STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285256	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball County Manor	810 East 7th Street Kimball, NE 69145

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.11(E)Based on observation, record review, and interview, the facility failed to date stored foods, and failed to ensure proper hand hygiene was performed to prevent the potential for cross contamination and food borne illness. Findings are: Observations made at 8:00 AM on 6/22/26 during the initial kitchen tour revealed the following:-A container of chicken base with no open, use by, or expiration date.-10 ceiling panels with water damage and staining and 1 ceiling tile with a hole in it-1 box baking soda w/o open date in a sealed Ziploc bag-4 boxes of krusteaz cornbread mix with no best by date, received date or expiration date.-1 box buttermilk biscuit mix open without an opened date marked-8 bottles of ketchup with no receive date or expiration date. -1 box of individual [NAME] mayo packets with no open, use-by, or expiration date-1 gallon of dill pickle relish with no open, use-by, or expiration date-1 gallon of miracle whip with a best-by date listed at 5/18/26-Four, 7-pound cans of banana pudding with open, use-by, or expiration dates-Two, 104-ounce cans apricot halves with open, use-by, or expiration dates-Five, 6.63-pound cans of apples with no open, use-by, or expiration dates-Four, 116-ounce cans of cherry pie filling with no open, use-by, or expiration date-4 loaves of bread in a white freezer with no use-by, or expiration date- 1 loaf of bread, opened with no opened, use-by, or expiration date.-1 Ziploc bag with 4 rolls/buns inside with no open, use-by, or expiration date-1 bag of long rolls with no open, use-by, or expiration date-2 separate half gallons of almond milk with expiration dates of 4/13/26-1 full unopened gallon and 1 partially used gallon of ice cream mix with best by dates of 6/18/26An interview with the Dietary Manager (DM) at 8:48 AM on 6/22/26 confirmed the expiration dates on the items listed above and discarded them. Continuous observations made on 6/23/26 from 9:14 AM to 10:30 AM revealed the following:-At 9:19AM the DM performed hand hygiene for 3 seconds with soap and water and then stated they were going to grab soap because they were out of it at the hand-washing sink. At 9:20 AM an observation of the soap dispenser at the hand-washing sink revealed there was no soap in it. The DM returned with new bag of soap and refilled the dispenser and then performed hand hygiene for 15 seconds. At this time the Dietary Aid (DA)-F performed hand hygiene with soap and water for 12 seconds.-At 9:26 the DM prepared 3 basins of vegetables and then performed hand hygiene with soap and water for 10 seconds. The DM then donned gloves and cut through butter with the wrapper still on, then removed the wrapper and cut the butter into smaller chunks with the same knife and added the pieces of butter to each basin of vegetables. The DM put the remaining butter away, removed their gloves and performed hang hygiene with soap and water for 13 seconds.-At 10:16 AM the DM walked into the bathroom with their kitchen apron on. An interview at 9:31 AM on 6/23/26 with the DM confirmed they should wash their hands for probably 30 seconds.Record review of a facility policy dates 2/27/23 and labeled 'Handwashing/hand hygiene' revealed information about when to wash hands using either 62% alcohol-based hand rub or soap and water. This includes washing hands before and after the use of gloves and before and after handling foods. This policy also revealed that hands should be washed for a minimum of 15 seconds when using soap and water.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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(E) Based on record review and interview, the facility failed to obtain informed consents from the resident or their representative prior to the use of psychotropic medication for 5 (Residents 1, 6, 7, 8, & 31) of 5 sampled residents. The facility identified a census of 39. Findings Are: An interview on 6/23/26 at 1:20 PM with the facility Administrator revealed the facility did not have any policies specific to psychotropic medications and confirmed that the facility had not obtained informed consents prior to the administration of psychotropic medications for any residents who were currently prescribed psychotropic medications. A. A record review of Resident 1's Continuity of Care Document dated 6/24/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's Medication Order revealed the resident had an order for mirtazapine (an antidepressant medication) 7.5 milligrams (mg) daily for a diagnosis of depression. The order had a start date of 3/3/2026. A record review of Resident 1's medical records revealed no evidence of the resident or their representative being informed in advance of the risks, benefits, and alternative treatment options for the mirtazapine medication. B. A record review of Resident 31's Continuity of Care Document dated 6/24/2026 revealed the resident was admitted to the facility on [DATE]. The document also revealed the resident had an order for Paxil (an antidepressant medication) 20mg to be taken at bedtime for a diagnosis of depression. The order had a start date of 6/6/2025. A record review of Resident 31's medical records revealed no evidence of the resident or their representative being informed in advance of the risks, benefits, and alternative treatment options for the Paxil medication. C. Record review of Resident 6's face sheet, dated 6/24/26, revealed an original admission date of 9/12/25 and the following relevant diagnoses: -Depression, unspecified Record review of Resident 6's undated Continuity of Care Document dated 6/24/25 revealed an order for Seroquel (atypical antipsychotic prescription medication used to treat schizophrenia, bipolar disorder (both manic and depressive episodes), and as an add-on treatment for major depressive (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder) 100milligram (mg) tablet, take twice a day for: Depression, unspecified, with a start date of 2/1/2026, and Duloxetine(a prescription medication used to treat depression, anxiety, and various forms of chronic pain) 30mg capsule delayed release, take twice a day for: Depression, unspecified, with a start date of 2/5/26. Record review of Resident 6's care plan with a last conference care date of 6/8/26, revealed a problem start date of 9/12/25 for: Category: Psychotropic Drug Use Resident has Depression and takes Duloxetine 30 mg twice a day (bid) and Seroquel 100mg bid. The following relevant approaches were listed with a start date of 9/12/25: - Assess for mood/behavior problems. - Attempt non-pharmacological interventions such as music, repositioning, new environment, pet therapy, take resident outdoors. - Convey an attitude of acceptance toward the Resident. - Report emergence of signs of isolation (e.g., sad, dull affect; non-communicative; withdrawn; lack of eye contact; expressions of loneliness/rejection; hostile, irritable behavior; lack of awareness of surroundings; inattention to self-care; etc.). The following approaches were listed with a start date of 2/10/26 - Acknowledge to the Resident that the current situation must be difficult. - Closely supervise resident. - Restrict access to potentially harmful items (e.g., glass, scissors, needles, razors, plastic bags, lighters, hangers, knives, medications, call light cords, electrical appliances, etc.). Continued record review of Resident 6's Electronic Medical Record (EMR) revealed there was no consent for the use of psychotropic medications or documentation of alternative treatment options and education. On 6/23/2026 at 1:20 PM an interview was conducted with the facility administrator. During the interview the facility Administrator reported having consent forms, however, the consent forms were not implemented for the use of psychotropic medications. D. Record review of Resident 7's face sheet, dated 6/25/26, revealed an original admission date of 6/14/17 and the following relevant diagnoses: - Dementia in other diseases classified elsewhere, unspecified severity, with agitation - Depression, unspecified Record review of Resident 7's undated Continuity of Care Document revealed an order for Mirtazapine (a prescription antidepressant primarily used to treat major depressive disorder) 15 mg, 1 tablet at (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedtime, with a start date of 10/8/2023. Record review of Resident 7's care plan with a last care conference date of 4/9/26 revealed the following problems: -a problem start date of 6/22/17 for: Category: Psychosocial well-being, Level II PASRR as evidenced by Depression, Parkinsons with Dementia/Psychosis. Mirtazapine 15mg at bedtime (hs) for depression. -a problem star date of 6/22/17 for: Category: Psychotropic Drug Use Resident has potential for adverse consequences while receiving antidepressant medication R/T DX: Depression, Parkinsons with Dementia/Psychosis. Currently takes Mirtazapine 15 mg at HS. This listed problem also revealed the following relevant approaches: - Approach Start Date: 06/27/2025 Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. - Approach Start Date: 06/27/2025 Attempt non-pharmacological interventions such as: music, repositioning, new environment, pet therapy and taking resident outdoors. - Approach Start Date: 06/27/2025 Pharmacy consultant review. - Approach Start Date: 03/28/2018 Observe for and report S/S of worsening depression (increased irritability, anxiousness, sadness, restlessness, tearfulness, frustration, anxiety, agitation, anger, difficulty sleeping, decreased energy, difficulty concentrating, remembering, making decisions, angry outbursts, increased aches/pain, appetite and/or weight changes) - Approach Start Date: 06/22/2017 Administer/record/adjust for depression medications as ordered by physician. Evaluate/record/report effectiveness and any adverse side effects. - Approach Start Date: 06/22/2017 Assess/record effectiveness of drug treatment. Observe for and report signs of sedation, hypotension, or anticholinergic symptoms (constipation, blurred vision, drowsiness, increased confusion, tremors, lip-smacking, involuntary tongue movement, shuffling gait). Continued record review of Resident 7's EMR revealed there was no consent for the use of psychotropic medications or documentation of alternative treatment options and education. On 6/23/2026 at 1:20 PM an interview was conducted with the facility administrator. During the interview the facility Administrator reported having consent forms, however, the consent forms were not implemented for the use of psychotropic medications. E. Record review of Resident 8's face sheet, dated 6/23/26 revealed an original admission date of: 12/9/22, with the following relevant diagnosis: - Schizophrenia, unspecified (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 8's undated Continuity of Care Document revealed the following relevant orders; - Risperidone (atypical (second-generation) antipsychotic medication used to help stabilize thinking, mood, and behavior.) 0.5 mg tablet Twice A Day for Schizophrenia, unspecified - Lexapro (escitalopram oxalate; a widely prescribed prescription antidepressant belonging to the selective serotonin reuptake inhibitor (SSRI) class used to treat major depressive disorder (MDD) and generalized anxiety disorder (GAD)) 10 mg tablet. Record review of Resident 8's care plan with a last care conference date of 5/21/26 revealed a problem start date of 12/19/22 Category: Psychotropic Drug Use Resident receives antipsychotic medication Risperidone 0.5 mg BID for DX of Schizophrenia. Also receives Lexapro 10 mg daily. This problem has the following listed approaches: - Approach Start Date: 08/08/2025 Attempt non-pharmacological interventions such as music, repositioning, new environment, pet therapy, taking resident outdoors. - Approach Start Date: 04/21/2025 If resident appears to be overstimulated, move resident to a new environment that is not as busy and is quieter. - Approach Start Date: 12/19/2022 Assess if the resident's behavioral symptoms present a danger to the resident and/or others. Intervene as needed. - Approach Start Date: 12/19/2022 Attempt yearly GDR thereafter unless clinically contraindicated. - Approach Start Date: 12/19/2022 Pharmacy consultant review Continued record review of Resident 8's EMR revealed there was no consent for the use of psychotropic medications or documentation of alternative treatment options and education. On 6/23/2026 at 1:20 PM an interview was conducted with the facility administrator. During the interview the facility Administrator reported having consent forms, however, the consent forms were not implemented for the use of psychotropic medications.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.09Based on record review and interview the facility failed to notify the provider of blood pressures being outside the set parameters per their order for 3 (Residents 5,6, and 31) of 5 sampled. The facility showed a census of 39Findings are: A. Record review of a facility policy with a revision date of 2/28/25 and a subject label of ' Notification of Physicians' revealed the following statements:The nurse will notify the resident's attending physician or physician on call when there has been:- specific instruction to notify the physician of changes in the residents condition-A significant change of condition is a major decline or improvement in the resident's status that: a.) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting)b.) impact more than one area of the residents healthc.) requires interdisciplinary review and/or revision to the care plan,. -The nurse will record in the resident's medical record information relative to changes in the residents medical/mental condition or statusThe nursing personnel at this facility are responsible for notification of the physician of the above information. All attempts to notify physicians will be noted in the residents' health record including the time and method of communication. If the physician is not contacted, the individual acknowledging contact, if any, will be documented. If the attending physician or his designee is not readily available, emergency medical care will be provided and emergency physicians contacted. Record review of Resident 6's face sheet, dated 6/24/2026, revealed an original admission date of 9/12/2025 with the following relevant diagnoses: -Hyperlipidemia, unspecified (high cholesterol) -Essential (primary) hypertension (High blood pressure with an unknown cause) -Cerebral infarction, unspecified (stroke caused by a clot in the brain) -Pain in left shoulder -Other abnormalities of gait and mobility -Repeated falls -Weakness -Dizziness -Abnormal results of thyroid function studies A Record review of Resident 6's care plan with a 'last review' date of 6/8/26 revealed a problem of: 'Category: Medical Condition; Resident is at risk for unstable blood pressure related to hypertension' with a problem start date f 9/12/25. The Goal listed for this problem revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 'Resident's Systolic pressure will not be greater than 180 or lower than 90 and her Diastolic pressure will not be greater than 100 or lower than 60' with a start date of 9/10/26. The relevent approaches listed for this goal revealed the following: -Administer medications as ordered by provider- Hydrochlorothiazide 25mg daily and Clopidogrel 75 mg daily. Evaluate/record/report effectiveness/adverse side effects with a start date of 9/12/25. Resident 6's care plan also revealed a problem of: 'Category: Falls Resident at risk for falling R/T dizziness and giddiness, unsteadiness on feet, Osteoarthritis, low back pain, Abnormalities of gait and mobility, Spondylosis with Myelopathy of lumbar region and weakness and repeated falls. High fall risk' with a problem start date of 9/12/25. Record review of a progress note dated 2/20/26 revealed: .It was reported that the resident has always had very high blood pressure and that (gender) is very high fall risk with 'normal' blood pressure range-(gender) gets lethargic and behaves not within normal limits (WNL). Record review of a 'Doctors order sheet' dated 9/12/26 revealed a note: Patient (Pt) has been severely hypertensive. Rapid correction is hazardous. Be permissive of Hypertension (HTN). Primary care provider (PCP) to slowly correct. Record review of Resident 6's order report dated 6/25/2025 revealed the following relevant orders and changes since their admission on [DATE]: Start date 9/11/25, Contact provider if Systolic blood pressure (the top number in a blood pressure reading,) is greater than 180 or less than 90 OR Diastolic blood pressure (the bottom number in a blood pressure reading) is greater than 100 or less than 60. Start date 2/20/26, Hydrochlorothiazide tablet, 25mg oral, HOLD if systolic is under 140 and had no end date when the order would be discontinued. Start date 9/13/25, Lisinopril (a blood pressure medication that works by blocking a substance that causes blood vessels to tighten) tablet, 5mg oral, once a day 7:00 AM. Discontinued on 10/28/25. Start date, 2/23/26, Lisinopril tablet, 20mg oral, once a date 7:00 AM. HOLD if systolic is less than 140. Discontinued 2/23/26 Start date 2/24/26, Lisinopril tablet, 20mg oral, once a day 7:00 AM. HOLD if systolic is under 140. There is no end date on this order Record review of Resident 6's administration records and vitals since admission on [DATE] in the electronic medical record (EMR) revealed the following blood pressures outside the ordered parameters set by the provider on the following dates: -09/27/25 3:57 PM Blood Pressure: 181 (systolic) / 90 (diastolic) -10/2/25 5:40 PM Blood Pressure: 185 / 85 -10/4/25 4:26 PM Blood Pressure: 187 / 80 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/13/25 9:06 AM Blood Pressure: 189 / 88 -10/14/25 7:00 AM Blood Pressure: 186 / 78 -10/15/25 4:16 PM Blood Pressure: 183 / 95 -10/16/25 5:42 PM Blood Pressure: 184 / 95 -10/17/25 4:29 PM Blood Pressure: 188 / 97 -10/20/25 5:43 PM Blood Pressure: 189 / 90 -10/21/25 7:00 AM Blood Pressure: 188 / 98 -10/22/25 7:00 AM Blood Pressure: 192 / 75 -10/22/25 5:28 PM Blood Pressure: 180 / 109 -10/23/25 7:00 AM Blood Pressure: 196 / 92 -10/23/25 4:42 PM Blood Pressure: 185 / 90 -10/25/25 10:36 AM Blood Pressure: 181 / 98 -10/25/25 11:45 AM Blood Pressure: 192 / 84 -10/27/25 7:00 AM Blood Pressure: 194 / 72 -10/27/25 8:45 AM Blood Pressure: 194 / 72 -10/27/25 4:04 PM Blood Pressure: 196 / 90 -10/30/25 11:35 AM Blood Pressure: 181 / 83 -10/30/25 6:44 PM Blood Pressure: 194 / 96 -11/5/25 4:23 PM Blood Pressure: 198 / 100 -11/9/25 6:46 AM Blood Pressure: 195 / 83 -11/10/25 7:00 AM Blood Pressure: 183 / 76 -11/12/25 4:12 PM Blood Pressure: 199 / 105 -11/18/25 7:00 AM Blood Pressure: 189 / 97 -11/19/25 7:00 AM Blood Pressure: 190 / 100 -11/19/25 10:16 AM Blood Pressure: 190 / 100 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11/20/25 7:00 AM Blood Pressure: 192/110 -11/22/25 7:00 AM Blood Pressure: 197 / 93 -11/23/25 7:00 AM Blood Pressure: 187 / 95 -11/25/25 7:00 AM Blood Pressure: 189 / 97 -11/26/25 3:53 PM Blood Pressure: 200 / 98 -12/2/25 3:00 PM Blood Pressure: 189 / 93 -12/3/25 5:39 PM Blood Pressure: 144 / 58 -12/13/25 4:00 PM Blood Pressure: 195 / 94 -12/14/25 4:21 PM Blood Pressure: 188 / 91 -12/17/25 4:09 PM Blood Pressure: 184 / 83 -12/18/25 4:05 PM Blood Pressure: 186 / 79 -12/19/25 10:19 AM Blood Pressure: 190 / 76 -12/20/25 3:00 PM Blood Pressure: 183 / 78 -12/21/25 5:39 PM Blood Pressure: 187 / 104 -12/23/25 7:00 AM Blood Pressure: 182 / 81 -12/23/25 10:53 AM Blood Pressure: 206 / 94 -12/23/25 3:58 PM Blood Pressure: 199 / 93 -12/24/25 6:10 PM Blood Pressure: 221 / 99 -12/25/25 7:00 AM Blood Pressure: 182 / 93 -12/25/25 6:12 PM Blood Pressure: 201 / 98 -12/29/25 11:34 AM Blood Pressure: 190 / 82 -12/29/2025 5:30 PM Blood Pressure: 184 / 86 -12/30/25 4:26 PM Blood Pressure: 190 / 96 -12/31/25 5:40 PM Blood Pressure: 187 / 95 -1/4/26 5:28PM Blood Pressure: 179 / 102 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1/7/26 9:30 AM Blood Pressure: 188 / 84 -1/14/26 4:31 PM Blood Pressure: 185 / 88 -1/15/2026 9:50 AM Blood Pressure: 183 / 95 -1/15/26 5:51 PM Blood Pressure: 188 / 77 -1/17/26 5:54 PM Blood Pressure: 185 / 83 -1/19/26 7:00 AM Blood Pressure: 207 / 94 -1/19/26 4:03 PM Blood Pressure: 189 / 91 -1/20/26 5:41 PM Blood Pressure: 182 / 94 -1/21/26 8:01 AM Blood Pressure: 204 / 102 -1/23/26 7:00 AM Blood Pressure: 187/104 -1/23/26 9:42 AM Blood Pressure: 193 / 87 -1/24/26 4:26 PM Blood Pressure: 180 / 105 -1/25/26 9:03 AM Blood Pressure: 184 / 100 -1/25/26 4:38 PM Blood Pressure: 194 / 100 -1/27/26 10:09 AM Blood Pressure: 182 / 83 -1/27/26 4:16 PM Blood Pressure: 190 / 90 -1/29/26 7:00 AM Blood Pressure: 193 / 106 -1/31/26 7:00 AM Blood Pressure: 205/111 -2/2/26 7:00 AM Blood Pressure: 183 / 83 -2/3/26 10:01 AM Blood Pressure: 209 / 114 -2/3/26 10:17 AM Blood Pressure: 183 / 89 -2/4/26 9:44 AM Blood Pressure: 194 / 83 -2/4/26 3:53 PM Blood Pressure: 191 / 102 -2/5/26 7:00 AM Blood Pressure: 196 / 85 -2/5/26 10:53 AM Blood Pressure: 197 / 70 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-0/12/26 1:31 PM Blood Pressure: 184 / 77 -2/14/26 9:26 AM Blood Pressure: 150 / 103 -2/15/26 11:24 AM Blood Pressure: 184 / 83 -2/15/26 5:43 PM Blood Pressure: 185 / 87 -3/4/26 7:30 AM Blood Pressure: 191 / 91 -3/6/26 7:30 AM Blood Pressure: 190 / 95 -3/7/26 7:30 AM Blood Pressure: 182 / 90 -3/9/26 7:30 AM Blood Pressure: 192 / 103 -3/10/26 7:30 AM Blood Pressure: 201 / 93 -3/10/26 5:46 PM Blood Pressure: 186 / 89 -3/11/26 7:30 AM Blood Pressure: 203 / 74 -3/12/26 7:30 AM Blood Pressure: 185 / 88 -3/14/26 7:30 AM Blood Pressure: 197 / 100 -3/15/26 7:30 AM Blood Pressure: 201 / 84 -3/19/26 7:30 AM Blood Pressure: 201 / 76 -3/20/26 7:30 AM Blood Pressure: 198 / 76 -3/23/26 7:30 AM Blood Pressure: 186 / 105 -3/25/26 7:30 AM Blood Pressure: 189 / 78 -3/26/26 7:18 AM Blood Pressure: 208 / 75 -3/27/26 7:30 AM Blood Pressure: 191 / 93 -3/28/26 9:26 AM Blood Pressure: 182 / 74 -4/1/26 7:30 AM Blood Pressure: 209 / 99 -4/5/26 7:30 AM Blood Pressure: 194 / 109 -4/8/26 4:41 PM Blood Pressure: 189 / 89 -4/9/26 7:30 AM Blood Pressure: 188 / 102 (continued on next page)

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	285256	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball County Manor	810 East 7th Street Kimball, NE 69145

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-4/13/26 12:30 PM Blood Pressure: 100 / 59 -4/14/26 7:30 AM Blood Pressure: 189 / 81 -4/15/26 3:51 PM Blood Pressure: 182 / 91 -4/20/26 7:30 AM Blood Pressure: 188 / 79 -4/22/26 10:23 AM Blood Pressure: 181 / 80 -4/25/26 7:30 AM Blood Pressure: 192 / 96 -4/27/26 7:30 AM Blood Pressure: 185 / 94 -5/4/26 7:30 AM Blood Pressure: 183 / 101 -5/5/26 7:30 AM Blood Pressure: 194 / 84 -5/6/26 7:30 AM Blood Pressure: 196 / 97 -5/8/26 7:30 AM Blood Pressure: 193 / 92 -5/9/26 7:30 AM Blood Pressure: 182 / 78 -5/9/26 9:34 AM Blood Pressure: 183 / 77 -5/11/26 7:30 AM Blood Pressure: 181 / 84 -5/12/26 7:30 AM Blood Pressure: 188 / 74 -5/13/26 7:30 AM Blood Pressure: 199 / 80 -5/15/26 7:30 AM Blood Pressure: 205 / 89 -5/17/26 10:07 AM Blood Pressure: 187 / 72 -5/18/26 10:08 AM Blood Pressure: 170 / 104 -5/19/26 7:30 AM Blood Pressure: 189 / 83 -5/22/26 7:30 AM Blood Pressure: 215 / 96 -5/23/26 7:30 AM Blood Pressure: 188 / 96 -5/23/26 2:08 PM Blood Pressure: 183 / 82 -5/30/26 9:16 AM Blood Pressure: 203 / 104 -6/3/26 4:25 PM Blood Pressure: 182 / 93 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/4/26 7:30 AM Blood Pressure: 183 / 101 -6/5/26 7:30 AM Blood Pressure: 194 / 84 -6/6/26 7:30 AM Blood Pressure: 196 / 97 -6/8/267:30 AM Blood Pressure: 193 / 92 -6/9/26 7:30 AM Blood Pressure: 182 / 78 -6/11/26 7:30 AM Blood Pressure: 181 / 84 -6/12/26 7:30 AM Blood Pressure: 188 / 74 -6/13/26 7:30 AM Blood Pressure: 199 / 80 -6/15/26 7:30 AM Blood Pressure: 205 / 89 -6/17/26 7:30 AM Blood Pressure: 160 / 123 -6/17/26 4:18 PM Blood Pressure: 182 / 81 -6/19/26 7:30 AM Blood Pressure: 189 / 83 -6/22/26 7:30 AM Blood Pressure: 215 / 96 -6/23/26 7:30 AM Blood Pressure: 188 / 96 Record review of a fax sheet dated 2/3/26 revealed: 'Message: Resident 6, DOB; Post fall with neuro x72 hors. Responding WNL.BP 201/109.No current concerns Record review of Resident 6's medical record from 9/11/25 to 6/25/26 revealed no evidence of a provider being notified of their abnormal blood pressures per their provider order. An interview with the Administrator at 2:00 PM on 6/24/25 confirmed there was not notification to the physician per the order every time that Resident 6's blood pressure was outside the set parameters. B. A record review of Resident 5's Continuity of Care Document dated 6/23/2026 revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Essential (primary) Hypertension (elevated blood pressure). A record review of Resident 5's Active Orders revealed the following orders: -losartan (a prescription angiotensin II receptor blocker (ARB) medication primarily used to treat high blood pressure) 100 milligrams (mg) daily, with a start date of 12/1/2025. -metoprolol succinate (an extended-release, once-daily beta-blocker medication used to treat high (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood pressure) 25 mg daily, with a start date of 12/3/2025. -Contact provider if systolic (the top number of a blood pressure) blood pressure is greater than 180 or less than 90 or diastolic (the bottom number of a blood pressure) blood pressure is greater than 100 or less than 60. This order had a start date of 10/16/2024. -Document vital signs (essential clinical measurements that indicate the state of a body's basic functions. The four primary vital signs routinely monitored to assess overall physical health are body temperature, pulse (heart rate), respiration rate, and blood pressure) once a day on Mondays and Thursdays. This order had a start date of 12/13/2025. A record review of Resident 5's Vital Signs documentation revealed the following: -On 4/30/2026 at 11:44 AM the resident had a blood pressure of 93/56. -On 6/8/2026 at 5:50 PM the resident had a blood pressure of 96/58. -On 6/11/2026 at 9:10 AM the resident had a blood pressure of 106/59. A record review of Resident 5's medical records from 4/30/2026 through 6/23/2026 revealed no evidence of a provider being notified of their abnormal blood pressures per their provider order. An interview on 6/24/26 at 7:30 AM with the facility Administrator confirmed the facility did not notify the provider of Resident 5's blood pressures being outside of the set parameters. C. A record review of Resident 31's Continuity of Care Document dated 6/24/2026 revealed the resident was admitted to the facility on [DATE] and had diagnoses of Essential (primary) Hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris (a condition where plaque builds up in the heart's original arteries without causing the classic chest pain known as angina. Also known as silent coronary artery disease, it requires careful management to prevent sudden heart attacks or disease progression), pulmonary heart disease (the enlargement and failure of the right side of the heart. It is caused by underlying lung diseases or high blood pressure in the lungs (pulmonary hypertension), which forces the right ventricle to overwork itself), peripheral vascular disease (a slow, progressive circulation disorder characterized by narrowing, blockage, or spasms in blood vessels outside the heart), and other nonrheumatic pulmonary valve disorders (refers to conditions affecting the heart's pulmonic valve that are unrelated to rheumatic fever). A record review of Resident 31's Active Orders revealed the following: -Contact provider if systolic blood pressure is greater than 180 or less than 90 or diastolic blood pressure is greater than 100 or less than 60. This order had a start date of 4/30/2024. -lisinopril 2.5 mg to be given twice a day with a start date of 2/16/2026. The order had instructions to hold the medication (don't give it) if the resident's systolic blood pressure was less than 90. A record review of Resident 31's Vital Signs documentation revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 3/4/2026 at 10:43 AM the resident's blood pressure was 106/59. -On 4/25/2026 at 3:29 PM the resident's blood pressure was 101/58. -On 5/6/2026 at 11:03 AM the resident's blood pressure was 110/54. -On 6/17/2026 at 10:04 AM the resident's blood pressure was 90/54. A record review of Resident 31's May 2026 Medication Administration Record (MAR) revealed the following: -On 5/8/2026 during the 7:00 AM medication administration time, the resident's blood pressure was 85/50. -On 5/16/2026 during the 7:00 AM medication administration time, the resident's blood pressure was 90/56. -On 5/30/2026 during the 7:00 AM medication administration time, the resident's blood pressure was 85/52. A record review of Resident 31's June MAR revealed the following: -On 6/18/2026 during the 7:00 AM medication administration time, the resident's blood pressure was 93/57. -On 6/20/2026 during the 6:00 PM medication administration time, the resident's blood pressure was 100/57. A record review of Resident 31's medical records from March 2026 through 6/23/2026 revealed no evidence of a provider being notified of their abnormal blood pressures per their provider order.

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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 12-006.18 & (B) & 1-005.06 The facility failed to ensure hand hygiene was performed to prevent the potential for cross contamination during medication administration for 7 Residents (5, 25, 26, 32, 39, 40, and 43) of 7 residents medications administered. The facility showed a census of 39.Findings areRecord review of a facility policy ?Hand Hygiene' dated 2/27/23 revealed information that reads: Use alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations . The relevant situations are as follows:-Before and after coming into direct contact with residents-Before preparing or handling mediations- After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident-After removing glovesContinuous observations made from 7:13 AM until 8:30 AM on 6/24/26 with Medication Aid (MA)B revealed the following:-At 7:13 AM MA-B began preparing medications for Resident 43, then grabbed a spoon and a pulse oximeter from the cart, locked the cart and their computer and walked to the residents room. After knocking, MA-B walked into Resident 43's room and did not perform hand hygiene before walking in. MA-B grabbed the residents water jug and handed it to the resident, then used a spoon to help give the resident their medications. MA-B [NAME] attempted to use a pulse oximeter to measure the residents pulse, which was not working and then took the residents radial pulse manually. MA-B stated the residents pulse, returned to the medication cart to grab one more medication for the resident, then returned to the residents room to give them the last medication. The MA-B then assisted the resident with their foot petals on their wheelchair, and finally left Resident 43's room. MA-B then performed hand hygiene with alcohol-based hand rub at the medication cart. -At 7:31 AM, MA-B began preparing one medication for Resident 5. MA-B brought this resident their medication to their room, watched the resident take it and then returned to the medication cart. MA-B did not perform hand hygiene before entering or leaving the residents room, or when returning to the medication cart to prepare medications for the next resident.-At 7:40 AM, MA-B began preparing one medication for Resident 40. Ma-B brought Resident 40 their medication to their room, knocked on the door and made their presence known while entering Resident 40's room. MA-B assisted this resident with their inhaled medication, holding it to the resident's mouth and giving warning of the medication being administered both times. MA-B then asked the Resident if they needed anything before leaving the room. MA-B did not perform hand hygiene after leaving this residents room or after returning to the medication cart.-At 7:43 AM, MA-B began preparing one medication for Resident 32. MA-B stated this resident refused this medication regularly. MA-B grabbed a bottle of MiraLAX powder from the cart, mixing it with water, and then bringing it to the Resident in the dining area. Resident 32 did refuse this medication. Then MA-B discarded this medication in the medication room. MA-B did not perform hand hygiene after leaving the residents room, discarding the medication, or after returning to the medication cart.At 7:45 AM, MA-B began preparing medications for Resident 25. Once medications were prepared, MA-B brought the medication to the dining hall. MA-B recorded a pulse on this resident using a pulse oximeter, and then gave this resident their medications with a spoon, while Resident 25 drank water to swallow their medications. Once Resident 25 was finished taking all medications, MA-B returned to the medication cart and did not perform hand hygiene.-At 8:17 AM, MA-B began preparing medications for Resident 39. Ma-B grabbed 2 creams out of the cart, and one donned a pair of gloved without performing hand hygiene. MA-B then mixed the 2 creams and then placed cream on Resident 39's back and chest. MA-B then removed their gloves, did not perform hand hygiene and then donned new gloves. MA-B helped hold open Resident 39's eyes while administering eye drops to the resident. Ma-B then removed their gloves and returned to the medication cart and did not perform hand hygiene.-At 8:22 AM, MA-D stated the resident they were giving medications too was in the bathroom and was waiting for the resident to finish. At 8:24 AM MA-D grabbed a pair of gloved and the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medications and proceeded to Resident 26's room. MA-D knocked on the resident's door, making their presence aware and then entered the resident's room, closing the door behind them to provide privacy to the residents. MA-D then [NAME] gloves without performing hand hygiene first, grabbed a Kleenex tissue for the resident, and then placed two eye drops in the bottom lid of the resident's eyes with their gloved hands holding the resident's eyes open.An interview with MA-B at 8:18 AM on 6/24/26 confirmed they were not washing their hands during their medication passes in between residents.An interview with the Administrator at 3:45 PM on 6/24/26 confirmed that staff frequently failed to perform hand hygiene due to not having hand sanitizer readily available at residents' rooms.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(S) Based on observations, interview, and record review; the facility failed to preserve 1 (Resident 27) of 1 sampled resident's dignity by ensuring their catheter bag was concealed when in view of other residents. The facility identified a census of 39.Findings Are: A record review of facility policy Resident Dignity Policy with a review date of 5/15/26 revealed the facility would maintain an environment that preserved each resident's dignity. A record review of Resident 27's Continuity of Care Document dated 6/23/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 27's undated Care Plan revealed the resident required an indwelling urinary catheter related to urinary retention. This section of the Care Plan contained an intervention stating, store collection bag inside a protective, dignity pouch. An observation on 06/23/2026 at 8:15 AM revealed Resident 27 walking out of the dining room and down the 100 hallway. Their catheter bag was hooked to their walker with no dignity bag concealing it. An observation on 06/23/2026 at 8:31 AM revealed Resident 27 in the therapy room sitting in a chair with their walker beside them. Their catheter bag was hanging from the walker without a covering on it and the bag was situated in a manner that the other resident in the room could see the urine in the bag. An observation on 06/23/2026 at 9:54 AM revealed Resident 27 sitting in a recliner in their room with their catheter bag hooked to a trash can. There was no dignity bag on the catheter bag, and the bag was visible from the hallway. An observation on 06/23/2026 at 12:00 PM revealed Resident 27 sitting at a table in the dining room with their catheter hanging from their walker without a dignity bag concealing it. There were several other residents present in the dining room. An observation on 06/24/2026 7:30 AM revealed Resident 27 walking with their walker up the 200 hallway and into the dining room. Their catheter bag was hanging from their walker without a covering on it and there was yellow urine visible in the bag from across the hallway. An observation on 06/24/2026 at 11:25 AM revealed Resident 27 walking from their room to the dining room with their walker. Their catheter bag was hanging from their walker without a cover on it and urine was visible from several feet away. An observation on 6/24/26 at 1:15 PM revealed Resident 27 sitting in their recliner with their catheter bag hooked to the side of their trash can. The bag was visible from the hallway and was not concealed within a dignity bag. An interview on 6/24/26 at 1:58 PM with Nurse Aide (NA)-A confirmed there was no dignity bag concealing Resident 27's catheter bag.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview, the facility failed to ensure 1 (Resident 1) of 5 sampled residents did not suffer adverse consequences from their psychotropic medication as evidenced by increasing Abnormal Involuntary Movement Scale (AIMS, a brief, 12-item clinician-rated examination used to detect and measure the severity of tardive dyskinesia (TD, a neurological movement disorder that causes uncontrollable, repetitive muscle movements, usually in the face, lips, jaw, and tongue)) assessment scores. The facility census was 39.Findings Are: An interview on 6/23/26 at 1:20 PM with the facility administrator revealed the facility did not have any policies specific to the use or monitoring of psychotropic medications. The administrator also revealed the facility performed AIMS assessments on all residents that were taking psychotropic medications. A record review of Resident 1's Continuity of Care Document dated 6/24/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's AIMS assessment dated [DATE] revealed a total score of 0, indicating the resident had no abnormal involuntary movements. A record review of Resident 1's Medication Order revealed the resident had an order for mirtazapine (an antidepressant medication) 7.5 milligrams daily, with a start date of 3/3/2026. A record review of Resident 1's AIMS assessment dated [DATE] revealed a total score of 2 and a severity judgement of minimal. The evaluation section revealed this score was an increase in symptoms compared to the prior assessment. The facility indicated there were no referrals necessary and they would continue the resident's current plan of care. A record review of Resident 1's AIMS assessment dated [DATE] revealed a total score of 4 and a severity judgement of mild. The evaluation section revealed this score was an increase in symptoms compared to the prior assessment. The facility indicated there were no referrals necessary and they would continue the resident's current plan of care. A record review of Resident 1's medical records revealed no evidence of the facility notifying the resident's provider or otherwise addressing the resident's increasing AIMS assessment scores. An interview on 6/24/26 at 7:30 AM with the facility Administrator revealed the nurse conducting the AIMS assessments on Resident 1 had not been aware they needed to do anything with the information gathered during the assessments. The administrator confirmed Resident 1 had been started on mirtazapine on 3/3/2026 and that the resident's provider had not been notified of their increasing AIMS assessment scores.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the Ombudsman (a state official who works with nursing home and assisted living residents who helps answer resident concerns and complaints and advocates for resident rights and their well-being) of 1 (Resident 47) of 1 sampled resident's discharge from the facility. The facility census was 39.Findings Are: A record review of Resident 47's Interdisciplinary Discharge Summary revealed the resident was admitted to the facility on [DATE] following a right hip fracture. The document revealed the resident was later discharged from the facility on 4/1/2026 to their family home. A record review of Resident 47's medical records revealed no evidence of the Ombudsman being notified of their discharge from the facility. An interview on 6/24/26 at 2:45 PM with the facility Administrator confirmed the facility had not notified the Ombudsman of Resident 47's discharge. Per the administrator, the facility only notified the Ombudsman of facility-initiated discharges.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an antibiotic was clinically indicated for 1 (Resident 42) of 1 sampled resident. The facility identified a census of 39.Findings Are: A record review of facility policy Antibiotic Stewardship Program with a review date of 2/14/19 revealed the facility's antibiotic stewardship program promotes the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. Antibiotics will be prescribed for the correct indication, dose, and duration to appropriately treat the resident while attempting to reduce the development of antibiotic-resistant organisms or other adverse consequences or outcomes. In the procedure section it states that the physician will be notified of results of diagnostics to ensure resident is taking the appropriate antibiotic or if antibiotic needs to be discontinued or changed. A record review of Resident 42's Continuity of Care Document dated 6/24/2026 revealed the resident was admitted to the facility on [DATE]. The resident had a diagnosis of Overactive Bladder with an effective date of 3/3/2026. A record review of Resident 42's Provider Visit dated 4/21/2026 revealed the resident was being seen for their 60-day recertification visit. The provider documented that the resident was having urinary frequency and urgency despite being on Myrbetriq (a medication used to treat overactive bladder symptoms) 25 milligrams (mg). The provider increased Resident 42's Myrbetriq dose to 50 mg during this appointment. A record review of Resident 42's Progress Notes from 6/1/2026 through 6/16/2026 revealed no evidence of the resident having urinary frequency, urgency, or painful urination. A record review of Resident 42's Provider Visit dated 6/16/2026 revealed the resident was being seen for their 60-day recertification visit. The provider documented that during the resident's last evaluation, their Myrbetriq had been increased to 50 mg, the resident was presently having frequency and burning sensations, and a urinalysis (UA, a test that evaluates the physical, chemical, and microscopic properties of urine) had not been ordered. The provider wrote in the assessment section Dysuria (pain, burning, or discomfort during urination)-urinalysis with reflex culture ordered and pending. Further record review of Resident 42's Progress Notes from 6/16/2026 through 6/18/2026 revealed no evidence of the resident having any symptoms indicative of a urinary tract infection. On 6/17/2026 there was documentation that a urine sample had been obtained and taken to the laboratory. On 6/19/2026 the facility received a call from the medical clinic and were notified the resident's urinalysis was positive for infection and had been sent to the provider. Later that same day, the facility documented they had received an order for Macrobid (an antibiotic medication) 100 mg twice a day for 7 days for a diagnosis of urinary tract infection. A record review of a Centers for Disease Control (CDC) document titled NHSN Long-term Care Facility Component-Urinary Tract Infection and dated January 2025 revealed in Figure 1: Criteria for Defining Non-Catheter Associated Symptomatic Urinary Tract Infection (SUTI) that one of the required criteria for a urinary tract infection was a positive urine culture with no more than 2 species of microorganisms, at least one of which is a bacterium of greater than or equal to 100,000 CFU/ml (colony-forming units per milliliter, a unit of measurement used in microbiology to estimate the number of viable (living and reproducing) bacteria or fungal cells in a liquid sample). A record review of Resident 42's Urine Culture for the urinalysis obtained on 6/17/2026, revealed the final culture result was dated 6/19/2026 and that the urine grew 10,000-50,000 CFU/ml of Escerichia Coli (a bacteria commonly found in human feces). This is less than the amount of growth required to constitute a urinary tract infection. Further record review of Resident 42's Progress Notes revealed the following:-On 6/19/26 at 11:37 PM staff documented the resident had started their antibiotic that evening, the resident denied burning or painful urination, and their frequency had subsided.-On 6/20/2026 at 2:15 PM staff documented the resident continued to have frequency and went to the bathroom often.-On 6/21/2026 at 10:39 AM staff documented the resident was having less frequency to the restroom and denied any pelvic pain or issues with urination.-On 6/22/2026 at 12:51 AM 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
	285256	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball County Manor	810 East 7th Street Kimball, NE 69145

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the resident denied burning or painful urination and their symptoms were improved. Observations of Resident 42 on 6/23/2026 revealed the following:-At 8:23 AM the resident was sitting on the toilet in their bathroom, and their urine had a foul odor. The resident exited the bathroom at 8:24 AM.-At 8:26 AM the resident stands up from their recliner and goes into the bathroom and sits on the toilet. The resident exited the bathroom at 8:27 AM.-At 10:44 AM the resident walked from the hallway and went into the bathroom and sat on the toilet. The resident exited their bathroom at 10:45 AM and walked into the hallway.-At 10:46 AM the resident went back into their bathroom and sat on the toilet. The resident exited their bathroom at 10:47 AM. Urine was observed in the toilet bowl; there was no toilet paper in the toilet or in the trashcan. Observations of Resident 42 on 6/24/2026 revealed the following: -At 11:14 AM the resident was sitting in their recliner; the resident then stood up and went into the bathroom. At 11:16 AM the resident exited the bathroom and sat back in their recliner.-At 11:24 AM the resident stood up from their recliner and went into the bathroom. Staff entered the resident's room and went into the bathroom with the resident, assisting them to change their incontinence brief. After the toilet use was completed, the resident was assisted to go to the dining room. -At 1:14 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:16 PM and sat in their recliner.-At 1:29 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:30 PM and sat in their recliner.-At 1:32 PM the resident went into their bathroom and then returned to their recliner within the same minute.-At 1:36 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:37 PM and sat in their recliner.- At 1:38 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:39 PM and sat in their recliner.- At 1:43 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:44 PM and sat in their recliner.- At 1:45 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:46 PM and sat in their recliner.- At 1:46 PM the resident went into their bathroom and sat on the toilet just seconds after sitting down in their recliner. The resident exited the bathroom at 1:47 PM and sat in their recliner.- At 1:48 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:49 PM and sat in their recliner.- At 1:50 PM the resident went into their bathroom and then returned to their recliner within the same minute.- At 1:54 PM the resident went into their bathroom and sat on the toilet. The resident exited the bathroom at 1:55 PM and was walking in their room. An interview on 6/15/2026 beginning at 8:45 AM with the facility Administrator and Infection Preventionist (IP) revealed facility staff had reported to them prior to the provider visit rounds on 6/16/2026 that Resident 42 had been more confused, having dysuria, and having increased urination. The IP stated this had then been reported to the provider on 6/16/2026, which then led to the provider ordering the urinalysis to be completed. The administrator and IP confirmed that Resident 42's urine culture grew less than the required 100,000 CFU/mL of bacteria to constitute an infection and necessitate antibiotic use.