noted.Record review of Medication Aid I revealed a hire date of 4/22/25 revealed they did not have 12 hours of training in the last year. Further review of Medication Aid I revealed they had no dementia training noted.Record review of Medication Aid J revealed a hire date of 3/24/21 revealed they did not have 12 hours of training in the last year. Further review of Medication Aid J revealed they had attended dementia training with no amount of time specified.In an interview with the Administrator on 6/9/26 at 3:25 PM it was confirmed the nurse aides/medication aids did not have the 12 hours of required annual training, and did not have 4 hours of dementia training.