STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285246	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Homes Health Care Center	1923 West 4th Avenue Holdrege, NE 68949

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(E) Based on record review, observations, and interviews, the facility failed to label and date foods stored in the kitchen and failed to ensure that foods were prepared and served in a manner to prevent food-borne illnesses. The facility also failed to ensure hand hygiene was followed during meal service. This had the potential to affect all individuals who received foods from the kitchen and dining rooms. The facility census was 71. Findings Are: Record review of the United States Department of Agriculture (USDA) 2022 Food Code dated 01/18/2023 revealed that the Food Code addresses risk factors of food borne illnesses and identified risk factors of improper temperatures, proper hygiene, contaminated equipment, inadequate cooking times, and foods from unsafe sources. The Food Code addresses several controls for risk factors and further establishes 5 key public health interventions to protect consumer health. Specifically, these interventions are demonstration of knowledge, employee health controls, controlling hands as a vehicle of contamination, time and temperature parameters for controlling pathogens, and consumer advisory. A. Observation during the initial inspection of the kitchen on 03/09/2026 at 8:20 AM revealed: In the walk-in refrigerator: -3 trays of food which had 8 individually wrapped slices of pie that were not labeled or dated. -1 tray with 7 cups of an orange-colored dessert that were not dated or labeled. -1 tray with 9 individually wrapped pieces of yellow dessert with a brown frosting that were not labeled or dated. -1 pan with 13 slices of the yellow dessert with a brown frosting that was not labeled or dated. -7 fruit cups with a red/pink dessert with fruit in it that were not dated or labeled. In the kitchen: -An undated sealed plastic bag of cornbread was sitting atop the workstation in the kitchen near the (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	oven. In an interview on 03/09/2026 at 10:10 AM with Dietary [NAME] (DA)-A revealed that the foods in the refrigerator had not been labeled at the time of the kitchen inspection of the walk-in refrigerator. Interview on 03/09/2026 at 10:12 AM with DC-B revealed the DC had no knowledge as to why the cornbread was sitting on the top of the workstation. B. An observation on 3/9/2026 beginning at 8:20 AM revealed there were plastic containers on wheels in the kitchen cooking area near the microwave which contained flour, sugar, and other dried ingredients. Each container had a lid and covering that had dried food stuff on the outside and were visibly soiled. There were also storage drawers near the oven at the workstation which had dried-on brownish, reddish sauce on the outside of the drawers as well as inside the second drawer down. One drawer had a black measuring cup or bowl that had specks of unidentifiable white and brown food particles. This drawer also had food scale that had grease- like film on it. C. Observation on 03/09/2026 at 10:15 AM revealed DC-A was wearing an apron that was covered in places with a white powdery residue, had a dried sauce on the front, as well as areas of unidentifiable food particulate on the front of the apron. The apron was wrapped around DC-A's waist and then tied in the front. DC-A had three pans of chicken breast that had just been removed from the oven. From a large stock pot of teriyaki sauce that had been sitting on the unheated stove, DC-A used a paint brush to paint teriyaki sauce on one side of each piece of chicken on tray one. DC-A dipped the paint brush in and out of the large stock pot from the sauce to the chicken until all of the chicken had been basted. The trays of chicken were then placed into the oven to cook further. DC-A then covered the remaining teriyaki sauce with foil and put this back onto the flat surface of the stove which was not being heated. Interview on 03/09/2026 at 10:18 AM with the Dietary Manager (DM) who had entered the kitchen confirmed that DC-A had been preparing parts of the noon meal and that some parts of the meal were already finished. Interview on 03/09/2026 at 10:37 AM with DC-A revealed that homemade teriyaki sauce had been prepared around 8:30 AM that morning by the kitchen staff. DC-A further confirmed that the teriyaki sauce was covered and sitting atop of the flat surface of the stove and had not been cooled after it was prepared nor was it being maintained at a holding temperature of 135 to 140 degrees Fahrenheit according to the recipe. Observation of DC-A on 03/09/2026 at 10:48 PM revealed DC-A checked the rice they had made and then left on the stove after cooking. The 2 stocks pots used to cook all the rice were left on the stove with no heat turned on. No HH was completed by DC-A after attending to the rice. Observation of DC-A on 03/09/2026 at 11:00 AM revealed DC-A, without first performing HH, measured and added the frozen peas required in the recipe for fried rice and then placed the peas into (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the oven to steam. DC-A then removed broccoli from the steamer oven. The temperature of the broccoli was 180 degrees F when it was removed from the steam oven. The broccoli was divided into 4 different service pans for distribution to 4 different dining rooms and then DC-A used an approximately 2-quart clear, plastic storage container with melted butter in it, and poured the melted butter into the 4 different service pans of food. The butter was not measured prior to pouring into the separate service pans of broccoli. Interview with DC-A on 03/09/2026 at 11:01 AM who stated that about 4 ounces of butter was poured on each pan of broccoli. Observation on 03/09/2026 at 11:02 AM of DC-A revealed they had stored the facility food scale in a drawer without cleaning or sanitizing after being used. The scale was covered in a greasy residue with unidentifiable small food particles. Inside the drawer there was also a small amount of dried brown sauce-like residue. Observation on 03/09/2026 at 11:37 AM revealed DC-A adding onions and eggs to the rice mixture on the unheated stove. The ties of DC-A's apron came untied, with the ends touching the floor. DC-A took the ties of the apron, wrapped the ties around (gender) waist again, and tied the apron to the front at the waist. DC-A then went back to preparing foods on the counter without first performing HH. Observation on 03/09/2026 at 11:43 AM revealed DC-A taking a measuring cup filled with soy sauce to the microwave to heat. Observation on 03/09/2026 at 11:58 PM revealed DC-A removed two trays of egg rolls from the oven. The egg rolls were checked for temperature, and this was noted to be 183 degrees F. No hand hygiene was performed by DC-A. The egg rolls were left on the trays on the countertop. Observation on 03/09/2026 at 12:02 PM revealed DC-A removed carrots from the stove and then mixed the mixture of rice, carrots, peas, and eggs without first performing HH. The mixture was then divided into 4 prepared pans to be distributed to 4 different dining rooms throughout the facility without a temperature first being obtained. After each container was filled with the needed amount of rice, the container was covered with foil, labeled, then put into a warmed box for distribution to the 4 different dining rooms. After the 3rd container was sealed, labeled, and loaded onto the cart for distribution, DC-A filled the 4th food container. DC-A then retrieved the container of soy sauce from the microwave and poured an unmeasured amount of soy sauce into the remaining fried rice in the 4th container and stirred it together without first obtaining the temperature of the sauce. Observation on 03/09/2026 at 12:14 PM revealed DC-A going to the walk-in freezer without first performing HH, obtained 4 frozen hamburger patties with their bare hands, then took them to the stove and placed the frozen patties in the frying pan. DC-A then took a small pan from the stove, filled it with tap water from the handwashing sink, returned it to the stove, and placed frozen hot dogs into the water that was being heated on the stove without first performing HH. DC-A then reached into the frying pan with a bare hand and moved one of the frozen hamburger patties in the pan without first performing HH. DC-A then got the food blender and placed egg rolls for the pureed meals into the blender. DC-A pureed the egg rolls and then added five 1-cup scoops of teriyaki sauce to the egg roll puree and poured these into two small pans. DC-A checked the temperature of the egg roll mixture, and it was 112 degrees Fahrenheit. DC-A then placed foil over the top of the egg rolls and placed the two pans back into the oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 03/09/2026 at 12:23 PM revealed DC-A was pureeing the steamed rice. Upon realizing there was not enough rice for the residents, DC-A walked into the dirty pan area (a room just past the oven and steamer with a large doorway and no door) and retrieved more rice from the stock pot of the rice which had been already discarded and taken to the soiled pan wash area but remained in the stock pot it had been cooked in, obtained more rice, added it to the blender, then finished the pureed steamed rice by adding broth that had been sitting on the work bench counter top without heat during the puree process. Prior to covering the steamed rice puree with a foil covering, DC-A temped the rice, which was 93 degrees Fahrenheit. DC-A then placed a foil covering over the top of the two pans, labeled both pans and put them in the oven. Observation on 03/09/2026 at 12:31 PM revealed the pureed egg rolls were removed from the oven by DC-A and the temperature of each pan was checked and found to be 146 degrees Fahrenheit and 162 degrees Fahrenheit. The pans were covered with foil and placed into the distribution boxes to be taken out for meal services. Observation on 03/09/2026 at 12:34 PM revealed DC-A removed the steamed rice from the oven and rechecked the temperatures of the two pans, which were 135 degrees Fahrenheit and 121 degrees Fahrenheit. The pans were again covered with foil and placed back in the oven. Observation on 03/09/2026 at 12:37 PM revealed DC-A removed the steamed rice from the oven and obtained the temperatures, which were 140 degrees Fahrenheit and 145 degrees Fahrenheit. DC-A then covered the pans, placed them into the heated distribution boxes and all meals were immediately taken to the dining rooms for service. In an interview on 03/09/2026 at 2:15 PM the Dietary Manager (DM) confirmed foods are supposed to be labeled prior to being put into the refrigerators, recipes are supposed to be followed, temperatures are supposed to be taken of foods on a regular basis during the preparation and service of meals, aprons worn by staff are to be changed regularly and kept clean or changed as needed, hands need to be washed regularly during the time of cooking, and once foods go into an area deemed dirty no foods can be retrieved from that area and used for service. The DM confirmed that the dirty pan area starts at the doorway of the dirty pan wash area. The DM also confirmed that the tops of the dry food containers on wheels were soiled and did need to be cleaned. DM confirmed the drawers in the kitchen needed to be cleaned on the inside and the outside. D. Record review of a facility policy titled Hand Hygiene dated 01/2026 revealed it is the policy of the facility that all staff will perform proper hand hygiene procedures to prevent the spread of infection, and it applies to all staff working in all locations within the facility. The policy stated the use of gloves does not replace hand hygiene and hand hygiene should be performed after removing gloves and prior to applying gloves. In an observation of meals being served to residents on 03/10/2026 from 8:18 AM through 8:50 AM the following was observed: -Dietary Aide J (DA-J) with gloved hands is serving drinks to residents sitting in the dining area. The DA removes a cup from the table in front of a resident and pours juice into the cup the replaces the cup in front of the resident handling the cup so that their gloved hand is over the top of the cup. With (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the same gloved hands, the DA then left the drink cart and with the gloved right hand pushed open the door to the meal service area. The DA gloved hand came into contact with the door surface possibly/probably causing contamination of the gloved hand. The DA exited the meal service area holding a coffee cup in their right gloved hand and proceeded to empty coffee into the cup and then take the cup over to a resident sitting at the table and with their gloved hand the dietary aide placed their hand over the top of the coffee cup and placed the cup on the table in front of the resident. DA-J with the same gloved hands then walked over to the meal service area and picked up a plate placing both of the thumbs of their gloved hands onto the surface of the plate where the food is. The DA then took the plate to a resident and placed it on the table in front of the resident. The DA did not change their gloves or perform hand hygiene after touching the door with their gloved hands, then placing their potentially soiled gloved hand over the top of the resident's coffee cup while setting it down on the table in front of the resident or serving the resident their plate with the gloved thumbs touching the surface of the plate where the food is located. The DA continued to serve meals to residents with the same gloved hands. The DA did not remove the potentially soiled gloves and perform hand hygiene during the meal service. -The Dietary Manager (DM) was assisting to serve meals to the residents with gloved hands. The DM was asked by a resident for some jelly. The DM went over and retrieved a white plastic container with jelly packages in it. With the same gloved hands the DM sorted through the jelly package container until they located the type of jelly the resident had requested. The DM placed the jelly package on the table beside the resident and then touched the resident's shoulder with their gloved hands. The DM then put the plastic container with the jelly packets in it down and returned to the meal service area and picked up a plate and took it to a resident seated at the table. The DM did not remove their gloves and perform hand hygiene prior to serving the meal to the resident after potentially contaminating their gloved hands with the plastic jelly container or sorting through the jelly packets and touching the resident's shoulder. In an interview completed on 03/10/2026 at 8:50 AM with the DM the DM confirmed that wearing gloved during meal service did not remove the need for hand hygiene during meal service after potentially contaminating hands. The DM stated hand hygiene should be performed after removing gloves, prior to putting gloves on, and when hands have potentially come in contact with items that could contaminate them. In an observation of meals being served to residents from 1:10 PM to 1:35 PM the following was observed: -DA-I was sitting at a table with other residents waiting on meal service to begin with gloved hands. DA-I was asked by a resident to assist with the resident's personal cell phone. The DA stood from the table went over to the resident and with their gloved hands took the cell phone from the resident and with a gloved finger pushed the buttons requested by the resident then handed the cell phone back to the resident. The DA then returned to the seated position at the table. The DA remained there with the gloves on both hands while awaiting meal service to begin. The DA stood from the table and walked over to the meal service area and obtained a tray with the resident's deserts on it. With the same gloved hands, the DA held the tray with one hand and served the individual desert dishes to each resident sitting in the dining area. The DA then returned to the meal service area and with the same gloved hands served meals to the resident handling the residents' plates with the gloved hands. The DA did not remove the gloves and perform hand hygiene after handling the resident's personal cell phone potentially contaminating the gloved hands and serving the residents their deserts then their food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview completed on 03/10/2026 at 1:35 PM with DA-I, DA-I confirmed that they should have removed their gloves and completed hand hygiene after handling the resident's cell phone and then going to serve the residents their desserts and food items. The DA confirmed that wearing gloves did not replace the need for hand hygiene during meal service.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Licensure Reference Number 175 NAC 12-006.05(S)Based on observation, record review, and interview the facility failed to consecutively serve meals to all residents seated at the same table to maintain resident dignity for 10 of 12 residents observed (Residents 62, 41, 27, 35, 72, 47, 36, 70, 31, and 12). The facility census was 71.Findings are:Record review of the facility admission Agreement dated 8/6/24 revealed that the facility will provide the resident with three meals a day. The resident and responsible person acknowledge being informed orally and in writing of Resident Rights. Record review of the facility Resident Handbook dated March 2024 revealed that the nutritional services department is directed by a Dietary Manager under the direction of a Consulting Registered Dietician. Meals are prepared in the facility and are served at established meal times. The section titled Resident Rights revealed that it is the facility policy to protect and promote the rights of each resident. The facility will care for residents in a manner and an environment that promotes maintenance or enhancement of each resident's quality of life, including their dignity, respect, and individuality. Observation on 3/10/26 at 12:46 PM in the [NAME] Peony (RP) dining room revealed that the first meal was plated from the kitchenette. Unidentified dietary staff covered the plate and carried it on a tray to a resident room. 12 residents were seated in the dining room at 5 different tables. The first plate served in the dining room was delivered to Resident 62 at 12:50 PM. Residents 47 and 70 sat at the table with Resident 62 (Residents 62, 47, and 70 were tablemates). Dietary staff carried a plated meal to another table for Resident 41. Dietary staff sat the plate on the table in front of Resident 41 at 12:50 PM. Resident 27 sat at the same table with Resident 41 (Residents 41 and 27 were tablemates). The next plated meal was delivered to Resident 5 at another table at 12:52 PM. Resident 6 sat at the same table with Resident 5 (Residents 5 and 6 were tablemates). The next plated meal was delivered to Resident 6 at 12:53 PM (the two residents (Residents 5 and 6) seated at the same table were served consecutively within 1 minute). Nurse Aide-E (NA-E) delivered the next plated meal to Resident 27 at 12:55 PM (Resident 27 was served 5 minutes after their tablemate Resident 41 had been served). Resident 70 was heard asking their tablemate (Resident 62 that had been served at 12:50 PM) if they were going to share their meal with them. Residents 47 and 70 watched their tablemate (Resident 62) continue to eat the meal. Residents 47 and 70 had not been served. The next plated meal was delivered to Resident 35 at another table at 12:57 PM. Residents 31 and 12 sat at the table with Resident 35 (Residents 35, 31, and 12 were tablemates). The next plated meal was delivered to Resident 72 at another table at 12:58 PM. Resident 36 sat at the table with Resident 72 (Residents 72 and 36 were tablemates). NA-E carried the next plated meal to a tray. NA-E covered the plate on the tray out of the dining room to a resident room at 12:59 PM. Unidentified dietary staff delivered the next plated meal to Resident 47 at 12:59 PM (Resident 47 was served 9 minutes after their tablemate Resident 62 had been served). The Dietary Manager (DM) came into the dining room and delivered the next plated meal to Resident 36 at 1:00 PM (Resident 36 was served 2 minutes after their tablemate Resident 72 had been served). The DM delivered the next plated meal to Resident 70 at 1:01 PM (Resident 70 was served 11 minutes after their tablemate Resident 62 had been served). The DM carried a plate of chicken to Resident 41 per the resident request for a second helping of chicken at 1:02 PM. The DM delivered the next plated meal to Resident 31 at 1:03 PM (Resident 31 was served 6 minutes after their tablemate Resident 35 had been served). The DM delivered the next plated meal to Resident 12 at 1:04 PM (Resident 12 was served 7 minutes after their tablemate Resident 35 had been served). Interview on 3/11/26 at 1:46 PM with Dietary Cook-H (DC-H) revealed that the dietary staff should serve all residents at a table before moving to the next table of residents. Interview on 3/11/26 at 3:19 PM with the Dietary Manager (DM) confirmed that the expectation is to serve all residents seated at one table prior to serving residents at the next table.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(D)&(E) Based on record reviews, observations and interviews, the facility failed to inform the resident and/or resident representative, in advance of care, of the risks and benefits and possible alternatives of treatment for 5 of 6 residents sampled (Residents 1, 4, 10, 53, and 60). The facility census was 71.Findings Are: Record review of the facility policy Psychotropic Medication Checklist dated May 2021 revealed that upon receiving physician orders staff must have permission from the Designated Power of Attorney (DPOA) (a legal document that authorizes a trusted person (the agent or attorney-in-fact) to manage the financial, legal, or medical affairs of another (the principal) person when that person is no longer able to make decisions) or the resident before administering medications. Verbal permission with a new order or order change may be obtained. Staff must give information to the DPOA and/or resident about possible side effects and benefits and place a care plan intervention for documentation. A. Record review of the Medical Diagnoses dated 03/09/2026 revealed Resident 4 was admitted to the facility on [DATE] with diagnoses of depression (a mental health disorder characterized by persistent sadness, loss of interest, fatigue, and cognitive difficulties) and dementia with agitation (decrease in mental functions like memory, reasoning, attention, and processing speed with agitation). Record review of Physician Orders printed 03/11/2025 revealed Resident 4 had orders for quetiapine (an atypical antipsychotic medication) 50 milligrams (mg) at 7:00 PM for dementia with agitation, and quetiapine 200 mg at 9:00 AM and 7:00 PM for dementia with agitation, and sertraline (a medication for depression) 50 mg once daily. Record review of the electronic medical record on 03/11/2026 for Resident 4 revealed no evidence that the resident and/or their representative were informed in advance of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications. In an interview with the DON on 03/10/2025 at 2:42 PM, the DON confirmed that residents receiving psychotropics were not given a form to sign that reveals the risks and benefits of psychotropic medications nor are alternatives discussed with the resident or the family representatives in advance of the medications being administered. The DON stated this was reviewed with family representatives and the residents and documented in the resident's care plan during their care plan meetings. B. Record review of the Medical Diagnoses dated 03/11/2026 revealed that Resident 60 was admitted to the facility on [DATE] with diagnoses of dementia and depression. Record review of the Physician's Orders dated 03/11/2025 revealed Resident 60 had orders for sertraline 100 mg daily and quetiapine 12.5 mg at 7:00 PM. Review of the electronic medical record on 03/11/2026 for Resident 60 revealed no evidence that the resident and/or their representative were informed in advance of care of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON on 03/10/2025 at 2:42 PM, it was confirmed that residents receiving psychotropic medications were not given a form to sign that revealed the risks and benefits of psychotropic medications nor are alternatives discussed with the resident or the family representatives in advance of the medications being administered. The DON stated this was reviewed with family representatives and the residents and documented in the resident's care plan during their care plan meetings. C. Record review of a Clinical Census dated 03/10/2026 revealed that the facility admitted Resident 1 on 04/21/2025 with diagnoses of depression and schizoaffective disorder (a mental health condition combining hallucinations, delusions, and disorganized speech with mood disorder like mania or depression). Record review of Resident 1's Physician Order Summary dated 03/10/2026 revealed the resident had an order dated 6/18/2025 for Celexa (an antidepressant medication) to be taken once daily, and an order dated 4/21/2025 for olanzapine (an antipsychotic medication) to be taken every evening. Record review of Resident 1's Electronic Medication Administration Record (EMAR) on 03/10/2026 revealed that Resident 1 was being administered the medications as ordered since admission to the facility. Record review of Resident 1's Electronic Medical Health Record (EMHR) on 03/10/2026 revealed no evidence that the resident and/or their representative were informed in advance of care of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications. In an interview completed on 03/11/2026 at 1:30 PM with the facility Director of Nursing (DON), the DON stated that the facility reviewed the resident's use of the antidepressant and antipsychotic medications with the resident and or responsible party during the residents' care plan meeting. The DON confirmed that there was no specific documentation presented to and signed by the resident or their responsible party of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications for Resident 1. D. Record review of a Clinical Census dated 03/10/2026 revealed that the facility admitted Resident 53 on 09/19/2025 with a diagnosis of Bipolar Disorder (a mental health condition characterized by extreme mood swings, alternating between intense highs and lows). Record review of Resident 53's Physician Order Summary dated 03/10/2026 revealed the resident had a orders dated 9/18/2025 for buspirone (an antidepressant medication) to be taken once daily, and risperidone (an antipsychotic medication) to be taken every evening. Record review of Resident 53's Electronic Medication Administration Record (EMAR) on 03/10/2026 revealed that Resident 53 was being administered the medications as ordered since admission to the facility. Record review of Resident 53's EMHR on 03/10/2026 revealed no evidence that the resident and/or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their representative were informed in advance of care of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications. An interview completed on 03/11/2026 at 1:30 PM with the facility DON confirmed that there was no specific documentation presented and signed by the resident or the responsible party of the risks, benefits, and possible alternative treatments for the use of the antidepressant and antipsychotic medications for Resident 53. E. A record review of Resident 10's admission Record dated 3/21/25 revealed an admission date of 3/21/25 and was signed by the Power of Attorney (POA; a person appointed to another to manage financial, legal, or health decisions on their behalf). A record review of Resident 10's Diagnosis Sheet dated 3/9/26 revealed the resident had the following diagnoses: -Alzheimer's disease (a progressive, incurable brain disorder that causes dementia (a progressive syndrome causing significant decline in memory, thinking, behavior, and daily functioning), -Down Syndrome (a genetic condition caused by an extra copy of chromosome 21), -Depression (mental health disorder characterized by persistent sadness, loss of interest, fatigue, and cognitive difficulties), and -Unspecified Mood (Affective) Disorder (clinical condition with symptoms of depression or mania). A record review of Resident 10's Order Recap Report dated 3/11/26 under Pharmacy revealed orders for: -Seroquel (an antipsychotic medication) oral tablet, give 75 milligrams (mg) by mouth two times a day for dementia. The start date of the order was 3/21/25 and the end date was 8/14/25. -Seroquel oral tablet, give 75 mg by mouth two times a day for Unspecified Mood (Affective) Disorder. The start date of the order was 8/14/25 and the end date was 1/16/26. -Seroquel oral tablet, give 25 mg by mouth two times a day for Unspecified Mood (Affective) Disorder. The start date of the order was 1/16/26 and the end date was 1/17/26. -Seroquel oral tablet, give 50 mg by mouth two times a day for Unspecified Mood (Affective) Disorder. The start date of the order was 1/17/26 and there was no end date. - Zoloft (an antidepressant medication) oral tablet, give 50 mg by mouth in the evening for depression, The order had a start date of 3/21/25 and an end date of 4/1/25. - Zoloft oral tablet, give 75 mg by mouth in the evening for depression. The order had a start date of 4/1/25 and no end date. An interview with the DON on 3/11/26 at 2:45 PM revealed the education for medication changes was (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	done at care planning meetings with the POA. Advance notification of the risks and benefits and possible alternatives of treatment for psychotropic medications were not completed prior to dispensing.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on record review and interview the facility failed to ensure an baseline care plan (a written plan required to be developed within 24 hours of admission detailing the instructions needed for staff to provide initial effective and person-centered quality care for a resident) was completed within 24 hours of admission for 7 (Residents 18, 60, 11, 53, 70, 2, and 9) of 10 sampled residents and failed to provide a written summary of the baseline care plan to the resident or their representative for 9 (Residents 18, 74, 60, 11, 53, 3, 70, 2, and 9) of 10 sampled residents. The facility census was 71. Findings are:Record review of the facility policy titled Care Plans dated January 2026 revealed that a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within 48 hours of admission (24 hours in Nebraska). The preliminary care plan will be used until the staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. The facility will provide the resident and their representative with a summary of the baseline care plan that includes the initial goals of the resident, a summary of the resident's medications and dietary instructions, and any service and treatments to be administered by the facility. Interview on 03/09/2025 at 1:40 PM with the Social Services Director (SSD) revealed a written summary of baseline care plans was not provided to residents or their representatives. Interview on 3/11/26 at 11:32 AM with the facility Director of Nursing (DON) confirmed that the facility failed to provide a written summary of the baseline care plan to the resident or their representative as required for Residents 18, 74, 60, 11, 53, 3, 70, 2, or 9. The DON revealed that the facility completed the baseline care plan but was not aware that it needed to be reviewed and by the resident or their representative. A. Record review of Resident 18's Clinical Census dated 3/9/2026 revealed the resident was admitted to the facility on [DATE]. Record review of Resident 18's Clinical-Assessments from admission through March 2026 revealed no evidence of a baseline care plan being completed. Further record review of Resident 18's Electronic Medical Records (EMR) revealed no evidence of a baseline care plan summary being provided to the resident or their representative. B. Record review of Resident 74's Clinical Census dated 3/12/2026 revealed the resident was admitted to the facility on [DATE]. Record review of Resident 74's Baseline Care Plan dated 12/16/2025, revealed no evidence of the Baseline Care Plan or a written summary being provided to the resident or their representative. Further review of Resident 74's EMR revealed no evidence of a baseline care plan summary being (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided to the resident or their representative. C. Record review of Resident 60's Clinical Census dated 3/9/2026 revealed the resident was admitted to the facility on [DATE]. Record review of Resident 60's Baseline Care Plan dated 3/18/2025 revealed sections 1, 4, and 5 were incomplete. There was no evidence of the baseline care plan or a written summary of it was provided to the resident or their representative. Further review of Resident 74's EMR revealed no evidence of a baseline care plan summary being provided to the resident or their representative. D. Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 11 on 01/19/2026 with a diagnosis of stage 3 pressure ulcer (which is a severe, full thickness wound extending through the skin into the subcutaneous fatty tissue often appearing as a deep crater). Record review of Resident 11 EMR on 03/10/2026 revealed no evidence of a baseline care plan being created. There was also no evidence present reflecting that the resident or the resident's representative was provided with a written summary of a baseline care plan for Resident 11. In an interview completed on 03/11/2026 at 11:32 AM with the facility Director of Nursing (DON), the DON confirmed that a baseline care plan was not present for Resident 11 and that a written summary of a baseline care plan was not provided to the resident or their responsible party. E. Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 53 on 09/19/2025 with a diagnosis of Epilepsy (which is a chronic neurological disorder characterized by recurrent, unprovoked seizures cause by abnormal electrical activity in the brain). Record review of Resident 53 EMR on 03/10/2026 revealed no evidence of a baseline care plan being created. There was also no evidence present reflecting that the resident or the resident's representative was provided with a written summary of a baseline care plan for Resident 53. In an interview completed on 03/11/2026 at 11:32 AM the facility DON confirmed that a baseline care plan was not present for Resident 11 and that a written summary of a baseline care plan was not provided to the resident or their responsible party. G. Record review of the admission Record dated 3/11/26 for Resident 3 revealed that Resident 3 was (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted into the facility on 7/29/25. Record review of the Baseline Care Plan assessment dated [DATE] for Resident 3 revealed that the section titled BCP (Baseline Care Plan) Summary and Signatures had a box to write the BCP summary. The box was left blank. The section contained a box for the resident signature and date that was blank. The section contained a box for the representative signature and date that was blank. Record review of Resident 3's EMR revealed no evidence that a written summary of the baseline care plan was provided to and reviewed with the resident/resident representative. Interview on 3/11/26 at 11:32 AM with the facility DON confirmed that the facility failed to provide a written summary of the baseline care plan to the resident/representative as required for Resident 5. H. Record review of the admission Record dated 3/11/26 for Resident 70 revealed that Resident 70 was admitted into the facility on [DATE]. Record review of the EMR for Resident 70 revealed no evidence of a Baseline Care Plan assessment. Record review of the EMR for Resident 70 revealed no evidence that a written summary of a baseline care plan was provided and reviewed with the resident/resident representative. Interview on 3/11/26 at 11:32 AM with the facility Director of Nursing (DON) confirmed that the facility failed to provide a written summary of the baseline care plan was provided to the resident/representative as required for Resident 70. I. A record review of Resident 2's admission Record dated 3/10/26 revealed an admission date of 12/31/2025. A record review of Resident 2's EMR revealed no evidence of a baseline care plan being completed or a written summary being provided to the resident or their representative. J. A record review of Resident 9's admission Record dated 3/10/26 revealed an admission date of 2/6/26. A record review of Resident 9's EMR revealed no evidence of a baseline care plan being completed or a written summary being provided to the resident or their representative. An interview with the DON on 3/10/26 at 3:00 PM revealed that the baseline care plans were in the assessments tab in the EMR and confirmed that the facility failed to complete a written summary of the baseline care plan for the residents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to ensure the Ombudsman was informed of all resident discharges and transfers. This affected 2 (Residents 74 and 76) of 2 sampled residents. The facility census was 71. In an interview with the Social Services Director (SSD) on 03/10/2026 at 11:20 AM it was revealed that the SSD sent a list of emergency transfers to the ombudsman monthly. A.Record review of Resident 74's Progress Notes dated 1/2/2026 revealed the resident had an emergency transfer to the hospital on that date at 7:45 AM.Record review of the Emergency Transfers from Facility for January 2026 revealed there were three residents listed on the form, which was provided to the ombudsman. Resident 74 was not included on this form. B.A record review of Discharge Instructions dated 2/9/2026 for Resident 76 revealed the resident was transferred from the facility on 02/09/2026.Record review of the Emergency Transfers from Facility dated February 2026 revealed there were two residents listed on the transfer form, which was provided to the ombudsman. Resident 76 was not included on this form.In a follow up interview on 03/10/2026 at 2:50 PM the SSD confirmed that the discharge for Resident 76 and the transfer of Resident 74 were not reported to the Ombudsman as required.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(D)Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) for 2 (Residents 1 and 63) of 18 sampled residents. The facility census was 71.Findings are:Record review of a facility policy titled Minimum Data Set (MDS) dated 10/2021 revealed it was the responsibility of the MDS Coordinator (MDSC) to complete both section H: Bladder and Bowel and Section N: Medications of the MDS as well as the submission of the MDS. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated 10/2025 revealed:-Coding Instructions for H0100C to code if the appliance was used at any time in the 7 days prior to the Assessment Reference Date (ARD).-Coding Instructions for N0350A to code or enter the number of days during the 7 days prior to the ARD that an insulin injection was received. A.Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 1 on 04/21/2025 with a diagnosis of Type 2 Diabetes Mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). Record review of Resident 1's Comprehensive MDS dated [DATE] revealed Section H0100C to be coded as the resident had an Ostomy (which is any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste) and Section N0350A was coded with a 1 indicating the resident received an insulin injection once during the 7 days prior to the ARD. Record review of Resident 1's Electronic Medical Health Record (EMHR) on 03/11/2025 revealed no evidence that the resident had an ostomy or orders to receive insulin injections for the period of 12/24/2025 through 12/31/2025 (the 7-day period prior to the ARD). In an interview completed on 03/11/2026 at 11:50 AM with the facility MDSC, the MDSC confirmed that Resident 1 did not have an ostomy and section H0100C of the MDS was coded incorrectly. The MDSC also confirmed that Resident 1 did not receive any insulin injections from 12/24/2025 through 12/31/2025 and section N0350A of the MDS was coded incorrectly. B.Record review of a Clinical Census on 03/10/2026 revealed the facility admitted Resident 63 on 11/07/2024 with a diagnosis of Type 2 Diabetes Mellitus. Record review of Resident 63's Quarterly MDS dated [DATE] revealed Section N0350A was coded with a 1 indicating the resident received an insulin injection once during the 7 days prior to the ARD. Record review of Resident 63's EMHR on 03/11/2025 revealed no evidence that resident had orders to receive insulin injections for the period of 01/28/2026 through 02/03/2026 (the 7-day period prior to the ARD). In an interview completed on 03/11/2026 at 11:50 AM with the facility MDSC, the MDSC confirmed that Resident 63 did not receive any insulin injections from 01/28/2026 through 02/03/2026 and section N0350A of the MDS was coded incorrectly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F) Based on record review and interview the facility failed to ensure the Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) reflected a discharge plan and goals for 1 (Resident 11) sampled resident, and accurately reflected a therapeutic diet and antipsychotic medication use for 1 (Resident 53) of 4 sampled residents. The facility census was 71. Findings are:Record review of a facility policy titled Care Plans dated 01/2026 revealed it was the policy of the facility that the Interdisciplinary team was responsible for the development of an individualized person centered comprehensive care plan for each resident. Record review of a facility policy titled admission of a Resident dated 01/15/2026 revealed the interdisciplinary plan of care should be developed within 21 days of admission. A.Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 11 on 01/19/2026 with a diagnosis of stage 3 pressure ulcer (a severe, full thickness wound extending through the skin into the subcutaneous fatty tissue often appearing as a deep crater). Record review of Resident 11's comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 01/26/2026 revealed the resident and/or their significant other provided the information for the MDS and the resident's overall goal was to discharge from the facility into the community. In an interview completed on 03/09/2026 at 11:06 PM with Resident 11, the resident stated that they planned to return to their home after their wound was healed. In an interview completed on 03/10/2026 at 1:46 PM with Resident 11's spouse, the spouse stated that the goal for the resident was for their wound to heal and then to return to their home. Record review of Resident 11's CCP revealed no Focus, Goal, or Interventions addressing the resident's desired discharge plan to return to their home after their wound healed. In an interview conducted on 03/11/2026 at 9:52 AM with the facility's Clinical Care Coordinator (CCC), the CCC stated that Resident 11's discharge plan was undetermined at that time and therefore the resident did not have an active discharge plan. The CCC confirmed that the resident and the resident's spouse wished for the resident to return to their home. The CCC confirmed that Resident 11's CCP did not have a discharge focus, goal, or interventions and should have. In an interview completed on 03/11/2026 at 12:51 PM with the facility Director of Nursing (DON), the DON confirmed that Resident 11 did not have a discharge plan in their care plan and should have. B.Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 53 on 09/19/2025 with a diagnosis of Epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain). Record review of Resident 53's Quarterly MDS dated [DATE] revealed the resident did not have any signs or symptoms of possible swallowing disorders and received a mechanically altered diet. Record review of Resident 53's CCP on 03/10/2026 revealed a focus of the resident having the potential of a nutritional problem due to rhabdomyolysis (a severe condition caused by muscle breakdown that releases toxins into the blood that can lead to kidney failure), epilepsy, bipolar disorder (a mental health condition characterized by extreme shifts in mood energy and activity levels ranging from manic highs to depressive lows), hypothyroidism (low thyroid hormone levels), and adult failure to thrive. It was documented that the resident had a no added salt diet with a mechanical soft texture and was drinking thin liquids. The resident was provided with a scoop plate and drinks in handled cups. The goal was for the resident to maintain adequate nutritional status and the last revision date was 02/18/2026. In an interview completed on 03/09/2026 at 2:41 PM with Resident 53, Resident 53 stated that they did not have any teeth or dentures. The resident stated that they had been getting a baby food diet and did not like it (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and wanted to eat regular food again. Record review of Resident 53's Physician Order Summary on 03/10/2026 revealed the resident had physician orders to receive a no salt added, pureed texture diet, dated 02/20/2026. In an interview completed on 03/10/2026 at 11:26 AM with Licensed Practical Nurse I (LPN-I), LPN-I stated that Resident 53's diet was changed to a pureed diet due to coughing during meal time. The LPN confirmed the physician's order was for the resident to receive a puree diet. In an interview completed on 03/10/2026 at 12:12 PM with the facility Clinical Care Coordinator (CCC), the CCC confirmed that Resident 53's care plan did not accurately reflect their current diet order of a pureed diet. The CCC confirmed that changes in a resident's diet should be on the resident's care plan. C.Record review of Resident 53's Quarterly MDS dated [DATE] revealed the resident received routine antidepressant and antipsychotic medication. Record review of Resident 53's Physician Order Summary on 03/10/2026 revealed the resident had physician orders to receive Buspirone (an antidepressant medication) once daily, and Risperidone (a antipsychotic medication) every evening. Record review of Resident 53's Electronic Medication Administration Record (EMAR) on 03/10/2026 revealed that Resident 53 had been receiving the antipsychotic medication as ordered since admission to the facility. Record review of Resident 53's CCP on 03/10/2026 revealed a focus of the resident having a psychosocial wellbeing problem due to their diagnosis of bipolar disorder with a last revision date of 11/26/2025. There was an intervention which stated to administer an antidepressant medication with a revision date of 11/26/2026. There was no evidence of the resident's antipsychotic medication use or the need to monitor for possible side effects on the care plan. In an interview completed on 03/10/2026 at 3:20 PM with the CCC, the CCC confirmed that the resident's use of the antipsychotic medication and possible side effects to monitor for were not listed on the resident's care plan and should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Licensure Reference Number 175 NAC 12-006.09 Based on record review and interviews, the facility failed to follow physician/providers orders for the administration of an as needed medication for 1 (Resident 11) of 1 sampled residents. The facility census was 71. Findings are:Record review of a Clinical Census dated 03/09/2026 revealed that the facility admitted Resident 11 on 01/19/2026 with diagnosis of orthostatic hypotension (a significant drop in blood pressure that occurs within 3 minutes of standing up, leading to dizziness, lightheadedness, or fainting). Record review of Resident 11's undated Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed a focus of the resident being at risk for falls due to hypotension with the latest revision date being 02/19/2026. Record review of Resident 11's Physician Order Summary dated 03/10/2026 revealed an order for Midodrine (a medication used to treat orthostatic hypotension) with direction to administer 1 tablet by mouth every 8 hours as needed for hypotension. The order had a start date of 2/6/2026 and stated to give the medication if the resident's blood pressure was below 100. Record review of Resident 11's Medication Administration Record (MAR) and blood pressure summary for the month of February 2026 revealed the following:-On 02/10/2026 at 8:24 AM the resident had a blood pressure reading of 75/48. There was no evidence of the resident's as needed Midodrine being administered.-On 02/11/2026 at 8:12 AM the resident had a blood pressure reading of 92/57. There was no evidence of the resident's as needed Midodrine being administered.-On 02/11/2026 at 8:28 PM the resident had a blood pressure reading of 98/62. There was no evidence of the resident's as needed Midodrine being administered.-On 02/12/2026 at 8:45 AM the resident had a blood pressure reading of 86/57. There was no evidence of the resident's as needed Midodrine being administered.-On 02/13/2026 at 9:15 AM the resident had a blood pressure reading of 96/64. There was no evidence of the resident's as needed Midodrine being administered.-On 02/13/2026 at 7:19 PM the resident had a blood pressure reading of 94/58. There was no evidence of the resident's as needed Midodrine being administered.-On 02/15/2026 at 8:57 AM the resident had a blood pressure reading of 82/54. There was no evidence of the resident's as needed Midodrine being administered.-On 02/18/2026 at 8:27 AM the resident had a blood pressure reading of 73/44. There was no evidence of the resident's as needed Midodrine being administered.-On 02/18/2026 at 7:09 PM the resident had a blood pressure reading of 80/50. There was no evidence of the resident's as needed Midodrine being administered.-On 02/20/2026 at 8:26 AM the resident had a blood pressure reading of 92/62. The MAR revealed the as needed Midodrine medication was administered with effective results documented and a blood pressure of 81/53. There was no evidence of an additional dose being administered for the continued blood pressure below 100.-On 02/22/2026 at 8:16 AM the resident had a blood pressure reading of 91/57. There was no evidence of the resident's as needed Midodrine being administered.-On 02/23/2026 at 8:16 AM the resident had a blood pressure reading of 95/63. There was no evidence of the resident's as needed Midodrine being administered.-On 02/25/2026 at 8:51 AM the resident had a blood pressure reading of 86/54. There was no evidence of the resident's as needed Midodrine being administered.-On 02/25/2026 at 7:35 PM the resident had a blood pressure reading of 99/76. There was no evidence of the resident's as needed Midodrine being administered.-On 02/26/2026 at 10:46 AM the resident had a blood pressure reading of 88/63. There was no evidence of the resident's as needed Midodrine being administered. Record review of Resident 11's Medication Administration Record (MAR) and blood pressure summary for the month of March 2026 through 3/10/2026 revealed the following:-On 03/01/2026 at 9:06 AM the resident had a blood pressure reading of 76/50. There was no evidence of the resident's as needed Midodrine being administered.-On 03/01/2026 at 10:48 AM the resident had a blood pressure reading of 95/60. There was no evidence of the resident's as needed Midodrine being administered.-On 03/02/2026 at 8:54 AM the resident had a blood pressure reading of 92/66. There (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285246	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Homes Health Care Center	1923 West 4th Avenue Holdrege, NE 68949

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no evidence of the resident's as needed Midodrine being administered.-On 03/03/2026 at 9:33 AM the resident had a blood pressure reading of 86/62. There was no evidence of the resident's as needed Midodrine being administered.-On 03/03/2026 at 10:33 AM the resident had a blood pressure reading of 75/49. There was no evidence of the resident's as needed Midodrine being administered.-On 03/03/2026 at 7:12 PM the resident had a blood pressure reading of 88/52. There was no evidence of the resident's as needed Midodrine being administered.-On 03/04/2026 at 8:46 AM the resident had a blood pressure reading of 95/63. There was no evidence of the resident's as needed Midodrine being administered.-On 03/04/2026 at 8:02 PM the resident had a blood pressure reading of 99/60. There was no evidence of the resident's as needed Midodrine being administered.-On 03/05/2026 at 9:00 AM the resident had a blood pressure reading of 96/62. There was no evidence of the resident's as needed Midodrine being administered.-On 03/06/2026 at 8:22 AM the resident had a blood pressure reading of 84/56. There was no evidence of the resident's as needed Midodrine being administered.-On 03/08/2026 at 10:29 AM the resident had a blood pressure reading of 94/62. There was no evidence of the resident's as needed Midodrine being administered.-On 03/09/2026 at 8:35 AM the resident had a blood pressure reading of 88/56 There was no evidence of the resident's as needed Midodrine being administered.-On 03/10/2026 at 9:00 AM the resident had a blood pressure reading of 70/46. There was no evidence of the resident's as needed Midodrine being administered. In an interview completed on 03/10/2026 at 9:37 AM with Licensed Practical Nurse I (LPN-I), LPN-I stated that either the nurse or the medication aide obtains Resident 11's blood pressure daily. The LPN stated that the residents suffered from hypotension, so they monitor it. The LPN stated if the result is a low blood pressure, then they tell the resident to be careful when sitting, standing, or walking and remind them to use the call light and not transfer alone to prevent falls. The nurse denied knowledge of the resident having an order for an as needed medication to be administered to the resident for a blood pressure below 100. The LPN reviewed Resident 11's physician orders and confirmed that the resident was to receive the as needed Midodrine medication for blood pressures below 100 and had not been. In an interview completed on 03/11/2026 at 11:56 AM with the facility Clinical Care Coordinator (CCC), the CCC confirmed that Resident 11 had an order to receive the Midodrine medication as needed for blood pressures less than 100 and this was not being administered as ordered by the provider. In an interview completed on 03/11/2026 at 2:40 PM with the facility Director of Nursing (DON), the DON confirmed the resident's blood pressure readings of less than 100 being recorded and no documentation of the as needed Midodrine medication.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Licensure Reference Number 175 NAC 12-006.15 Based on record review and interview the facility failed to identify a resident's preference to, or not to, have dental services on admission to the facility for 1 (Resident 53) of 1 sampled residents. The facility census was 71. Findings are:Record review of a facility policy titled Dental Services and dated 01/2026 revealed it was the policy of the facility to assist the residents to obtain routine and emergency dental care. The resident and or their representative during the admission process are notified of dental services available under the State Plan, and of the potential charges that may apply in case of routine or emergency dental care provided by outside resources. An interview completed on 03/09/2026 at 2:41 PM with Resident 53 revealed that the resident was getting a food texture that they did not like due to not having any teeth. The resident stated that they previously had dentures for a long time and was not sure how long it had been since they used dentures. The resident stated the dentures stopped fitting a while ago so they just stopped wearing them. The resident stated they were not offered dental services on admission and would like to see if they can get new dentures so they can eat regular food again. In an interview completed on 03/10/2026 at 11:05 AM with Licensed Practical Nurse I (LPN-I), LPN-I stated that Resident 53 was edentulous and did not have dentures on admission to the facility, the nurse stated that the resident was on a modified texture diet due to coughing and choking at meals and stated they were aware that the resident did not like the modified texture diet. The LPN was unaware of why/if the resident had dentures before and the resident did not have a dental appointment that the nurse was aware of. In an interview completed on 03/10/2026 at 2:59 PM with the facility Social Service Director (SSD), the SSD stated that they ask residents about dental services during the admission process to the facility but they did not ask Resident 53 if they wanted dental services upon admission and should have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18(D) Based on record review and interview, the facility failed to perform hand hygiene between glove changes during completion of catheter care and wound care for 1 (Resident 11) of 1 sampled resident. The facility census was 71. Findings are:Record review of a facility policy titled Hand Hygiene dated 01/2026 revealed it is the policy of the facility that all staff will perform proper hand hygiene procedures to prevent the spread of infection, and it applies to all staff working in all locations within the facility. The policy stated that hand hygiene should be performed after removing gloves and prior to applying new gloves. Record review of a Clinical Census on 03/10/2026 revealed that the facility admitted Resident 11 on 01/19/2026 with a diagnosis of stage 3 pressure ulcer (which is a severe, full thickness wound extending through the skin into the subcutaneous fatty tissue often appearing as a deep crater). Record review of Resident 11's Order Summary revealed the resident had provider orders dated 01/19/2026 stating to complete a dressing change to the resident's right buttock, directions to remove the old dressing including packing strip, and to cleanse the wound with wound cleanser. To saturate, place gauze packing strip in Vashe (a hypochlorous acid wound cleanser) wound solution and gently pack the gauze into the wound bed and cover the wound with a 4X4 gauze secured with a Mepilex (a type of bordered foam adhesive) dressing. In an observation completed on 03/11/2026 from 9:48 AM to 10:15 AM the following was observed during wound care being provided by Licensed Practical Nurse I (LPN-I) for Resident 11:-The LPN placed the wound care supplies directly onto Resident 11's bed without the benefit of a barrier being placed, then provided supra pubic catheter care to Resident 11 with gloved hands. The LPN then removed their gloves and assisted the resident to roll onto their left side. The LPN obtained gloves from a box sitting directly on the resident's bed and placed the gloves on each hand without first performing hand hygiene. The LPN then assisted with pulling down the resident's pants and unfastening the resident's incontinence brief. -The LPN removed the soiled dressing from the resident's right buttock wound and placed it on the resident's unfastened incontinence brief. The LPN removed their gloves from their hands and got another pair of gloves from the box placed on the resident's bed. The LPN then placed the new gloves onto both of their hands without first performing hand hygiene. -After cleansing Resident 11's wound, the LPN removed their gloves from both of their hands and put on a new pair of gloves from the box on the bed without first performing hand hygiene. The LPN then picked up a Q-Tip off of a clear measurement device that was sitting directly on top of the resident's bedding and used the wooden blunt end of the Q-Tip to place a packing strip into the resident's wound, packing the area of depth that the LPN had previously measured with the cotton-tipped end of the Q-Tip. -The LPN then used the clear plastic measuring device that had been laying directly on top of the residents' bed with the soiled cotton tipped Q-Tip on top of to measure the resident's wound. The LPN placed the clear plastic measuring device directly onto the wound and the surrounding skin. The LPN then removed their gloves and put another pair of gloves out of the box placed on the bed without first performing hand hygiene. In an interview completed on 03/11/2026 at 10:16 AM with LPN-I, LPN-I confirmed that hand hygiene should have been completed when removing gloves and prior to putting on new gloves. In an interview completed on 03/11/2026 at 10:16 AM with the facility Clinical Care Coordinator, the CCC confirmed that hand hygiene should be completed after removing gloves and before placing new gloves on.