STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285263	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westfield Quality Care of Aurora	1313 1st Street Aurora, NE 68818

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on observations, record review, and interview the facility failed to ensure a thorough investigation for 3 of 3 resident to resident abuse incidents affecting Residents 3, 4, 6, 1, and 2; and failed to develop interventions to protect other residents from further adverse behaviors for 2 residents (Residents 6 and 1). The facility census was 54.Findings are:A.Record review of the facility policy titled Abuse, Neglect, and Exploitation dated June 2025 revealed that it is the facility policy to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. Written procedures for investigations include:1- Identifying staff responsible for the investigation.2- Exercising caution in handling evidence.3- Investigating different types of alleged violations.4- Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.5- Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause.6- Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure that all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Efforts include examining the alleged victim for signs of injury, increased supervision, room or staffing changes to protect the resident from the alleged perpetrator, and revision of the resident's care plan. Record review of the admission Record dated 3/4/26 for Resident 4 revealed that Resident 4 admitted into the facility on [DATE] and lives in the facility memory care unit. Diagnoses included dementia, high blood pressure, and osteoporosis. Record review of the admission Record dated 3/4/26 for Resident 3 revealed that Resident 3 admitted into the facility on 6/20/23 and lives in the facility memory care unit. Diagnoses included anxiety disorder, depression, and myalgia (muscle aches and pains). Record review of the progress note dated 9/27/25 at 5:46 PM for Resident 4 revealed thatstaff witnessed Resident 4 walking to the dining room and through the open door. Resident 4 proceeded into the dining room. Staff went to the dining room to check on Resident 4. Staff entered the dining room and heard Resident 4 holler out. Staff witnessed Resident 4 with their pants down with their brief still in place. Resident 4 told the staff member that the other resident had hit them on the bottom and yelled for them to pull their pants up (a resident to resident abuse incident). The residents were separated. Resident 4 was toileted. The other resident returned to their room. 15-minute checks were started on both residents. Record review of the progress note dated 9/27/25 at 6:01 PM for Resident 3 revealed thatstaff witnessed another resident walking to the dining room and through the open door. The other resident proceeded into the dining room. Staff went to the dining room to check on the resident that entered. Resident 3 was in the dining room sitting at table. Staff entered the dining room and heard the other resident holler out. Staff witnessed the other resident with their pants down with their brief still in place. The other resident told the staff member that Resident 3 had hit them on the bottom and that Resident 3 yelled for them to pull their pants up (a resident to resident abuse incident). The residents were separated. The other resident was toileted. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3 returned to their room. 15-minute checks were started on both residents. Record review of the progress note for Resident 4 dated 9/27/25 at 5:49 PM revealed that the nurse called the Adult Protective Services (APS) hotline to report the resident to resident abuse incident. Record review of the facility investigation report dated 9/29/25 revealed that it was for the Resident 3 to Resident 4 abuse incident on 9/27/25. The report documented the incident as a physical altercation that occurred on 9/27/25 at 5:47 PM. The section titled Equipment/Causal factor potentially involved contained no information. The section titled Interventions to prevent the accident/incident from reoccurring revealed that the facility immediately separated the residents and Resident 4 was taken to the bathroom and checked by the nurse. No injuries were noted and both residents were put on 15 minute checks. The investigation report packet contained a copy of progress notes dated 10/1/25 (printed on 10/1/25) for Resident 3 with the progress notes from 9/25/25 at 9:49 AM through 10/1/25 at 5:32 AM. The investigation report packet contained a copy of the care plan for Resident 3. The care plan had an entry dated 9/27/25 that Resident 3 had an altercation with another resident who was trying to void in the dining room. Resident 3 intervened and slapped the resident on the brief and told them to pull their pants up. The facility investigation report contained no documentation of identifying and interviewing any involved persons and witnesses. The investigation report documented the resident to resident incident but did not include investigation of the incident. Interview on 3/4/26 at 5:12 PM with the Facility Administrator (FA) confirmed that the facility did not do interviews with staff or residents for the resident to resident investigation and did not complete and document a thorough investigation for the incident as required. B.Record review of the admission Record dated 3/4/26 for Resident 4 revealed that Resident 4 admitted into the facility on [DATE] and lives in the facility memory care unit. Diagnoses included dementia, high blood pressure, and osteoporosis. Record review of the admission Record dated 3/4/26 for Resident 6 revealed that Resident 6 admitted into the facility on 8/13/25 and lives in the facility memory care unit. Diagnoses include dementia with agitation, major depressive disorder, and Other Conduct Disorders (persistent pattern of behavior that involves severe antisocial actions like aggression and destruction of property).Record review of the progress note for Resident 4 dated10/12/25 at 7:00 PM revealed that the nurse aide witnessed Resident 4 being hit in the upper back by another resident. Resident 4 was in the hallway and was attempting to go into the other resident's room. The nurse aide separated the residents and notified this nurse. Resident 4 was assessed and no marks, redness, or bruising were noted. Resident 4 denied pain. The DON and resident power of attorney were notified. Record review of the progress note dated 10/12/25 at 7:09 PM for Resident 6 revealed that a nurse aide witnessed Resident 6 hit another resident in the upper back. Resident 6 was in the hallway when the other resident began to enter the room of Resident 6. Resident 6 walked up to the other resident and hit them in the back. The nurse aide separated the residents and notified the nurse. Resident 6 was redirected back to their room. The Director of Nursing was notified. Record review of the progress note for Resident 4 dated 10/12/25 at 7:14 PM revealed that the nurse called the Adult Protective Services (APS) hotline to report the resident to resident abuse incident. Record review of the facility investigation report dated 10/14/25 revealed that it was for the Resident 6 to Resident 4 abuse incident on 10/12/25. The report documented the incident as a physical altercation that occurred on 10/12/25 at 6:30 PM. The section titled Equipment/Causal factor potentially involved revealed close quarters with two wandering residents. The section titled Interventions to prevent the accident/incident from reoccurring revealed that the facility would continue separation between the two residents, intervene when they are wandering together with guided distraction. Resident 6 was placed on 15 minute checks. The investigation report packet contained a copy of progress notes dated 10/13/25 for Resident 6 with progress notes from 10/12/25 at 7:09 PM through 10/13/25 at 3:06 AM. The investigation report packet contained a copy of page 4 of 7 of the care plan for Resident 6. The care plan had an entry dated 10/12/25 that read 15 minute checks and monitoring after physical altercation with other residents. The facility investigation report contained no documentation of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identifying and interviewing any involved persons and witnesses. The investigation report documented the resident to resident incident but did not include investigation of the incident. Interview on 3/4/26 at 5:12 PM with the Facility Administrator (FA) confirmed that the facility did not do interviews with staff or residents for the resident to resident investigation and did not complete and document a thorough investigation for the incident as required. C.Record review of the facility policy titled Abuse, Neglect, and Exploitation dated June 2025 revealed that it is the facility policy to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. The section titled Prevention of Abuse, Neglect and Exploitation revealed that the facility will establish a safe environment that supports policies and protocols for preventing sexual abuse. The facility will identify, correct, and intervene in situations in which abuse and neglect are more likely to occur. The facility will assure that staff assigned have the knowledge of the individual resident's care needs and behavioral symptoms. The identification, ongoing assessment, care planning of appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Record review of the admission Record dated 3/4/26 for Resident 2 revealed that Resident 2 admitted into the facility on 9/17/24 and lives in the facility memory care unit. Diagnoses included Alzheimer's Dementia, depression, and high blood pressure. Record review of the admission Record dated 3/4/26 for Resident 1 revealed that Resident 1 admitted into the facility on 1/12/26 and lives in the facility memory care unit. Diagnoses included vascular dementia, anxiety disorder, and stroke. Record review of the progress note for Resident 1 dated 2/4/26 revealed that Resident 1 was being sexually inappropriate to staff and other resident's family members. Resident 1 attempted to reach out and grab a staff member and visitor's breast at two separate times. Resident 1 made a vulgar comment about touching staff member's genitals. Resident 1 was informed that the behavior was inappropriate and staff attempted to redirect Resident 1 away from others. Record review of the progress note for Resident 1 dated 2/6/26 at 9:34 AM revealed that the facility spoke to the nurse practitioner related to Resident 1 having increased inappropriate behaviors of groping others. Record review of the progress note for Resident 1 dated 2/14/26 at 6:30 PM revealed that police arrived at the facility and took a statement from staff regarding an incident. Record review of the progress note for Resident 2 dated 2/16/26 at 12:31 PM revealed that the resident's physician faxed back to the facility regarding incident with another resident on 2/14/26.Record review of the physician notification dated 2/14/26 revealed that Resident 2 was found in the dining room with Resident 1. Resident 1 had their hands in the groin area of Resident 2. Record review of the facility investigation report dated 2/16/26 revealed that it was for the Resident 1 to Resident 2 sexual abuse incident on 2/14/26. The report revealed that on 2/14/26 at 5:10 PM the medication aide notified the nurse that they were needed. The nurse noticed Resident 2 in the dining room sitting on their buttocks with their pants and brief around their knees upon the nurse's arrival. The medication aide explained that Resident 2 did not fall. Resident 2 sat down. The medication aide explained that the medication aide had placed Resident 2 in the dining room for the meal. Resident 1 was in Resident 1's room at that time. The medication aide revealed that they went down the hall to give medication to a resident and brought another resident to the dining room. The medication aide revealed that they witnessed Resident 2 with their pants pushed down and Resident 1 had their hand in Resident 2's groin area. Resident 1 immediately went to their room upon seeing the medication aide return to the dining room. The section titled Equipment/Causal factor potentially involved revealed Leaving resident in dining room by self The section titled Interventions to prevent the accident/incident from reoccurring revealed that the facility immediately separated Resident 1 and Resident 2. Resident 2 was assessed with no injury noted. Resident 2 was assisted to a standing position and redressed. Resident 1 was placed on 15 minute checks. The investigation report packet contained a copy of the 15 minute check logs for Resident 1 dated 2/14/26 through 2/16/26. The investigation report packet contained a copy of page 10 of 13 of the care plan for Resident 1. The care plan had an entry dated 2/14/26 that (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 and Resident 2 were immediately separated. Resident 2 was assessed for injury and none was noted. Resident 1 was put on 15 minute checks. The investigation report packet contained provider recommendations for Resident 1 dated 2/5/26 for medication changes for Resident 1 due to sexual behaviors extending to other residents and family members that visit the memory care unit (this was prior to the 2/14/26 resident to resident sexual abuse incident). The facility investigation report contained no documentation of identifying and interviewing any involved persons and witnesses. The investigation report documented the resident to resident sexual abuse incident but did not include investigation of the incident. Interview on 3/4/26 at 5:12 PM with the Facility Administrator (FA) confirmed that the facility did not do interviews with staff or residents for the resident to resident investigation and did not complete and document a thorough investigation for the incident as required.D.Record review of the facility policy titled Abuse, Neglect, and Exploitation dated June 2025 revealed that it is the facility policy to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse and neglect. The facility will make efforts to ensure that all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Efforts include examining the alleged victim for signs of injury, increased supervision, room or staffing changes to protect the resident from the alleged perpetrator, and revision of the resident's care plan. The section titled Prevention of Abuse, Neglect and Exploitation revealed that the facility will establish a safe environment that supports policies and protocols for preventing sexual abuse. The facility will identify, correct, and intervene in situations in which abuse and neglect are more likely to occur. The facility will assure that staff assigned have the knowledge of the individual resident's care needs and behavioral symptoms. The identification, ongoing assessment, care planning of appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect. Record review of the facility policy titled Dementia Care dated 4/1/25 revealed that it is the facility policy to provide the appropriate treatment and services to every resident who displays sings of, or is diagnosed with, dementia to meet his or her highest practicable physical, mental, and psychosocial well-being. The facility will assess, develop, and implement care plans. The care plan goals will be achievable and the facility will provide resources necessary for the resident to be successful in meeting their goals. The care plan interventions will be related to each resident's individual symptomology. Care and services will be person-centered and reflect each resident's individual goals while maximizing safety. Individualized non-pharmacological approaches to care will be utilized. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed/revised as necessary. All staff will be trained on dementia and dementia care practices to ensure that they have the appropriate competencies and skill sets to ensure resident's safety. Record review of the admission Record dated 3/4/26 for Resident 4 revealed that Resident 4 admitted into the facility on [DATE] and lives in the facility memory care unit. Diagnoses included dementia, high blood pressure, and osteoporosis. Record review of the admission Record dated 3/4/26 for Resident 6 revealed that Resident 6 admitted into the facility on 8/13/25 and lives in the facility memory care unit. Diagnoses include dementia with agitation, major depressive disorder, and Other Conduct Disorders (persistent pattern of behavior that involves severe antisocial actions like aggression and destruction of property).Record review of the progress note for Resident 4 dated10/12/25 at 7:00 PM revealed that the nurse aide witnessed Resident 4 being hit in the upper back by another resident. Resident 4 was in the hallway and was attempting to go into the other resident's room. The nurse aide separated the residents and notified this nurse. Resident 4 was assessed and no marks, redness, or bruising were noted. Resident 4 denied pain. The DON and resident power of attorney were notified. Record review of the progress note dated 10/12/25 at 7:09 PM for Resident 6 revealed that a nurse aide witnessed Resident 6 hit another resident in the upper back. Resident 6 was in the hallway when the other resident began to enter the room of Resident 6. Resident 6 walked up to the other resident and hit them in the back. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse aide separated the residents and notified the nurse. Resident 6 was redirected back to their room. The Director of Nursing was notified. Record review of the progress note for Resident 4 dated 10/12/25 at 7:14 PM revealed that the nurse called the Adult Protective Services (APS) hotline to report the resident to resident abuse incident. Record review of the care plan dated 3/4/26 for Resident 6 revealed that the care plan had an entry dated 10/11/25 that read 30 minute checks and monitoring after physical altercation (this intervention was started prior to the Resident 6 to Resident 4 abuse incident on 10/12/25). The care plan had an entry dated 10/12/25 that read 15 minute checks and monitoring after physical altercation with other residents, ended 11/2/25. The care plan had no new interventions developed and implemented for the 10/12/25 resident to resident abuse to prevent Resident 6 from physically abusing other residents.Record review of the progress note for Resident 6 dated 11/2/25 at 3:04 AM revealed that Resident 6 was knocking on another resident's door. The other resident opened the door. The two residents began to verbally argue. The nurse aide attempted to verbally redirect them but was not effective. Resident 6 then began to punch the other resident. The nurse aide was able to separate the residents when another nurse aide and the nurse entered the memory care unit. Record review of the progress note for Resident 6 dated 12/18/26 revealed that Resident 6 has been physically aggressive this shift. Resident 6 gets upset when seeing other residents walking and talking in the hallway. Record review of the progress note for Resident 6 dated 1/6/26 at 1:05 PM revealed that Resident 6 stood up and punched another resident in the face. Staff immediately intervened and assisted Resident 6 back to their room.Record review of the progress note for Resident 6 dated 2/14/26 at 5:01 AM revealed that Resident 6 showed irritability towards others. Resident 6 became aggressive and was hard to redirect.Record review of the progress note for Resident 6 dated 3/4/26 at 12:18 PM revealed that Resident 6 is always on the go. Observation on 3/4/26 at 11:56 AM in the memory care unit dining room revealed that Resident 6 entered the dining room unattended and walked around. Resident 6 exited the dining room and walked down the hall towards other residents before entering Resident 6's room. Observation on 3/4/26 at 1:21 PM at the memory care dining room revealed that Resident 6 walked unattended into the dining room. Medication Aide-B (MA-B) directed Resident 6 to a chair at a table with Resident 1. Resident 6 sat down in the chair. Interview on 3/4/26 at 4:08 PM with Nurse Aide-C (NA-C) revealed that NA-C was not aware of any care plan interventions to protect other residents from Resident 6. NA-C revealed that staff try to keep Resident 6 within arm's length of staff when Resident 6 is out of their room. Interview on 3/4/26 at 4:55 PM with Medication Aide-D (MA-D) confirmed that there are resident to resident incidents in the memory care unit involving Resident 6. MA-D revealed that staff keep an eye on Resident 6 when Resident 6 gets close to a group of residents to prevent Resident 6 from initiating resident to resident incidents. MA-D revealed that staff stand between Resident 6 and other residents and try to redirect Resident 6.Interview on 3/4/26 at 5:14 PM with the facility Assistant Director of Nursing (ADON) confirmed that the facility did not develop any new interventions beyond the initial actions to prevent resident to resident incidents by Resident 6 after the 10/12/25 resident to resident abuse incident. E.Record review of the admission Record dated 3/4/26 for Resident 2 revealed that Resident 2 admitted into the facility on 9/17/24 and lives in the facility memory care unit. Diagnoses included Alzheimer's Dementia, depression, and high blood pressure. Record review of the admission Record dated 3/4/26 for Resident 1 revealed that Resident 1 admitted into the facility on 1/12/26 and lives in the facility memory care unit. Diagnoses included vascular dementia, anxiety disorder, and stroke. Record review of the progress note for Resident 1 dated 2/4/26 revealed that Resident 1 was being sexually inappropriate to staff and other resident's family members. Resident 1 attempted to reach out and grab a staff member and visitor's breast at two separate times. Resident 1 made a vulgar comment about touching staff member's genitals. Resident 1 was informed that the behavior was inappropriate and staff attempted to redirect Resident 1 away from others. Record review of the progress note for Resident 1 dated 2/6/26 at 9:34 AM revealed that the facility spoke to the nurse practitioner related to Resident 1 having increased inappropriate behaviors of groping others. Record (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the progress note for Resident 1 dated 2/14/26 at 6:30 PM revealed that police arrived at the facility and took a statement from staff regarding an incident. Record review of the progress note for Resident 2 dated 2/16/26 at 12:31 PM revealed that the resident's physician faxed back to the facility regarding incident with another resident on 2/14/26.Record review of the physician notification dated 2/14/26 revealed that Resident 2 was found in the dining room with Resident 1. Resident 1 had their hands in the groin area of Resident 2. Record review of the care plan dated 3/4/26 for Resident 1 revealed that the care plan had an entry dated 2/14/26 that Resident 1 and Resident 2 were immediately separated. Resident 2 was assessed for injury and none was noted. Resident 1 was put on 15 minute checks. The care plan had an entry dated 2/14/26 that an orange magnetic gait was placed in the doorway to keep other residents from entering the room of Resident 1. The care plan had no new interventions developed and implemented for the 2/14/26 resident to resident sexual abuse to prevent Resident 1 from sexually or physically abusing other residents, visitors, or staff.Record review of the progress note for Resident 1 dated 2/17/26 at 6:07 PM revealed that staff had to repeatedly tell Resident 1 to go back to their room and not touch staff and other residents. Record review of the progress note for Resident 1 dated 2/27/26 at 1:27 PM revealed that Resident 1 told the medication aide that the medication aide had a sexy ass. Resident 1 was redirected.Record review of the progress note for Resident 1 dated 3/2/26 at 4:23 PM revealed that Resident 1 approached a staff member and told the staff member to turn around. The staff told Resident 1 that is not appropriate and told Resident 1 to back up. Resident 1 told the staff that they were not moving. Resident 1 told the staff to turn around I need to spank you. The staff member tried again to get Resident 1 to withdraw but Resident 1 continued to refuse. Interview on 3/4/26 at 12:05 PM with Medication Aide-A (MA-A) revealed that Resident 1 continues to have inappropriate behaviors towards staff, residents, and family members. MA-A revealed that staff try not to have their backs towards Resident 1 to protect themselves. MA-A revealed that staff try to keep their eye on Resident 1 to protect other residents and family from inappropriate behaviors by Resident 1. MA-A revealed that Resident 1 is very fast and it is a challenge to keep an eye on Resident 1. MA-A revealed that after medication changes Resident 1 leveled out for a few days but has returned to inappropriate behaviors as prior to the medication changes. MA-A was not aware of any specific care plan interventions for Resident 1 to protect residents, family, and staff from inappropriate behavior. Interview on 3/4/26 at 12:10 PM with Medication Aide-B (MA-B) revealed that Resident 1 was pretty good and not exhibiting inappropriate behaviors for a few days last week but this week Resident 1 is having behaviors. Observation on 3/4/26 at 10:52 AM outside the room of Resident 1 revealed that the orange mesh gate was hanging from the left side of the doorway and was not in place across the doorway. Observation on 3/4/26 at 1:45 PM in the memory care unit dining room revealed that Resident 1 pushed the chair back from the table. Resident 1 stood up and walked out of the dining room. Resident 1 looked down the hallway and then entered Resident 1's room. Interview on 3/4/26 at 4:08 PM with Nurse Aide-C (NA-C) revealed that staff are to document 15 minute checks for Resident 1. NA-C revealed that staff are to be with Resident 1 when Resident 1 is out of their room. NA-C was not aware if this was a care planned intervention for Resident 1. Observation on 3/4/26 at 4:54 PM in the memory care unit revealed that Resident 1 walked from the tv area in the middle of the unit towards the resident's room. Resident 1 was unattended. 4 residents of the opposite sex were seated in the tv area along with 2 staff. Resident 1 entered their room. Interview on 3/4/26 at 5:14 PM with the facility Assistant Director of Nursing (ADON) confirmed that the facility did not develop any new interventions beyond the initial actions to prevent resident to resident incidents by Resident 1 after the 2/14/26 resident to resident sexual abuse incident.