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	02/24/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18Based on observation, interview and record review, the facility failed to ensure a staff member wore a face shield or goggles in a droplet/contact isolation room, failed to restrict sharing of communal food items, and failed to ensure a staff member disinfected goggles between resident rooms in droplet/contact isolation to prevent cross contamination. The facility staff identified a census of 122.Findings are:Record review of an e-mail from an Infection Preventionist at the Nebraska Infection Control Assessment and Promotion Program (ICAP) to the Infection Preventionist and Assistant Director of Nursing (ADON) A at the facility dated February 18, 2026, at 3:20 PM revealed the following list of immediate prevention actions to follow regarding a Norovirus (a highly contagious virus that causes gastroenteritis, leading to vomiting, diarrhea, and stomach cramps) outbreak : -Ill residents should be isolated in contact precautions (gown, gloves, and mask and protective eyewear (due to aerosols produced with vomiting) until 48 hours after vomiting and diarrhea has ended.-Facility should use a disinfectant with claim against norovirus-Facility should encourage frequent hand hygiene-- Alcohol based hand rub can be used, but soap and water hand hygiene is preferred after providing care for isolated residents.-Consider stopping dining room service and group activities temporarily, to limit transmission of illness.-Nebraska Department of Health and Human Services (DHHS) has a great Norovirus toolkit: Norovirus Outbreak Toolkit for Healthcare. This toolkit addresses most infection prevention concerns, in an easy-to-use reference check-list format A. An observation on 2/18/26 at 10:23 AM revealed signage on the door of resident room [ROOM NUMBER] which stated the resident was in Droplet/Contact PrecautionsSTOP Droplet/Contact Precautions: Everyone Must: Donning (put on) order: Hand sanitize, gown, mask, face shield or goggles, glovesDoffing (take off) order: Gloves, face shield or goggles, gown, mask, hand sanitizeDisinfect face shield/goggles with D1 plus wipes before entering another room. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. An observation on 02/19/2026 10:23 AM revealed Medication Aide (MA) J donned a mask, gloves, gown and goggles and entered resident room [ROOM NUMBER]. MA J exited resident room [ROOM NUMBER] at 10:29 AM and proceeded to the next resident room with eyewear/goggles on top of their head without disinfecting. An interview with MA J on 02/19/2026 at 10:31 AM revealed that MA J did not think they needed to clean/disinfect goggles between residents. In an interview with ADON A on 02/19/2026 at 10:42 AM confirmed they would expect the eye wear to be cleaned/disinfected between residents. B.Record review of a Norovirus Outbreak Toolkit dated October 2023 page 3, section Food Service and Dining revealed the facility shouldRestrict sharing of communal food items and food brought from outside the facility or prepared by residents An observation on 2/19/26 at 10:25 AM revealed signage on the door of resident room [ROOM NUMBER] which stated the resident was in Droplet/Contact PrecautionsSTOP Droplet/Contact Precautions: Everyone Must: Donning (on) order: Hand sanitize, gown, mask, face shield or goggles, glovesDoffing (off) order: Gloves, Face shield or goggles, gown, mask, hand sanitizeDisinfect face shield/goggles with D1 plus wipes before entering another room. Use dedicated or disposable equipment. An observation on 02/19/2026 at 10:25 AM revealed Nursing Assistant (NA) K donned gown, gloves and mask and entered resident (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] carrying a plastic tray. An observation of NA K on 2/19/26 at 10:34 AM revealed NA K exited resident room [ROOM NUMBER] with a tray containing 7 plates of individually wrapped single donuts. In an interview on 2/19/26 at 10:38 AM NA K confirmed they forgot to put on a face shield. NA K confirmed they had entered a contact/droplet isolation room carrying a tray with individually wrapped donuts. NA K confirmed they did not know if that consisted of a breach of contact/droplet isolation procedure. In an interview on 02/19/2026 at 10:42 AM with ADON A confirmed the NA K should have worn a face shield and the tray of donuts should not have been taken into an isolation room. ADON A confirmed this was a breach of contact/droplet isolation.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report and investigate an allegation of abuse for Resident 22 within the required timeframe. The facility claimed a census of 122. A record review of the facility's undated Abuse and Neglect Prevention Standard, revised 1/2023, revealed the following Required Elements:It is the responsibility of all team members to immediately report any act of witnessed, suspected, or reported abuse to the Administrator or their supervisor.InvestigationAll allegations of abuse and/or neglect will be investigated and reported in accordance with the state and federal laws.In the situation of an allegation of abuse, the following people will be notified immediately: Administrator, Director of Nursing (DON), and Social Services.The suspected team member(s) will be suspended immediately while an in-depth, documented investigation is conducted.ProtectionResidents will be protected from harm during an investigation.Team members suspected of abuse will be immediately suspended until the results of the investigation are complete.Reporting/ResponseReport all alleged violations involving abuse (physical, mental, verbal, or sexual) immediately, but no later than 2 hours after the allegation has been made.Report all alleged violations involving neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property if the resident property, if the allegation does not involve serious bodily injury immediately, but no later than 24 hours.A record review of Resident 22's Clinical Resident Profile revealed Resident 22 was admitted to the facility on [DATE] with a diagnosis of Rhabdomyolysis (a serious, potentially fatal syndrome involving the rapid breakdown of skeletal muscle, releasing toxic contents into the blood causing kidney damage).A record review of Resident 22's Minimum Data Set (MDS - a federally mandated clinical assessment tool used in Medicare/Medicaid certified nursing homes to evaluate the health, functional capabilities and needs of residents) submitted to and accepted by the Centers for Medicare and Medicaid Services (CMS - the federal agency that administers Medicare and Medicaid) revealed Resident 22 had a Brief Interview for Mental Status (BIMS - a standardized cognitive screening tool mandated for all long-term care residents to measure memory, orientation and attention) of 14 indicating Resident 22 is cognitively intact. MDS also revealed Resident 22 had a diagnosis of Anxiety Disorder (a functional abnormality in physical or mental health, causing distress or impaired functioning) and was dependent for assistance with footwear (a health status where an individual cannot independently manage their own shoes, socks, or foot care, necessitating help from a caregiver, nurse or professional). A record review of a physician orders dated 01/05/2026 revealed the following: Ace wraps (a stretchable wrap used to reduce swelling, support injured muscles, and stabilize joints like ankles, wrists, and knees) on in the AM and off at HS one time a day for edema (the buildup of fluid in body tissues, causing swelling) On in the AM and Off at HS remove per schedule. An interview on 2/18/26 at 2:40 PM with Resident 22 revealed on 2/17/2026 at 8:00 PM nurse assistant (NA) G came to Resident 22's room. Resident 22 revealed one of the ace wraps was off one and the other one partially off the other leg. Resident 22 reported NA G pulled the ace wrap roughly from their leg and hurt the resident. Resident 22 reported they told NA G that they did not want them to come back to their room. Resident 22 reported later that evening they told the evening Medication Assistant (MA) D what had happened and MA D told the resident to tell the night shift nurse. Resident 22 spoke to Licensed Practical Nurse (LPN) H about the incident on 2/17/2026. Resident 22 did not know if LPN H told anyone else, but a Nurse boss came to talk to the resident the next day. Resident22 reported they were afraid to have NA G provide their cares. An interview with an Assistant Director of Nursing B (ADON) on 2/18/26 at 3:20 PM confirmed they were instructed to talk to Resident 22 on 2/18/26 and Resident 22 informed ADON B that they did not want NA G to care for them again. ADON B confirmed they had asked Resident 22 if that would be enough to fix the problem and the resident agreed. ADON B confirmed the NA G was not suspended, the facility had not opened an abuse investigation and had not reported it as (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse to APS or DHHS. An interview on 2/18/26 at 3:25 PM with MA D confirmed Resident 22 had informed them on 2/17/2026 that NA G was rough when they removed their leg wraps and had hurt Residents 22's legs. MA D confirmed Resident 22 did not want NA G to take care of them again. MA D confirmed they told LPN H they needed to speak with Resident 22 about NA G. An interview on 2/18/2026 at 4:20 PM with ADON A revealed the facility had decided to treat the incident as an abuse investigation based on the surveyor informing ADON A Resident 22 had said the NA G was rough with the residents cares. An interview on 2/23/26 at 9:50 AM with the Director of Nursing (DON) confirmed LPN H called the DON on 2/17/26 at midnight. LPN H reported Resident 22 had said NA G hurt them when they removed the residents ace wraps. DON confirmed they decided to open the issue as a grievance and instructed ADON A to address it in the morning. DON confirmed they did not open an abuse investigation until the afternoon of 2/18/2026.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 (Resident 129) of 1 Care Plan included a Risk for Elopement along with goals and interventions. The facility identified a census of 122 A record review of the Elopement (a patient or resident leaving a nursing home without authorization, supervision, or proper discharge) Risk Manual (the facility system to identify residents who are at risk for elopement) on the Lakeview unit revealed a resident sheet for Resident 129 containing an up-to-date picture and Resident 129's description details. A record review of the [NAME] Health Services Operating standards manual revealed the following: Elopement Prevention and Management Standard Resident Risk Review.All resident will be evaluated prior to admission for concerns related to elopement risk and resident safety. Appropriate placement of the resident is of utmost importance. Ongoing review will occur with all residents to ensure proper placement and a safe environment. Pre-admission/Admission. Upon admission, Social Services or Nursing will complete the elopement risk assessment, Med-pass form MP5472 as a component of admission paperwork.The facility has a system to identify resident who are at risk for elopement, and this is the Elopement Risk Manual. This manual is available to all staff and is maintained at the nurses' station.For those residents determined to be at risk, an admission photograph is taken by Nursing, and the Missing Resident Identification Form is completed, including resident photo, and placed in the Elopement Risk Manual at the nurses station for easy access during an emergency. Care Plan and Ongoing Review All residents at risk are care planned for elopement risk by Social Services or Nursing and approaches are implemented and maintained.Elopement Risk Assessment is a tool used to assist in determining and documenting Resident's elopement risk potential. The Elopement Risk Assessment is done on:Day of Admission, Quarterly, Change of Condition MDS (To assist in identifying when a change in resident status may now predispose a resident to elopement attempts). A. Record review of Resident 129's Clinical Resident Profile sheet, copied 2/19/2026 revealed Resident was admitted to the facility on [DATE].A record review of Resident 129's Comprehensive Minimum Data Set (MDS - a federally mandated clinical assessment tool used in Medicare/Medicaid certified nursing homes to evaluate the health, functional capabilities and needs of residents) submitted to and accepted by the Centers for Medicare and Medicaid Services (CMS - the federal agency that administers Medicare and Medicaid) on 01/12/2026 revealed Resident 129 had a Brief Interview for Mental Status (BIMS - a standardized cognitive screening tool mandated for all long-term care residents to measure memory, orientation and attention) of 10, indicating Resident 129 was moderately cognitively impaired.A record review of Residents 129's undated Care Plan (a comprehensive personalized document in healthcare that outlines an individual's specific health and social care needs, goals and the actions required to address them) revealed Resident 129 had the following diagnoses: Frontal lobe and executive function deficit following cerebral infarction (difficulty with planning, organization, impulse control, working memory and emotional regulation following a stroke), unspecified dementia, moderate with mood disturbance (a progressive decline in memory and cognitive function where the specific cause is not yet identified), Major Depressive Disorder (a serious mental health condition characterized by persistent, intense feelings of sadness and worthlessness) and generalized Anxiety disorder (a mental health condition defined by chronic, excessive and uncontrollable worry about everyday events, activities or potential disasters). A record review of the residents Risk Elopement assessments revealed Resident 129 was identified as a high Elopement Risk on 10/22/24, 12/12/24, 1/18/25, 2/17/25, 3/25/25, 6/25/25, 9/25/25, 12/25/25, 12/30/25 and 2/2/26.A record review of the residents undated care plan revealed it did not include a Risk of Elopement focus and did not contain any elopement interventions. An observation on 2/19/2026 at 11:35Am of the exterior of Resident 129's room revealed an electronic alarm was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attached to the top of the residents door.An interview on 2/19/26 at 11:45 AM with Licensed Practical Nurse (LPN) I confirmed Resident 129 was on the elopement list. LPN I confirmed there was an alarm device on the top exterior of Resident 129's door which would alarm if Resident 129 exited their room.An interview on 2/19/2026 at 11:55 AM with Registered Nurse L (RN) confirmed a list of elopement risk residents was visible on every nurse station, an Elopement Risk Manual is on every station and the organization's home page had a list of elopement risk residents.An interview on 2/19/2026 at 12:10 PM with the Social Services Supervisor confirmed the Elopement management process is as follows: elopement assessments are to be completed by the floor nurse. If a resident is determined to have a high risk for elopement, the residents name is placed on a list, and the list is given to the front desk and also updated on the organizations internal internet page that all staff can access. An elopement sheet with details and a picture is placed in the elopement book on the unit the resident lives on. An interview on 2/19/2026 at 2:10 PM with LPN I confirmed nursing is responsible for completing the elopement risk assessment and the Assistant Director of Nursing (ADON) was responsible for updating the care plan.An interview on 2/19/2026 at 2:20 PM with ADON A confirmed Residents 129's care plan did not contain a risk for elopement and interventions to prevent it. ADON A confirmed the care plan update had not been completed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) Based on observation, interview, and record review, the facility failed to implement interventions to prevent pressure injury for 1 (Resident 58) of 1 sampled resident. The facility census was 122. Findings are:A record review of the facility's Skin and Wound Management Standard with a revised date of 04/2019 revealed each resident would be assessed for their risk for developing a pressure ulcer/injury and each high-risk area would have an individualized care plan to address each risk area, and interventions implemented immediately to avoid development of a pressure ulcer. A record review of Resident 58's Clinical Census dated 02/24/2026 revealed the resident was admitted to the facility on [DATE] to room [ROOM NUMBER]-A and transferred to room [ROOM NUMBER]-A on 01/27/2026. A record review of Resident 58's Order Summary Report dated 02/24/2026 revealed the resident had diagnoses of Nondisplaced Intertrochanteric Fracture of the Right Femur (right hip fracture), Presence of Orthopedic Joint Implant (joint bone replacement), Peripheral Vascular Disease (blood flow disorder most commonly affecting the legs), Lymphedema (fluid build-up in arms or legs), and Foot Drop, Left Foot (nerve injury that causes difficulty lift front part of left foot). A record review of Resident 58's admission Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 01/27/2026 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 10 which indicated the resident was moderately cognitively impaired (confused). The resident was independent with eating and oral hygiene (cleaning), required partial/moderate assistance with upper body dressing, and personal hygiene, required substantial/maximal assistance with bathing and footwear and lower body dressing. The resident required partial/moderate assistance with sit to lying positioning and lying to sitting on the side of the bed, substantial/maximal assistance with rolling left and right, and was dependent on staff for sit-to-stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. The resident was at risk of developing a pressure ulcer/injury and the resident did have 1 stage I pressure ulcer (wound), 1 unstageable pressure (severe wound) injury, and surgical wound at the time of the assessment. A record review of the facility's Braden Scale For Predicting Pressure Sore Risk * - V 2 dated 01/22/2026 revealed Resident 58 was chairfast (couldn't bear weight and must be assisted into chair), the resident's mobility was very limited, and the resident had a potential problem with friction and shear (skin probably slides against other surfaces with movement). The Resident's score was 17 which indicated the resident was at risk for developing a pressure injury. A record review of Resident 58's Progress Note dated 01/22/2026 revealed the resident's skin condition was assessed on admission and did not reveal any concerns with the skin except edema (excess fluid in the arms or legs) was noted. A record review of Resident 58's Daily Skilled Documentation - V 9 dated 01/23/2026 revealed normal skin color with a surgical wound and no notable changes to the skin integrity (intact and undamaged). A pressure-reducing device was being used for chair and bed. A record review of Resident 58's Daily Skilled Documentation - V 9 dated 01/24/2026 revealed normal skin color with a surgical wound and notable changes to the skin integrity of the right hip surgical wound. A pressure-reducing device was being used for chair and bed. A record review of Resident 58's Daily Skilled Documentation - V 9 dated 01/25/2026 revealed normal skin color with a surgical wound and no notable changes to the skin integrity. A pressure-reducing device was being used for chair and bed. A record review of Resident 58's Daily Skilled Documentation - V 9 dated 01/26/2026 at 9:00 AM revealed normal skin color with a surgical wound and no notable changes to the skin integrity. A pressure-reducing device was being used for chair and bed. A record review of Resident 58's Progress Note dated 01/26/2026 at 5:38 PM revealed Registered Nurse (RN)-M was called to the spa (bath/shower room) by the Nursing Assistant who observed an area to the left heel. RN-M observed the left heel and the resident had a large fluid filled blister that measured 3 centimeters (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(cm) by (x) 2.8 cm. The blister was dark red and purple in color and was not open. The resident was educated not to wear shoes, only gripper socks and Prevalon boots to protect the left heel. An air mattress was also ordered. A record review of Resident 58's Pressure Ulcer Record - V 1 dated 01/26/2026 revealed it was marked that the resident's pressure ulcer was marked as community acquired even though the date of onset was 01/26/2026. The pressure ulcer was marked as an unstageable (full thickness tissue loss) pressure ulcer that was 3 cm x 2.8 cm in size. Specialty interventions needed was a specialized air mattress and positioning device of Prevalon boot. A record review of the facility's New Pressure Ulcer incident report dated 01/26/2026 revealed that Resident 58's left heel [NAME] a large fluid filled blister that measured 3 cm x 2.8 cm. An assessment was completed by RN-M and the resident was educated not to wear shoes until healed, and Prevalon boot while in bed. Predisposing (underlying) factors were gait imbalance (difficulty walking) and footwear type. Other information revealed history of left foot drop and extended period of time lying on the floor after a fall before Emergency Medical Services arrived with pressure on heel and the surgery at the hospital. A record review of Resident 58's Tasks list dated 02/24/2026 did not reveal a turning and repositioning task or other pressure reducing interventions tasks until 01/26/2026 when the task to ensure the resident had a Prevalon boot (thick boot designed to keep the pressure of the heel) to the left heel and float right heel while at rest was put in place. A record review of Resident 58's Care Plan Report with an admission date of 01/22/2026 did not reveal a focus area or interventions were initiated until 01/26/2026 for the potential impairment (damage) to skin. On 01/26/2026 the facility added the interventions of encourage good nutrition, elevate legs when resting, float heels using pillows or offloading boots as needed, and keep skin clean and dry and apply lotion to dry skin. A record review of the facility's Work Order Number (#) 38477 dated 01/26/2026 revealed a work order was placed for the resident to have an air mattress on 01/26/2026 and it was completed 01/27/2026. An observation on 02/19/2026 at 9:56 AM revealed Resident 58 was sitting in a wheelchair in the resident's room with both heels directly on the footrests of the wheelchair. An observation on 02/23/26 at 7:00 AM revealed RN-N completed wound care on Resident 58's left heel. The left heel had a intact (not open) partially fluid filled blister that was purple in color. RN-N painted the blister with betadine (brownish-red antiseptic), applied a new sock, edema wraps, and gripper socks to both of the resident's feet and exited the room with the resident still seated in the wheelchair and feet flat on the footrest. The NA then took the resident to get weighed, returned the resident to the room and left the resident in the wheelchair in the room with both heels flat on the footrests. In an interview on 02/19/2026 at 9:23 AM, RN-N confirmed the resident had a pressure related intact blister to the left heel. Interventions were that the staff were to apply the Prevalon boot to the left heel while the resident was in bed. In an interview on 02/23/2026 at 10:38 AM, NA-C confirmed that NA-C recalled taking care of Resident 58 when the resident was on the 700 hall before the resident was transferred to a different hall. NA-C confirmed the resident did not have anything they were doing for the resident to prevent pressure on the left heel prior to the resident getting the left heel wound. In an interview on 02/23/2026 at 10:08 AM, RN-M confirmed Resident 58 did not have any pressure reducing interventions in place prior to finding the resident had a wound to the left heel. In an interview on 02/23/2026 at 1:57 PM, the facility's Assistant Director of Nursing (ADON)-A confirmed the pressure reducing mattress the resident had before 1/26/2026 was the facility's standard mattress, not an air mattress. The air mattress was not put on until 01/26/2026. ADON -A confirmed the facility should have put pressure reducing interventions in place to protect Resident 58 from developing a pressure ulcer after the Braden Scale For Predicting Pressure Sore Risk * - V 2 dated 01/22/2026 revealed Resident 58 was at risk for developing a pressure ulcer and there was not. The pressure reducing mattress the resident

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, interview, and record review, the facility failed to ensure 2 (Resident 144 and 147) of 2 sampled resident's oxygen (o2) orders contained a dosage (settings) and ensure 1 (Resident 160) of 2 sampled residents had a Positive Airway Pressure (PAP) device order. The facility census was 122. Findings are:A.A record review of the National Library of Medicine's undated Nursing Skills, Chapter 11 Oxygen Therapy revealed that oxygen was considered a medication and required a prescription. www.ncbi.nlm.nih.gov/books/NBK593208/ A record review of the National Library of Medicine's undated Nursing Skills, Basic Concepts of Administering Medications revealed that according to the Centers for Medicare & Medicaid Services, all orders for the administration of drugs and biologicals must contain the following information: - Drug name - Dose, frequency, and route - Name/Signature of the prescriber - Specific instructions for use, when applicablehttps://www.ncbi.nlm.nih.gov/books/NBK593215/#:~:text=Components%20of%20a%20Medication% A record review of Resident 144's Order Summary Report dated 02/23/2026 revealed the only order the resident had for oxygen was: Titrate oxygen to maintain an oxygen level of 90 percent (%) two times a day for safe mobility. The order did not contain the dose and route of administration. A record review of Resident 144's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February 2026 revealed the order to titrate oxygen to maintain an oxygen level of 90% was marked two times a day except for 2 shifts. An observation on 02/18/2026 at 10:21 AM revealed Resident 144 was sitting in the resident's room, and the resident had an oxygen nasal cannula (tubing that goes in the nose to administer oxygen) on and the oxygen concentrator (a machine used to purify oxygen) was on and set at 2 liters per minute (l/m). An observation on 02/23/2026 at 6:27 AM revealed Resident 144 was lying in bed with a nasal cannula on and the resident's oxygen concentrator was on and set at 2 l/m. An observation on 02/23/2026 at 10:17 AM revealed Resident 144 was on an exercise bike with Therapy, and the resident did not have oxygen on. The resident's oxygen saturation (percentage of oxygen in the blood) was 82%. The Therapy staff went and got the resident's oxygen tank and placed the resident on oxygen at 2 l/m per nasal cannula and the resident's oxygen saturation increased to 95%. In an interview on 02/18/2026 at 12:33 PM, Resident 144 confirmed the resident had been on oxygen at 2 l/m since the resident was admitted to the facility from the hospital. In an interview on 02/23/2026 at 1:57 PM, the Assistant Director of Nursing (ADON)-A confirmed the only order the facility had for Resident 144's oxygen was the titrate oxygen to maintain an o2 level at or above 90% and the resident's oxygen order did not contain a setting. B.A record review of the National Library of Medicine's undated Nursing Skills, Chapter 11 Oxygen Therapy revealed that oxygen was considered a medication and required a prescription. www.ncbi.nlm.nih.gov/books/NBK593208/ A record review of the National Library of Medicine's undated Nursing Skills, Basic Concepts of Administering Medications revealed that according to the Centers for Medicare & Medicaid Services, all orders for the administration of drugs and biologicals must contain the following information: - Drug name - Dose, frequency, and route - Name/Signature of the prescriber - Specific instructions for use, when applicablehttps://www.ncbi.nlm.nih.gov/books/NBK593215/#:~:text=Components%20of%20a%20Medication% A record review of Resident 147's Order Summary Report dated 02/23/2026 revealed the order the resident had for oxygen was: Oxygen via nasal cannula two times a day. The order did not contain the dose. A record review of Resident 147's MAR & TAR dated February 2026 revealed the oxygen via nasal cannula was marked administered two times a day except for 2 shifts (02/09/2026 and 02/15/2026). An observation on 02/18/2026 at 9:55 AM revealed Resident 147 was lying comfortably in bed, and the resident had an oxygen nasal cannula on, and the oxygen concentrator was on and set at 2 l/m. An observation on 02/19/2026 at 1:13 PM revealed Resident 147 was lying in bed with a nasal cannula on and the resident's oxygen concentrator was on and set at 2 l/m while the staff (continued on next page)

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	02/24/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performed wound vac dressing change. In an interview on 02/23/2026 at 1:57 PM, ADON-A confirmed the only order the facility had for Resident 144's oxygen was the Oxygen via nasal cannula two times a day and the resident's oxygen order did not contain a setting. C.A record review of the National Library of Medicine's undated Nursing Skills, Chapter 11 Oxygen Therapy revealed that a prescription was required for a PAP device. www.ncbi.nlm.nih.gov/books/NBK593208/ A record review of Resident 160's Clinical Physician Orders dated 02/19/2026 did not reveal an order for the resident's PAP device. A record review of Resident 160's Baseline Care Plan - V 2 dated 02/10/2026 revealed the resident was admitted to the facility 02/07/2026 but did not reveal the resident was on a PAP device. A record review of Resident 160's Care Plan Report with an admission date of 02/07/2026 revealed the resident had a focus area of at risk for altered respiratory function related to sleep apnea and asthma but did not reveal the resident was on a PAP device. A record review of Resident 160's Progress Notes dated 02/07/2026 - 02/22/2026 revealed Skilled Notes on 02/12/2026, 02/17/2026, 02/18/2026, and 02/19/2026 that staff documented the resident used a PAP machine. An observation on 02/18/2026 at 9:46 AM revealed Resident 160 had a PAP device on the bedside table. An observation on 02/18/2026 at 12:58 PM revealed Resident 160 had a PAP device on the bedside table. In an interview on 02/19/2026 at 1:57 PM, Resident 160 confirmed the resident brought the PAP machine when the resident was admitted to the facility and wore it every night. The facility changed the mask and tubing for the device when the resident brought the machine in. In an interview on 02/23/2026 at 1:57 PM, ADON-A confirmed the Resident 160 had a PAP device, did not have an order for the PAP device, and should have.