STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285242	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone Village	4330 South 144th Street Omaha, NE 68137

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to ensure that 1 (Resident 1) of 3 sampled residents' representative's preference of female caregivers only was honored. The facility census was 130. Findings are:A record review of the facility's Resident Rights dated 05/19 revealed the resident had the right to designate a legal representative who can make choices about care and to make choices about aspects of your life in the facility that are significant to the resident. The resident had the right to choose activities, schedules, health care and health providers.A record review of Resident 1's Clinical Census dated 03/23/2026 revealed that Resident 1 was admitted to the facility 12/12/2025. A record review of Resident 1's Medical Diagnosis dated 03/23/2026 revealed the resident had diagnoses that included Major Depressive Disorder and Cognitive Communication Deficit (problems communicating caused by a cognitive impairment).A record review of Resident 1's Physician's Order Sheet And Progress Notes dated 03/20/2021 revealed the physician documented the resident had previously undocumented Dementia.A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/04/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 7 of 15 which indicated the resident was severely cognitively impaired (confused). The resident was independent with eating, required supervision or touching assistance with oral and personal hygiene (cleaning), substantial/maximal assistance with upper body dressing, bathing was not attempted, and the resident was dependent on staff for toileting hygiene, lower body dressing, and footwear. The resident was substantial/maximal assistance with mobility and transfers. A record review of the facility's submitted Level I (roman numeral one) Screen Preadmission Screen and Resident Review (PASARR) For Serious Mental Illness (SMI) and/or Intellectual Disability (ID) or Related Conditions submitted documentation dated 01/08/2026 revealed Resident 1 had a diagnosis of Dementia (confusion)/Neurocognitive Disorder (decline in mental function), Alzheimer's Disease, or Organic Disorder (mental or cognitive decline) and had a diagnosis of Dementia or Neurocognitive Disorder that was considered advanced, primary, or late stage. A record review of Resident 1's admission Agreement dated 12/12/2025 revealed the contact information for the resident was a family member and the relation to the resident was the Responsible Party. The signature pages had the Responsible Party/Legal Representative listed as the resident's representative and signed and dated by the resident's responsible party. The resident was provided with the Resident's [NAME] of Rights.A record review of Resident 1's Representative Signatures and Responsible Party Acknowledgement signed by the resident representative and dated 12/12/2025 revealed the responsible party had been identified by the resident to be responsible for handling certain matters on behalf of the resident. A record review of the facility's Investigation Report dated 03/14/2026 revealed the allegation of sexual abuse had been investigated and the permanent steps that were put into place to prevent reoccurrence (happening again) included Resident 1 would only be cared for by female caregivers. A record review of Resident 1's Progress Notes dated 03/23/2026 revealed on 03/13/2026 the nursing assistant (NA) provided perineal cares (peri)(cleaning of the genital and anus area). After leaving the room, the resident started screaming and crying and the nurses went into the room and the resident told the staff a man came into the room and (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285242	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone Village	4330 South 144th Street Omaha, NE 68137

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriately touched and groped (feel or fondle for sexual pleasure) Resident 1. The staff tried to calm the resident down and assured the resident that the NA would not come back into the room. On 03/13/2026 at 2:27 PM the Progress Notes revealed the staff contacted the resident's representative about the incident and agreed the resident would have female only caregivers. A record review of Resident 1's Care Plan Report with an admission date of 12/12/2025 revealed an intervention of FEMALE ONLY CAREGIVERS created 03/13/2026. A record review of Resident 1's Clinical Physician Orders page dated 03/23/2026 revealed under the Care Profile section there were Special Instructions that included FEMALE ONLY CARE GIVERS. A record review of the facility's Nursing Staffing Assignments dated 02/25/2026 - 03/29/2026 revealed the following in Resident 1's unit: - 03/12/2026 night shift - NA-B was the only NA scheduled and was a male. - 03/13/2026 night shift - Registered Nurse (RN)-A was the only RN scheduled and was a male. - 03/17/2026 night shift - NA-B was the only NA scheduled and was a male. - 03/19/2026 day shift - NA-C was the only NA scheduled and was a male. - 03/19/2026 night shift - NA-B was the only NA scheduled and was a male. - 03/21/2026 day shift - NA-C was the only NA scheduled and was a male. A record review of NA-B's Previous Pay Period and Current Pay Period timecards dated 03/01/2026 - 03/21/2026 revealed NA-B worked: - 03/11/2026 from 10:24 PM to 03/12/2026 at 6:30 AM. - 03/12/2026 from 10:24 PM to 03/13/2026 at 6:43 AM. - 03/17/2026 from 10:24 PM to 03/18/2026 at 6:40 AM. - 03/19/2026 from 10:24 PM to 03/20/2026 at 6:41 AM. A record review of RN-A's Last 30 day timecard dated 02/21/2026 - 03/21/2026 revealed RN-A worked 03/13/206 from 6:27 PM to 03/14/2026 at 6:52 AM. In an interview on 03/24/2026 at 7:25 AM, NA-C, a male NA, confirmed the resident had been female caregivers only for about a week now and NA-C did not take care of Resident 1. In a telephone interview on 03/23/2026 at 2:38 PM, NA-B, a male NA, confirmed NA-B was the NA involved in the sexual abuse allegation on 03/13/2026 and NA-B had provided care to the resident when NA-B worked on 03/17/2026 - 03/18/2026 and 03/19/2026 - 03/20/2026. In a telephone interview on 03/23/2026 at 2:57 PM, RN-A, a male RN, confirmed RN-A did provide cares to Resident 1 on the night shift that started 03/13/2026. In a telephone interview on 03/24/2026, Resident 1's resident representative revealed that following the allegation of sexual abuse, the facility contacted the resident's representative, and they agreed that an intervention would be that the resident would have no male caregivers. The resident's representative confirmed it was the preference of the resident's representative that the resident does not have male caregivers. In an interview on 03/24/2026 at 11:51 AM, the Director of Nursing (DON) confirmed male caregivers should not have provided cares for Resident 1 as per the Special Instructions, Care Plan, and Resident 1's representative's preferences.