STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285272	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Rest Haven	400 East 7th Street Harvard, NE 68944

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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 inform the resident/resident representative of the benefits, risks, and alternatives prior to the initiation of psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) for 3 of 5 residents (Residents 14, 2, and 7). The facility census was 23.Findings are:A. Record review of the facility policy titled Use of Psychotropic Medications dated 3/11/25 revealed that it is the intent to ensure that residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Psychotropic medications are to be used only when a practitioner determines that the medications are appropriate to treat a resident's specific, diagnosed, and documented conditional and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medications. The resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings prior to initiating or increasing a psychotropic medication. B. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 14 dated 12/11/25 revealed that Resident 14 admitted into the facility on [DATE]. The MDS revealed that Resident 14 took antipsychotic (a psychotropic medication used to manage psychotic disorders), antianxiety, and antidepressant medications since admission into the facility. Diagnoses included anxiety, bipolar disorder, and depression. Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a resident at a facility by a health care professional) for the month of November 2025 for Resident 14 revealed that Resident 14 was administered Clonazepam 1 milligram (mg) (a psychotropic medication for anxiety) for anxiety disorder on 11/28/25, 11/29/25, and 11/30/25. Resident 14 was administered Quetiapine 50mg at bedtime (an antipsychotic medication for bipolar disorder) for bipolar disorder on 11/28/25, 11/29/25, and 11/30/25. Resident 14 was administered Sertraline 25mg (a psychotic medication for depression) for depression on 11/29/25 and 11/30/25. Record review of the medical record for Resident 14 revealed no consent or education provided to Resident 14 prior to the initiation/administration of the psychotropic medications Clonazepam, Quetiapine, and Sertraline. Record review of the Consent for Use of Psychoactive Medication Therapy dated 3/11/26 (3 months and 11 days after the resident admitted into the facility) for Resident 14 revealed that psychotropic medications ordered were Seroquel (Quetiapine), Zoloft (Sertraline), and Clonazepam. The consent listed target behaviors for which the medication was ordered as depression, rejection of cares. The section titled Clinical side effects or risks associated with the medication revealed that (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antipsychotic, antidepressant, and antianxiety were checked. The section revealed that many antipsychotic medications contain additional warnings such as increased mortality (death) in elderly patients with dementia-related psychosis. The section titled Specific condition to be treated revealed that depression was checked. The box for bipolar disorder was not checked. The box titled Other was checked and handwritten next to it was Used for with no clarification of what the other condition was. The consent form contained no information related to alternate treatment alternatives. Interview on 5/26/26 at 4:45 PM with the Facility Administrator (FA) confirmed that the facility did not complete a psychoactive consent for Resident 14's sertraline, quetiapine, or clonazepam until 3/11/26. The FA confirmed that the facility did not have a consent for the use of psychoactive medications prior to administering the medications to Resident 14. Interview on 5/27/26 at 1:25 PM with the FA confirmed that the consent for psychoactive medications for Resident 14 dated 3/11/26 did not address educating the resident/resident representative on alternate treatments and non-pharmacological interventions as required. The FA revealed that the form needed to be modified to include that education to the resident. C. Record review of an admission Record revealed that the facility admitted Resident 7 on 02/13/2026 with diagnosis of Bipolar Disorder(a mental health condition that causes extreme emotional highs and lows) and Schizophrenia (a severe chronic brain disorder that impairs how and individual interprets reality). Record review of the comprehensive MDS dated [DATE] for Resident 7 revealed coding to reflect that Resident 7 received an antipsychotic (a psychotropic medication used to treat or manage psychosis, schizophrenia, bipolar disorder, and severe agitation)medication, an antianxiety (a psychotropic medication used to treat or manage anxiety) medication, and an antidepressant (a psychotropic medication used to treat or manage major depressive disorder, anxiety, PTSD and chronic pain) medication during the 7 day look back period for the assessment. Record review of Resident 7's Medication Administration Record for the Month of February 2026 revealed documentation that Resident 7 was administered Citalopram (an antidepressant medication)10 milligrams every day, Paliperidone (an antipsychotic medication) 6 milligrams every day, Quetiepine (an antipsychotic medication) 25 milligrams on 02/14/2026, 02/18/2026, 02/23/2026, and 02/27/2026, and Trazadone (an antidepressant medication) 100 milligrams on 02/14/2026, 02/18/2026, 02/23/2026, and 02/27/2026. Record review of a facility document titled Consent for use of Psychoactive Medication Therapy and dated 02/26/2026 revealed in the area titled Psychotropic Medication Ordered Elavil (an antidepressant medication), Citalopram (an antidepressant medication), Seroquel (an antipsychotic medication), Trazodone (an antidepressant medication), and Paliperidone (an antipsychotic medication) listed. The form listed the target behavior for which the medications were ordered as Depression. The form listed the clinical side effects or risks associated with the medications. The resident's legal representative consented to the use of the medications as listed and signed and dated the form on 03/04/2026. This was 19 days after the resident was admitted to the facility and the facility started administering the residents' medications. The form did not list the benefits to the use of the medication, the alternative treatment options or choices, and or the specific targeted behaviors (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the use of the medications. In an interview conducted on 05/26/2026 at 10:14 AM with the ADON, the ADON stated that the facility had identified that they were not completing the facilities Psychoactive Medication Therapy form prior to the residents receiving the medication in the facility. The ADON confirmed that the form that the facility was using did not address the benefits to using the medications and the targeted behaviors that the medication was being used for or the alternative treatment options to be attempted and should. The ADON confirmed that the form for Resident 17 was not completed at the correct time and did not contain all the information needed. D.Record review of Resident 2's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 05/16/2026 revealed an admission date of 02/06/2026. The high-risk medications (specific drug classes identified that carry a high risk of causing significant patient harm, adverse effects, or mortality if misused) identified on the MDS were Sertraline (a medication used for depression), Eliquis (a prescription blood thinner), and Aspirin (a medication used to keep platelets from sticking together). Record review of the Order Summary Report revealed the high-risk mediations that were ordered on admission as of 02/06/2026 were Aripiprazole (used to treat mental health and mood condition), which was not noted on the MDS or on the psychoactive consent, Aspirin, Plavix, and Sertraline. Record review of the Order Summary Report revealed the high-risk medications that were active as of 05/21/2026 were Aspirin, Plavix, and Sertraline. Record review of facility policy titled the Use of Psychotropic Medication(s) dated 03/11/2025 revealed that prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives, for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. Record review revealed the Psychoactive Medication Therapy consent was dated and signed on 03/07/2026 by the residents Power of Attorney (POA- a trusted person to make decisions or act on behalf of someone else) and date and signed on 03/11/2026 by the Facility Administrator (FA). There were no noted benefits or alternatives on the consent. An interview with the Assistant Director of Nursing (ADON) and the Interim Director of Nursing (Interim DON) on 05/26/2026 at 10:14 AM revealed there were identified concerns with Psychotropic Consents not completed. The ADON confirmed that the consent should be completed on admission for all residents with medications that are appropriate. The ADON confirmed that original consent on admission for Resident 2 was not completed and then confirmed that there was no psychotropic (the Aripiprazole) checked on the consent.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 3 of 3 sampled residents (Resident 5, Resident 7, and Resident 17) to accurately reflect the medications provided. The facility census was 23.Findings are:Record review of a facility policy titled Conducting and Accurate Resident Assessment and dated 03/11/2025 revealed that all residents were to receive an accurate assessment reflective of the resident's status at the time of the assessment.A.Record review of Resident 5's Comprehensive MDS dated [DATE] revealed Section N0300 Injections was coded to reflect that Resident 5 received one injection during the look back period (the 7 days prior to the assessment reference date of 04/27/2026).Record review of Resident 5's Physician Orders for the month of April 2026 revealed that Resident 5 did not have physician orders to receive any injectable medications or injections during the month of April 2027.Record review of Resident 5's Medication Administration Record (MAR) for the Month of April 2026 revealed no documentation reflecting the resident received an injection or injectable medication during the look back period for the Comprehensive MDS dated [DATE].Record review of Resident 5's Treatment Administration Record (TAR) for the Month of April 2026 revealed no documentation reflecting the resident received an injection or injectable medication during the look back period for the Comprehensive MDS dated [DATE].Record review of Resident 5's Progress Notes for the Month of April 2026 revealed no documentation reflecting the resident received an injection or injectable medication during the during the look back period for the Comprehensive MDS dated [DATE].In an interview completed on 05/26/2026 at 4:05 PM with the facility Assistant Director of Nursing (ADON), the ADON confirmed that Resident 5 did not receive an injection or injectable medication during the look back period for the Comprehensive MDS dated [DATE]. The ADON, who also acts as the MDS Coordinator and is responsible for coding the MDS confirmed that the MDS for Resident 5 dated 04/27/2026 was coded incorrectly.In an interview completed on 05/26/2026 at 4:05 PM with the facility Interim Director of Nursing (IDON) the IDON confirmed that Resident 5's MDS dated [DATE] was not coded correctly.B.Record review of Resident 7's Comprehensive MDS dated [DATE] revealed in section N0415 High risk Drug Classes letter K Anticonvulsant medication was coded to reflect that the resident did not receive an anticonvulsant medication during the look back period (the 7 days prior to the assessment reference date of 02/26/2026).Record review or Resident 7's Physician Orders for the month of February 2026 revealed Resident 7 had orders to receive Lamotrigine (an anticonvulsant medication) 225 milligrams twice a day every day, Levetiracetam (an anticonvulsant medication) 250 milligrams twice a day every day,Record review or Resident 7's MAR for the month of February 2026 revealed documentation that Resident 7 was administered Lamotrigine 225 milligrams twice a day every day and Levetiracetam 250 milligrams twice a day every day during the look back period for the Comprehensive MDS dated [DATE].In an interview completed on 05/26/2026 at 4:05 PM with the facility ADON, the ADON confirmed that Resident 7 did receive the Lamotrigine and Levetiracetam which were anticonvulsant medications as ordered twice daily during the look back period. The ADON confirmed that the Comprehensive MDS dated [DATE] was coded incorrectly.In an interview completed on 05/26/2026 at 4:05 PM with the facility IDON, the IDON confirmed that Resident 7's MDS dated [DATE] was not coded correctly.C.Record review of Resident 17's Quarterly MDS dated [DATE] revealed in section N0415 High risk Drug Classes letter K Anticonvulsant medication was coded to reflect that the resident did not receive an anticonvulsant medication during the look back period (the 7 days prior to the assessment reference date of 05/19/2026).Record review or Resident 17's Physician Orders for the month of May 2026 revealed Resident 17 had orders to receive Gabapentin (an anticonvulsant medication) 800 milligrams three times daily.Record review or Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	17's MAR for the month of May 2026 revealed documentation that Resident 17 was administered Gabapentin 800 milligrams three times daily every day during the look back period for the Quarterly MDS dated [DATE].In an interview completed on 05/26/2026 at 4:05 PM with the facility ADON, the ADON confirmed that Resident 17 did receive the Gabapentin 800 milligrams three times daily every day during the look back period for the Quarterly MDS dated [DATE]. The ADON confirmed that the Quarterly MDS dated [DATE] was coded incorrectly.In an interview completed on 05/26/2026 at 4:05 PM with the facility IDON, the IDON confirmed that Resident 17's MDS dated [DATE] was not coded correctly.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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(E)(i) Based on record review and interview the facility failed to develop a comprehensive care plan for identified resident care needs for 1 residents (Resident 7) of 8 sampled residents. The facility census was 23. Findings are: A. Record review of a facility policy titled Comprehensive Care Plans and dated 03/11/2025 revealed it was the policy of the facility to develop and implement a 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) person centered care plan for each resident that includes measurable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment and meet professional standards of quality. All care assessment areas triggered by 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) will be considered in developing the plan of care. Record review of an admission Record revealed that the facility admitted Resident 7 on 02/13/2026 with diagnosis of Bipolar Disorder (a mental health condition that causes extreme emotional highs and lows) and Schizophrenia (a severe chronic brain disorder that impairs how and individual interprets reality). Record review of the comprehensive MDS dated [DATE] for Resident 7 revealed coding to reflect that Resident 7 received an antipsychotic (a psychotropic medication used to treat or manage psychosis, schizophrenia, bipolar disorder, and severe agitation)medication, an antianxiety (a psychotropic medication used to treat or manage anxiety) medication, and an antidepressant (a psychotropic medication used to treat or manage major depressive disorder, anxiety, PTSD and chronic pain) medication during the 7 day look back period for the assessment. Record review of Resident 7's Care Plan on 05/26/2027 revealed a Focus of the resident was at risk for adverse reactions due to the daily use of antipsychotic medications due to mental illness dated 03/03/2026. Interventions were listed to discuss with the resident and family the number and type of medications the resident was taking and the potential for drug interactions and side effects, if the resident had more than one prescribing provider to ensure that each provider had the full list of the residents medications available, to monitor the resident for possible signs and symptoms of adverse drug reactions, to request that the residents provider review and evaluate the residents medications, and for the pharmacy consultants recommendations be reviewed. Resident 7's Care Plan did not address the residents use of antidepressant and anti-anxiety medications. The residents Care Plan did not address the resident's diagnosis of Schizophrenia and risks to the resident and interventions for the plan of care for the resident due to this diagnosis. In an interview completed on 05/26/2027 at 10:15 AM with the ADON, the ADON confirmed that Resident 17 had a diagnosis of Schizophrenia, and was receiving antidepressant medications. The ADON confirmed that Resident 17's Care Plan did not address the residents diagnosis of Schizophrenia and or the care needs of the resident due to this diagnosis. The ADON confirmed that the residents Care Plan did not address the residents use of the antidepressant medication and the risks to the resident due to taking this medication. The ADON confirmed that the care needed to be provided for the resident due to these things should be covered in the residents Care Plan and was not.In an interview completed on 05/26/2027 at 10:15 AM with the facility Interim Director of Nursing (IDON), the IDON confirmed that Resident 17's Care Plan was not comprehensively completed to identify the care needs of Resident 17 and should be.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12(D)(i)Based on observation, interview, and record review the facility failed to ensure expired insulin was disposed of and not being utilized for 1 (Resident 16) of 4 sampled residents. The facility census was 23.Findings are:Record review of a document titled Lantus and dated 2022 revealed to discard the Lantus vial 28 days after opening or the first use. In an observation completed on [DATE] at 11:30 AM of the small refrigerator located in the locked medication storage room revealed the following:-An opened vial labeled Lantus and Resident 16's name was being stored in a bin on the top shelf of the refrigerator. The vial had a white label on it written on the label was an expiration date/discard date of [DATE]. In an interview completed on [DATE] at 11:30 AM with Registered Nurse A (RN)-A, RN-A confirmed that all opened insulin should be discarded 28 days after opening and the open or discard date is written on the insulin at the time it is opened. The RN confirmed that the Lantus insulin vial for Resident 16 had an expiration/discard date of [DATE] and should have been discarded on that date. The RN confirmed that the insulin was expired for Resident 16. In an interview completed on [DATE] at 12:15 with the facility Interim Director of Nursing (IDON), the IDON confirmed that Resident 16's vial of Lantus insulin was expired and should not be being used and should have been discarded on [DATE].

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Licensure reference number 175 NAC 12-006.05(B) Based on record review and interview, the facility failed to ensure 1 resident (Resident 32) out of 3 residents sampled, signed a SNF (Skilled Nursing Facility) ABN (Advanced Beneficiary Notice) and NOMNOC (Notice of Medicare Non-Coverage) prior to when the facility determined services would no longer qualify as covered under Medicare. The facility census was 23. Findings are:Record review of the undated Harvard Rest Haven admission Agreement revealed a resident was notified if the resident utilized Medicare Part A SNF benefits, the facility would bill Medicare for covered services. When eligibility had been determined retroactively, the facility would return all payments made by the resident, or by any person on the resident's behalf, for services covered by Medicare. If facility did not believe that Medicare would pay because the resident did not require a Medicare Part A SNF level of care, the facility would provide the NOMNOC indicating the reason the resident's stay would not be paid by Medicare and that the resident would be responsible for any financial cost incurred during the continued stay. Record review revealed that the Utilization Review Committee (UR- a committee that evaluated the appropriateness, medical necessity, and efficiency of healthcare services provided to residents. The multidisciplinary team ensured residents received the correct level of care while managing costs and optimizing facility resources) met on 03/05/2026 and determined that Resident 32's last covered day (LCD- the final calendar day that Medicare paid for an individual's SNF care and after which the resident was responsible for out-of-pocket costs) was on 03/07/2026. There was no documentation that the resident or the resident representative was informed of the date at that time. Record review revealed that Resident 32's SNF ABN (a form that informed patients that Medicare may deny coverage for items or services and required the patient to assume financial responsibility if they chose to proceed) was provided to the resident and signed on 03/09/2026. Record review revealed that Resident 32's NOMNOC (a form given to patients who used Medicare covered services when covered care was ending and explained how to file an expedited appeal if they disagreed with the discharge) was provided to the resident and signed on 03/09/2026. An interview with the Social Services Director (SSD) on 05/26/2026 at 9:30 AM confirmed Resident 32 signed the SNF ABN and NOMNOC after the LCD and the date the resident was to pay out of pocket.

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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 reviews and interview, the facility failed to notify the ombudsman (a state official who advocates and protects the rights, health, safety, and welfare of individuals residing in nursing facilities) of a resident discharge for 1 (Resident 28) of 1 resident reviewed as required. The facility census was 23. Findings are:Record review of the discharge Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities) for Resident 28 dated 04/14/2026 revealed that they admitted to the facility on [DATE]. Per the MDS, the resident had a discharge date of 04/14/2026. Record review of the ombudsman notifications sent and dated 03/11/2026, 04/03/2026, and 05/06/2026, there was no record of notification that the ombudsman was notified of Resident 28's discharge. The record of notifications indicated that the ombudsman is notified only of hospital transfers. An interview with the Social Services Director (SSD) on 05/26/2026 at 12:56 PM revealed that there was no notification to the ombudsman for the discharge of Resident 28. They confirmed that they only notified the ombudsman of hospital transfers and they did not notify the ombudsman for discharges to home or transfers to other nursing facilities.

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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 12-006.10Based on observation, record review, and interview the facility failed staff failed to administer insulin per manufacturer direction for 2 residents (Resident 10 and Resident 6) of 2 sampled residents. The facility census was 23.Findings are:A.Record review of a document titled Injection FlexPen dated 02/2023 revealed to keep the needle in the skin for at least 6 seconds keeping the push button pressed all the way to ensure that the full dose of insulin has been administered. In an observation completed on 05/21/2026 from 11:05 AM through 11:30 AM the following was observed during insulin administration by Registered Nurse A (RN)-A the following was observed:A. With gloved hands RN-A used an alcohol wipe to wipe the tip of the insulin pen for 30 seconds and then applied a needle cap to the insulin pen. With the needle cap applied the RN turned the dosage dial to 2 and depressed the push button on the opposite end of the insulin pen releasing the dialed amount of insulin into the needle cap. RN -A then turned the dosage dial to 4 units took the prepared insulin pen to Resident 10 and explained to the resident the procedure about to complete of administering the resident's prescribed insulin. The resident exposed their left arm indicating to the RN the placement of the insulin. The RN used an alcohol wipe to cleanse and area to the back of the residents' arm and then applied the needle end of the insulin pen into the residents skin. The RN then depressed the push button end of the insulin pen injecting the dialed dose of insulin into the residents arm. RN-A then immediately removed the needle from the residents abdomen, thanked the resident and returned to the Medication room. The RN did not hold the insulin pen in place.B. With gloved hands the RN used an alcohol wipe to wipe the tip of the insulin pen for 30 seconds and then applied a needle cap to the insulin pen. With the needle cap applied the RN turned the dosage dial to 2 and depressed the push button on the opposite end of the insulin pen releasing the dialed amount of insulin into the needle cap. RN-A then turned the dosage dial to 6 units took the prepared insulin pen to Resident 6 and explained to the resident the procedure about to complete of administering the resident's prescribed insulin. The RN used an alcohol wipe to wipe a section of the residents abdomen, removed the protective cap from the needle end of the insulin pen, placed the needle into the cleansed area of the resident's abdomen and depressed the push button releasing the dialed dosage of insulin into resident 6's abdomen. The RN then immediately removed the needle from the resident's abdomen thanked the resident and returned to the Medication room. The RN did not hold the insulin pen in place for 6 seconds. In an interview conducted on 05/21/2026 at 11:30 AM with RN-A, RN-A stated that they were unaware that it was the manufacturer instruction for administration of insulin using a pen device to hold the device in place for 6 seconds with the push button depressed to ensure the full dose of insulin was administered.In an interview conducted on 05/21/2026 at 11:50 AM with the facility Interim Director of Nursing (IDON), the IDON stated that the facility did not have a policy or procedure for insulin administration using an insulin pend should ensuring that insulin administration using an insulin pen was performed correctly ensuring that residents received the prescribed dose of insulin. In an interview conducted on 05/21/2026 at 12:02 PM with RN-A, RN-A stated that they had looked up the manufacturer instructions for administration of insulin using the FlexPen and confirmed that the pen should have been held in place for 6 seconds ensuring the prescribed dose of insulin was administered to the resident. The RN confirmed that they did not hold the needle in place as outlined in the manufacturer's instructions for use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285272	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Rest Haven	400 East 7th Street Harvard, NE 68944

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Licensure reference number 175 NAC 12-006.09(H)(vi)(3)(g) Based on observation, record review, and interview, the facility staff failed to change the oxygen (O2) tubing as ordered for 1 (Resident 2) of 1 resident sampled. The facility census was 23. Findings are: Record review of the facility Policy and Procedure: Oxygen Administration dated 02/26/2023 revealed that the oxygen tubing would be replaced every two weeks by nursing staff. When oxygen was not in use, the tubing should be placed in the mesh bag provided. Record review of Resident 2's Order Summary dated 05/21/2026 revealed an order to change the O2 tubing on night shift every 14 days. Record review of the Administration Record dated 05/26/2026 revealed that the oxygen tubing was changed on 05/15/2026. An observation on 05/20/2026 at 10:41 AM revealed the O2 tubing on the concentrator was loose, not in the mesh bag but off the floor, and dated 05/08/2026 on the tubing. An observation on 05/20/2026 at 1:05 PM revealed the O2 tubing in the mesh bag and dated 05/08/2026 on the tubing. An observation on 05/21/2026 at 7:44 AM revealed the O2 tubing on the concentrator was loose, not in the bag but off the floor, and dated 05/08/2026. An observation on 05/26/2026 at 8:45 AM revealed the O2 tubing in the mesh bag and dated 05/08/2026 on the tubing. An observation on 05/27/2026 at 8:00 AM revealed the O2 tubing in the mesh bag and dated 05/26/2026 on the tubing. An interview with the Assistant Director of Nursing (ADON) and the Interim Director of Nursing (Interim DON) on 05/26/2026 at 10:14 AM confirmed the expectation of the O2 tubing is that the tubing should be in a mesh bag and that the tubing should be changed every 14 days. The ADON confirmed that according to the Administration Record, Resident 2's O2 tubing was changed on 05/15/2026. The ADON visually confirmed that Resident 2's O2 tubing in the room was dated 05/08/2026.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285272	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Rest Haven	400 East 7th Street Harvard, NE 68944

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure reference number 175 NAC 12-006.04(B)(i)(ii)(1) Based on record reviews and interviews, the facility failed to ensure 12 hours of ongoing training per year was completed for 3 of 5 Medication Aides (MA) and Nursing Assistants (NA) reviewed. The facility census was 23. Findings are: Record review of facility in-service training for Medication Aide-E (MA-E) revealed that they only completed 8.5 hours of continuing education from 04/12/2025-04/12/2026. Record review of facility in-service training for Medication Aide-F (MA-F) revealed that they only completed 6.4 hours of continuing education from 05/13/2025-05/13/2026. Record review of facility in-service training for Medication Aide-G (MA-G) revealed that they only completed 9.5 hours of continuing education from 08/26/2025-08/26/2026. An interview with the Infection Prevention Nurse (IP nurse) on 05/26/2026 at 1:50 PM confirmed that multiple staff members are not up to date on appropriate continuing education hours including the staff members listed.