| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285285 | A. Building<br>B. Wing | 12/30/2025 |

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| Good Samaritan Society - Grand Island Village | 4061 & 4055 Timberline Street & 2912 Good Samarita<br>Grand Island, NE 68803 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Licensure Reference Number 175 NAC 12-006.09 (F)(i)Based on record review and interview the facility failed to ensure that a baseline care plan (a written plan required to be developed within 48 hours of admission detailing the instructions needed by staff to provide initial effective and person-centered quality care for a resident) was developed and reviewed with the resident/resident representative and ensure that a written summary was offered to the resident/resident representative for 3 of 3 residents reviewed (Residents 7, 2, and 9). The facility census was 46.Findings are:A.Record review of the facility policy titled Care Plan dated 12/1/25 revealed that the baseline care plan includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. A baseline care plan will be developed upon admission according to state and federal regulations. The facility must provide the resident and resident representative with a written summary of the baseline care plan. Use the Care Conference Note progress note to document that the meeting occurred with the resident and representative and any significant discussion that occurred. The resident /family or legal representative will have the opportunity to participate in the planning of his or her care to the extent possible. Record review of the admission Record for Resident 7 dated 12/22/25 revealed that Resident 7 admitted into the facility on 3/20/25. Diagnoses included Acquired Absence of the Right and Left Legs, Diabetes, and Anxiety.Record review of the medical record for Resident 7 revealed no baseline care plan for Resident 7.Record review of the progress notes for Resident 7 revealed no documentation of any baseline care plan discussion or summary of a baseline care plan with the resident or resident representative. Interview on 12/29/25 at 3:33 PM with the facility Director of Nursing (DON) confirmed that the facility did not complete a baseline care plan for Resident 7 due to a gap in the facility process. The DON confirmed that the facility had no documentation of a baseline care plan review with the resident or resident representative. The DON confirmed that the resident/resident representative were not offered a summary of a baseline care plan as required. B.Record review of the admission Record for Resident 2 dated 12/22/25 revealed that Resident 2 admitted into the facility on 3/26/25. Diagnoses included High Blood Pressure, Fracture of the Right Upper Leg, and Sleep Apnea.Record review of the medical record for Resident 2 revealed no baseline care plan for Resident 2.Record review of the progress notes for Resident 2 revealed no documentation of any baseline care plan discussion or summary of a baseline care plan with the resident or resident representative. Interview on 12/29/25 at 3:33 PM with the facility Director of Nursing (DON) confirmed that the facility did not complete a baseline care plan for Resident 2 due to a gap in the facility process. The DON confirmed that the facility had no documentation of a baseline care plan review with the resident or resident representative. The DON confirmed that the resident/resident representative were not offered a summary of a baseline care plan as required. C.Record review of the admission Record for Resident 9 dated 12/22/25 revealed that Resident 9 admitted into the facility on 6/24/25. Diagnoses included Chronic Kidney Disease, Obesity, and Peripheral Vascular Disease (A circulatory problem where narrowed blood vessels reduce blood flow to the limbs, most commonly the legs, requiring care, medications, or procedures to prevent severe complications like<br>(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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | limb loss or stroke). Record review of the medical record for Resident 9 revealed no baseline care plan for Resident 9.Record review of the progress notes for Resident 9 revealed no documentation of any baseline care plan discussion or summary of a baseline care plan with the resident or resident representative. Interview on 12/29/25 at 3:33 PM with the facility Director of Nursing (DON) confirmed that the facility did not complete a baseline care plan for Resident 9 due to a gap in the facility process. The DON confirmed that the facility had no documentation of a baseline care plan review with the resident or resident representative. The DON confirmed that the resident/resident representative were not offered a summary of a baseline care plan as required. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Licensure Reference Number 175 NAC 12-006.10(D) Based on record review, observations and interviews, the facility failed to ensure that the medication error rate was not 5% or higher. This affected 4 of 8 residents (Residents 21, 26, 40, and 58). The facility census was 46. Findings were:Record review of the facility policy Medication: Administration Including Scheduling and Medication Aides dated 4/08/2025 revealed the policy purpose was to administer medications correctly and in a timely manner and to provide direction regarding medications aides among other purposes. This policy also stated the medications are administered to the resident according tot he Six Rights; right medication, right dose, right time, right resident, right route, and right documentation. All employees passing medications are familiar with action and adverse reactions of medications. Record review of the Certified Medication Aide; Trained Medication Aide competency training for Medication Aide (MA) A which was completed on 11/4/2025 at the time of new hire orientation. The skills testing revealed that MA-A had completed the self assessment (which were then signed off by a preceptor) indicating that MA-A was able to perform without supervision the following skills, among others: 1. Verbalizes and demonstrates that medications must be administered in a timely manner within 60 minutes on each side of ordered time, except for state medications which must be given immediately or other time sensitive medications. 2.Demonstrates providing the Six Rights of Medication right medication to the right person at the right time in the right dose and by the right route , right documentation ensuring all changes in medications are responded to in a timely manner. 3. Demonstrates appropriate delivery of medications. 4. Demonstrates appropriate action per location policy for missed medications 5. Follows location procedure including timelines for documenting medication immediately after being provided. A. Record review of the medication orders revealed that during the AM medication pass, Resident 58 was to receive the following medications: 1. Amiodarone 200 milligrams (mg) oral daily for Paroxysmal Atrial fibrillation (intermittent irregularly-irregular heart beat) 2. Cholecalciferol 50 mg oral daily for osteoporosis of the bones 3. Choline Fenofibrate 135 mg oral daily for elevated lipids 4. Cyanocobalamin 1000 mg oral daily for end stage renal disease 5. Folic Acid 1 mg oral daily for end stage renal disease 6. Isosorbide mononitrate 30 mg oral daily for high blood pressure 7. Pantoprazole 40 mg oral daily for gastroesophageal reflux disease (heartburn) 8. Torsemide 100 mg oral daily for congestive heart failure 9. Doxycycline 100 mg oral daily (last dose) for a urinary tract infection 10. Gabapentin 100 mg oral for diabetic neuropathy (pain caused by diabetes) 11. Metoprolol 25 mg oral daily for elevated blood pressure 12. Midodrine 5 mg to be taken with meals at 8:00 AM for anemia 13. Sevelamer 800 mg oral daily for end stage renal disease Observation on 12/29/2025 at 10:23 AM of Medication Aide (MA) A who prepared medications for administration to Resident 58. MA-A pulled all of the medications from the drawer, checked off each medication one at a time with the bubble pack holding the medication to the electronic medical record to assure accuracy. MA-A then put each pill ordered into a small medication cup. MA-A then marked all of the medications as given in the electronic medical record. MA-A then went to Resident 58's room only to find Resident 58 was gone. In an interview on 12/29/2025 at 10:38 AM, MA stated that Resident 58 had left the facility and gone to dialysis because this was Monday. MA stated Usually the van driver tells me they are leaving and asks if Resident 58 has had ordered medications yet. But Resident 58 is already gone. I usually give the medications to Resident 58 between 9 and 10 because breakfast has already been served and I know this resident will not get sick taking medications on an empty stomach. I cannot give any of these medications now because there is a risk that I would duplicate some medications when Resident 58 returns from dialysis. Observation on 12/29/2025 at 10:40 AM as MA-A worked with the Clinical admission Specialist (CNE) to mark the medications in the electronic medical record (EMAR) as not given. The CNE assisted MA-A with the policies and protocols needed to destroy the medications in the medication room, to inform the charge nurse, to contact the dialysis center, and to fill out a medication error form. B. Record review of the EMR for<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 21 revealed an order for Gabapentin 400 mg oral 3 times daily for osteoarthritis. The medication was due to be given at 11:30 AM. Observation on 12/29/2025 at 12:38 PM of MA-A as the medication was double checked on the bubble pack and the EMR. The medication was highlighted in a red box on the EMR. MA-A gave the medication to the resident and then MA-A charted the medication as given. In an interview with MA-A on 12/29/2025 at 12:42. MA-A revealed that the medication was highlighted on the EMR by a red box and was due to be given at 11:30 AM. Because MA-A was helping with other resident cares prior to the medication pass, MA-A was a little bit behind on giving all of the medications. MA-A confirmed that the Gabapentin was administered late as the staff only have 1 hour before or one hour after the designated time to administer medications. C. Record review of the EMR for Resident 26 revealed an order for Torsemide 20 mg oral twice a day for edema. The medication was due to be given at 11:30 AM. The medication was highlighted in a red box on the EMR. Observation on 12/29/2025 at 12:47 PM of MA-A as the medication was double checked on the bubble pack and the EMR. The medication was highlighted in a red box on the EMR. MA-A gave the medication to the resident and then MA-A charted the medication as given. In an interview with MA-A on 12/29/2025 at 12:53 PM confirmed that the medication was late and given a the wrong time. D. Record review of the EMR for Resident 40 revealed that there were orders for Sinemet 25/100 mg 1 1/2 tabs to be given for Parkinson's disease at 11:30 AM and another medication midodrine 5 mg to be given at 11:30 AM for hypotension (low blood pressure). Observation on 12/29/2025 at 12:55 PM of MA-A as the medications were double checked against the EMR. Both medications were highlighted by a red box on the EMR. MA-A gave the medications to the resident and then MA-A charted the medications as given. In an interview with MA-A 12/29/2025 at 1:00 PM MA-A confirmed that both medications given to Resident 40 were given late and at the wrong time. Medications listed in red are actually late. We have one hour to give the medications. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05 (D)Licensure Reference Number 175 NAC 12-006.05 (E)Based on record review and interview the facility failed to be inform the resident/resident representative of the risks and benefits of proposed care, or treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer prior to administering psychotropic medications (any medication that affects behavior, mood, thoughts, or perception) for 2 (Resident 3 and Resident 4) of 5 residents. The facility census was 46.Findings are:A.<br><br>Record review of the facility policy titled Psychotropic Medications dated 12/9/25 revealed that before the administration of non-emergency psychotropic medications a consent form must be signed for the use of psychotropic medications. The Permission for Use of Psychotropic Medications will be used to obtain consent.<br><br>Record review of the admission Record for Resident 3 dated 12/22/25 revealed that Resident 3 admitted into the facility on 5/16/23. Diagnoses included Paranoid Personality Disorder, Dementia, and Anxiety.<br><br>Record review of the current care plan for Resident 3 revealed that Resident 3 takes psychotropic medications and staff are to monitor and document side effects and effectiveness of the medications initiated 9/18/24.<br><br>Record review of the November 2025 medication administration record (MAR) (a legal record of the prescriber ordered medications administered to a patient at a facility by a health care professional) for Resident 3 dated 12/30/25 revealed that the prescriber ordered medication Rexulti (a psychotropic medication used to manage psychotic disorders- possible side effects of Rexulti include sleepiness, dizziness, and increased risk of death in certain elderly patients) 3 milligrams once a day had an order start date of 7/22/25. The MAR revealed documentation that the ordered medication Rexulti was administered daily to Resident 3.<br><br>Record review of the December 2025 MAR for Resident 3 dated 12/30/25 revealed documentation that the ordered medication Rexulti was administered daily to Resident 3 from 12/1/25-12/30/25.<br><br>Record review of the medical record for Resident 3 revealed no documented consent for use of psychotropic medications for the prescriber ordered Rexulti 3 milligrams once a day that started on 7/22/25, or documentation informing the resident/resident representative of the risks and benefits of proposed care, or treatment and treatment alternatives or treatment options and to choose the alternative or option they prefer.<br><br>Interview on 12/30/25 at 10:24 AM with the facility Director of Nursing (DON) confirmed that the facility did not have a consent for use of the psychotropic medication Rexulti for Resident 3.<br><br>B.<br><br>Record review of the New Prescription Summary for Resident 3 dated 12/15/25 revealed a prescription order for Trintellix (a psychotropic medication used to treat Major Depressive Disorder-possible side effects of Trintellix include nausea, vomiting, and thoughts of suicide) 10 milligrams take 1 tablet in the morning.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of the December 2025 MAR for Resident 3 dated 12/30/25 revealed documentation that the ordered medication Trintellix was started on 12/16/25. The MAR revealed documentation that the Trintellix was administered daily to Resident 3 from 12/16/25-12/30/25.<br><br>Record review of the medical record for Resident 3 revealed no documented consent for use of psychotropic medications for the prescriber ordered Trintellix 10 milligrams take 1 tablet in the morning that started on 12/16/25.<br><br>Interview on 12/30/25 at 10:24 AM with the facility Director of Nursing (DON) confirmed that the facility did not have a consent for use of the psychotropic medication Trintellix for Resident 3 as required.<br><br>C.<br><br>A review of a admission Record indicated the facility admitted Resident 4 on 05/23/2025 with diagnoses of major depressive disorder (a mood disorder causing persistent sadness and loss of interest, affecting how one feels, thinks, and acts), and generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities (e.g., work or school performance) that occurs more days than not, for at least 6 months).<br><br>A review of Resident 4 Physician Orders on 12/29/2025 revealed that Resident 4 was prescribed Zoloft (a psychotropic antidepressant medication) and Alprazolam (a psychotropic anti-anxiety medication) when admitted to the facility on [DATE].<br><br>The comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 05/29/2025 revealed Resident 4 had received routine antianxiety and antidepressant medication during the assessment period.<br><br>A review of a facility supplied document titled Permission for Use of Psychotropic Medications and dated 08/04/2025 revealed in the section titled Antidepressant Medication the Zoloft and the Alprazolam medications to be listed under this section. In the area of the form titled the symptoms that you are experiencing that the medication is intended to help there are no symptoms listed the area of the form is left blank. In the area of the form titled nonpharmacological alternatives attempted are listed below there is no documentation or no alternatives attempted listed in this area of the form.<br><br>In an interview completed on 12/30/2025 at 02:55 PM with the facility Social Services Director (SSD), the SSD confirmed that there were no symptoms listed that the medications were being used to treat on the form and should have been, that there were no nonpharmacological alternatives listed to attempt for Resident 4. The SSD confirmed that the resident was admitted to the facility on [DATE] receiving these medications. The SSD confirmed that the form was not completed and signed until 08/04/2025 and not at the time of admission. The SSD confirmed that no education was provided in regard to the symptoms or alternatives to the medications to be provided. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Licensure Reference Number 175 NAC 12-006.02 (H)State Statute 28-372Based on record review and interview, the facility failed to report all allegations of mistreatment and abuse within the regulatory reporting parameters. This affected 1 (Resident 4) of 1 sampled resident. The facility census was 46.Findings are:Review of a facility policy titled Abuse and Neglect dated 04/07/2025 revealed the location will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse. Results of all investigations will be reported to officials in accordance with state law including to the state survey and certification agency with in five working days of the event or sooner as designated.A review of a admission Record indicated the facility admitted Resident 4 on 05/23/2025 with diagnoses of major depressive disorder (a mood disorder causing persistent sadness and loss of interest, affecting how one feels, thinks, and acts), and generalized anxiety disorder (a condition characterized by excessive anxiety and worry about a variety of events or activities (e.g., work or school performance) that occurs more days than not, for at least 6 months), chronic pain, and age related osteoporosis (a condition that is characterized by decrease in bone mass with decreased density and enlargement of bone spaces producing porosity and fragility).The comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 10/17/2025 revealed that the resident was coded as to be understood and to understand others and had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15 indicating the resident was cognitively intact.A.In an interview completed on 12/29/2025 at 3:50 PM with Resident 4, Resident 4 stated that they have had episodes where staff have yelled at them and been rude. The residents stated that they reported these incidents by telling staff and completing a grievance form.Record review of a facility supplied document titled Suggestion or Concern and dated 08/07/2025 revealed Resident 4 completed the form and writing that a named staff member yelled at them several times and was rude to them. The residents wrote that they did not want the staff member to ever return to their room. Documentation on the other side of the form dated 08/12/2025 and signed by the facility Director of Nursing (DON), stated that the DON reached out to the employee in question and the employee resigned their position with the facility written in the investigatory section of the form, in the resolution portion it is documented that the employee resigned. In an interview completed on 12/30/2025 at 09:10 AM with the facility Director of Nursing, the DON stated that when attempted to speak with the staff member in question to validate the complaint made by Resident 4 the staff member resigned do did not investigate the matter further. The DON stated that they did not notify the regulatory agencies of the allegation or submit a report of the allegation's investigation to the regulatory agencies. The DON confirmed that staff yelling and being rude to residents met the definition of abuse. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Licensure Reference Number 175 NAC 12-006.09 (G)(i)Based on record review and interviews, the facility failed to provide evidence that the required information was conveyed to the hospital at the time of transfer and failed to notify the resident or responsible party of the facility bed hold policy at the time of transfer for 1 Resident (Resident 5) of 1 sample resident. Facility census was 46Findings are:A.Review of a facility policy titled Discharge and Transfer dated 12/18/2025 revealed when a transfer or discharge occurs, the location must ensure that the transfer or discharge is documented in the medical record and appropriate information is communicated to the receiving healthcare center or provider.Review of Resident 5's medical record revealed an admission date of 09/30/2025 and a discharge date of 12/19/2025.Review of Resident 5's Progress Notes revealed a late entry with effective date of 12/19/2025 stating that Resident 5's primary care physician was notified of the resident's condition and the resident's power of attorney and spouse wished for the resident to be transported to the hospital. Further documentation stated that the resident was transported to the hospital via ambulance. There is no documentation indicating the receiving hospital/facility or provider were notified of the appropriate information needed to care for Resident 5. In an interview completed on 12/29/2025 at 11:49 AM with the facility Director of Nursing (DON), The DON stated they were not aware of the facility contacting the receiving facility or provider with the appropriate information needed to care for the resident. The DON stated that they provide information to the ambulance personnel only. The DON confirmed that there was no documentation of information being communicated to the ambulance personnel or the receiving facility or provider needed to care for Resident 5.B.Review of a facility policy titled Bed Hold and dated 12/23/2025 revealed at the time of transfer the facility will provide written information to the resident or representative that specified the duration of the bed hold policy. At the time of transfer the social worker or designated individual will provide the notice of bed hold.Review of Resident 5's medical record revealed an admission date of 09/30/2025 and a discharge date of 12/19/2025.Review of a facility supplied document titled Notice of Bed Hold Policy and dated 12/22/2025 revealed the residents written name and the resident's spouses signature dated 12/22/2025. The residents discharge date to the hospital was 12/19/2025.In an interview completed on 12/29/2025 at 11:47 AM with the facility Social Service Director (SSD), the SSD stated that in the absence of the SSD the nurse in charge is to provide the bed hold policy to the resident or representative. The SSD stated that the nurse then records the communication of the bed hold policy in the residents progress notes. The SSD confirmed that the nurse did not complete Resident 5's notification of bed hold policy when the resident was transferred on 11/19/2025 so the SSD completed it on 12/22/2025. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Licensure Reference Number 175 NAC 12-006.09(H) (iii)(2)Based on observation, record review, and interview the facility failed to ensure that pressure ulcer (A localized wound of the skin and/or underlying tissue, usually over a bony area. A bedsore.) assessments including wound size were documented as required to determine healing or worsening of the pressure ulcers for 1 of 1 residents reviewed (Resident 2). The facility census was 46.Findings are:A.Record review of the facility policy titled Pressure Ulcers dated 2/17/25 revealed that the purpose is to provide assessment and prevention of pressure ulcers as well as treatment when necessary. The facility will use prevention and assessment interventions to ensure that residents entering the facility without pressure ulcers do not develop a pressure ulcer. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing. Residents will receive assessments and services to promote and maintain skin integrity. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 2 dated 4/1/25 revealed that it was the admission assessment for Resident 2. The MDS revealed that Resident 2 admitted into the facility on 3/26/25. Resident 2 required moderate staff assistance to roll left and right in bed. Resident 2 required maximal staff assistance for going from lying in bed to sitting on the side of the bed. Resident 2 required maximal staff assistance for standing from a sitting position. The MDS revealed that Resident 2 did not have any unhealed pressure ulcers.Record review of the current MDS for Resident 2 dated 12/23/25 revealed that Resident 2 now had two unstageable pressure ulcers (a severe wound where the base is hidden by dead, sloughy (yellow, tan, brown) or leathery eschar (black) tissue, making its true depth and stage (like Stage 3 or 4) impossible to determine until the dead tissue is removed (debrided)). These wounds indicate full-thickness tissue loss and require urgent care, as they can mask extensive damage, potentially revealing deep muscle or bone involvement) that were not present on admission. Interview on 12/22/25 at 1:25 PM with Resident 2 confirmed that the resident has pressure ulcers on the left and right heels that developed after admission. Resident 2 revealed that they hurt real bad. Record review of the Order Summary Report dated 12/29/25 for Resident 2 revealed the prescriber order to complete wound care to the left and right heels every other day and as needed. Cleanse the areas and cover with 2-3 layers of xeroform gauze (a sterile, fine-mesh gauze dressing infused with moisturizer and antimicrobial compounds that creates a moist healing environment), and cover with ABD pad (abdominal pad) (a highly absorbent, multi-layered gauze dressing). Secure with kerlix (a woven gauze bandage) and tape. Observation on 12/30/25 at 9:38 AM in the room of Resident 2 revealed that Licensed Practical Nurse-F (LPN-F) entered the resident's room to perform wound care on the left and right heel pressure ulcers. LPN-F removed the kerlix dressing from the left heel and removed the ABD pad with the xeroform dressing. The back of the left heel had a pressure ulcer measuring approximately 2.8 centimeters (cm) long, 1.7 cm wide, and 0.1 cm deep per visual measurement. The wound was covered with 90% yellow slough (a soft, stringy, or creamy yellowish tissue in a wound, composed of dead cells, proteins, and fibers) and had a small 10% area of eschar (a hard, black, layer of dead skin) at the bottom of the wound bed. LPN-F completed the wound care on the left heel. LPN-F removed the kerlix dressing from the right foot and removed the ABD pad with the xeroform dressing. The back of the right heel had a pressure ulcer that measured approximately 1.5 cm long, 1.7 cm wide and no depth per visual measurement. The wound bed was covered with yellow crusty tissue. LPN-F completed the wound care on the right heel.Record review of the Wound RN (Registered Nurse) Assessment for Resident 2 dated 11/6/25 revealed that Resident 2 had a pressure ulcer on the left heel that was unstageable. The assessment documented that the pressure ulcer was not present on admission.Record review of the Wound Data Collection Assessment (A facility assessment form containing the documentation of the assessment of a wound. The assessment documentation includes the wound's characteristics, tracking changes to guide treatment, including resident info, location, size (length, width, depth), tissue type<br>(continued on next page) |

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| | 285285 | A. Building<br>B. Wing | 12/30/2025 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (granulation, slough, eschar), drainage (amount, color, odor), wound edges, skin condition of the skin surrounding the wound, and pain.) for Resident 2 dated 11/6/25 revealed that it was completed for the initial data collection of the pressure ulcer on the left heel of Resident 2. The wound measurements were 1.5 centimeters (cm) long, 1.3 cm wide, and a depth of 0.1 cm. The assessment form revealed that wound measurements are required every 7 days.Record review of the Wound Data Collection for Resident 2 dated 11/22/25 revealed that the left heel pressure ulcer measured 1.5 cm long, 1.5 cm wide, and 0.1 cm deep. The wound bed was 100% covered with slough (a soft, stringy, or creamy yellowish tissue in a wound, composed of dead cells, proteins, and fibers). Record review of the Outpatient Nursing Home Wound Care Progress Note for Resident 2 dated 12/3/25 revealed that the non-facility Nurse Practitioner saw Resident 2. Resident 2 had an unstageable pressure ulcer on the left heel that measured 1.7 cm long, 1.2 cm wide, and had a depth of 0.1cm per the nurse practitioner. The bed of the pressure ulcer wound was 50% covered with yellow slough (a soft, stringy, or creamy yellowish tissue in a wound, composed of dead cells, proteins, and fibers) and 50% covered with eschar (a hard, black, layer of dead skin). The surrounding skin had redness and swelling. (This assessment was 11 days after the previous assessment of Resident 2's left heel pressure ulcer by the facility on 11/22/25.)Record review of the Wound Data Collection for Resident 2 dated 12/4/25 revealed that the left heel pressure ulcer measured 1.7 cm long, 1.2 cm wide, and 0.1 cm deep. The wound bed was covered with 50% slough and 50% eschar. (This assessment by the facility was 12 days after the previous facility wound assessment of Resident 2's left heel pressure ulcer on 11/22/25.)Record review of the Wound Data Collection for Resident 2 dated 12/18/25 revealed that the left heel pressure ulcer measured 1.7 cm long, 1.4 cm wide, and 0.1 cm deep. The wound bed was covered with 10% granulation tissue, 40% slough, and 40% eschar. Record review of the Wound Data Collection for Resident 2 dated 12/24/25 revealed that it contained no measurements or wound characteristics of the left heel pressure ulcer.Record review of the Wound Data Collection for Resident 2 dated 12/26/25 revealed that it contained no measurements or wound characteristics of the left heel pressure ulcer.Record review of the Wound Data Collection for Resident 2 dated 12/28/25 revealed that it contained no measurements or wound characteristics of the left heel pressure ulcer.Record review of the Wound Data Collection for Resident 2 dated 12/29/25 revealed that it contained no measurements or wound characteristics of the left heel pressure ulcer. (This assessment by the facility was 11 days after the previous facility wound assessment of Resident 2's left heel pressure ulcer on 12/18/25.)Interview on 12/30/25 at 11:14 AM with the facility Director of Nursing (DON) confirmed that resident pressure ulcers are to be monitored weekly by the facility wound nurse. The DON confirmed that measurements and description of pressure ulcers are required to be completed at least every 7 days to determine if a wound is improving or getting worse. The DON revealed that the Nurse Practitioner comes to the facility weekly for wound care rounds. Interview on 12/30/25 at 2:55 PM with the facility DON confirmed that the facility did not measure the pressure ulcers for Resident 2 every 7 days as required. B.Record review of the Wound RN (Registered Nurse) Assessment for Resident 2 dated 11/10/25 revealed that Resident 2 had a pressure ulcer on the right heel that was classified as a stage 3 (full-thickness skin loss, where the wound deepens through the skin into the fatty (subcutaneous) tissue, appearing as a deep crater but without exposing bone, muscle, or tendon. These painful wounds can involve rolled edges, dead tissue (slough/eschar), and may have signs of infection). The assessment documented that the pressure ulcer was not present on admission.Record review of the Wound Data Collection for Resident 2 dated 11/10/25 revealed that it was completed for the initial data collection of the pressure ulcer on the right heel of Resident 2. The assessment did not include any measurements of the wound. The assessment revealed that the wound bed was 100% covered with slough. Record review of the Wound Data Collection for Resident 2 dated 11/13/25 revealed that the right heel pressure ulcer measured 1.1 cm long, 2.0 cm wide, and 0.0 cm deep. The assessment contained no wound characteristics of the right heel pressure ulcer. Record review of the Wound Data Collection for Resident 2 dated 11/21/25 revealed that the right heel<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | pressure ulcer measured 1.2 cm long, 2.5 cm wide, and 0.1 cm deep. The wound was covered with 90% slough and 10% granulation tissue.Record review of the Outpatient Nursing Home Wound Care Progress Note for Resident 2 dated 12/3/25 revealed that the non-facility Nurse Practitioner saw Resident 2. Resident 2 had a stage 3 pressure ulcer on the right heel that measured 1.8 cm long, 1.5 cm wide, and had a depth of 0.1cm per the nurse practitioner. The bed of the pressure ulcer wound was covered in 90% tan crusting and 10% light pink moist tissue with a moderate amount of drainage. The surrounding skin had redness and swelling. (This assessment was 12 days after the previous assessment of Resident 2's right heel pressure ulcer by the facility on 11/21/25.)Record review of the Wound Data Collection for Resident 2 dated 12/4/25 revealed that the right heel pressure ulcer measured 1.8 cm long, 1.5 cm wide, and 0.1 cm deep. The wound was covered with 90% eschar and 10% granulation tissue. (This assessment by the facility was 13 days after the previous facility wound assessment of Resident 2's right heel pressure ulcer on 11/21/25.)Record review of the Wound Data Collection for Resident 2 dated 12/18/25 revealed that the right heel pressure ulcer measured 1.2 cm long, 1.3 cm wide, and had no depth. The wound bed was covered with 100% eschar. Record review of the Wound Data Collection for Resident 2 dated 12/24/25 revealed that it contained no measurements or wound characteristics of the right heel pressure ulcer.Record review of the Wound Data Collection for Resident 2 dated 12/26/25 revealed that it contained no measurements of the right heel pressure ulcer. The right heel pressure ulcer was covered with 100% slough.Record review of the Wound Data Collection for Resident 2 dated 12/28/25 revealed that it contained no measurements or wound characteristics of the right heel pressure ulcer. Record review of the Wound Data Collection for Resident 2 dated 12/29/25 revealed that it contained no measurements or wound characteristics of the right heel pressure ulcer. (This assessment by the facility was 11 days after the previous facility wound assessment data was documented for Resident 2's right heel pressure ulcer on 12/18/25.)Interview on 12/30/25 at 2:55 PM with the facility DON confirmed that the facility did not measure the pressure ulcers for Resident 2 every 7 days as required. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Licensure Reference Number 175 NAC 12-006.12(D)Licensure Reference Number 175 NAC 12-006.12(D)(i)(2) Based on record review, observation, and interview, the facility failed to ensure that medications that are subject to abuse were counted correctly in order to easily account for these medications on individual resident's narcotic count sheets. This had the potential to affect one of one resident sampled (Resident 1) . The facility census was 46. Findings were:Record review of the facility policy dated 04/08/2025 Medication Administration Including Scheduling and Medication Aides revealed that the purpose of the policy is to provide direction regarding medication aides and to administer medications correctly and in a timely manner among other purposes. Record review of the Individual Resident's Narcotic Record with a start date of 12/29/2025 revealed that the count sheet was for Tramadol illegible (50) milligrams (mg) to be given by mouth 1 tab po q qid (one tablet orally every 4 times a day). The first count was completed and revealed on 12/29/2025 the beginning total was 6 tablets at 6:30 AM. Signed by Medication Aide (MA) A and one other person initials whose were illegible. On 12/29/2025 at 7:30 AM, one tablet was administered and there were 5 tablets remaining. Signed by MA-AOn 12/29/2025 at 12:15 PM one tablet was administered and there were 4 tablets remaining. Signed by MA-A Observation on 12/29/2025 at 12:18 of MA-A who entered that medication count for Resident 1 into the Individual Resident's Narcotic Record. In an interview on 12/29/2025 at 1:00 PM with MA-A it was revealed that the process is to prepare the medication for the residents, administer the medication for the residents, and any medications that must be counted are then recorded on the narcotic count record sheet to ensure that all of the medications are accounted for. When asked about the narcotic count sheet, MA-A revealed uncertainty as to how many milligrams the narcotic count sheet for the tramadol belonging to Resident 1 indicated on the sheet. It did state that the resident was to receive 1/2 tablet of the medication and that is what MA-A had given to Resident 1 and that the number of tablets left in the bubble packet of the Tramadol matched the number of tablets that the narcotic record indicated. MA-A indicated that Resident 1 had received 25 mg (1/2 tablet of a 50 mg tablet) of tramadol as was indicated on the bubble packet. MA-A stated I thought when we were taught about medications and orders, we were taught that we were to be accurate and we were to write legibly. In an interview on 12/29/2025 at 1:05 PM, the charge nurse Licensed Practical Nurse (LPN) B revealed the medication written on the Individual Resident's Narcotic Record for Resident 1's Tramadol was for 50 mg tablets and that for each tablet signed out, 50 mg of tramadol would have been given. When LPN B reviewed that orders for Resident 1, LPN B confirmed that the narcotic sheet needed to be rewritten as the amount of milligrams being counted was very hard to read, but did feel that it said 50 mg of Tramadol. In a confirmation interview on 12/29/2025 at 1:20 PM with the Director of Nursing confirmed that the Individual Resident's Narcotic Record for the tramadol belonging to Resident 1 was very difficult to read, but did say 50 mg tablets of Tramadol. Because those giving the medication had to sign this medication out on this narcotic count sheet to ensure that medications at risk of abuse could be easily accounted for, the DON was to review the narcotic count sheets on all medication carts to ensure that the count sheets were legible and accurate. The DON also confirmed that because resident 1 was only receiving Tramadol 25 mg (a 1/2 tablet of a 50 mg tablet) that the count was incorrect as the count on the narcotic sheets stated Resident 1 was receiving Tramadol 50 mg. However, the DON also confirmed that this could have had a bad outcome trying to track medications had this not been found and corrected. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**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 interviews, the facility failed to ensure the dishwashing machine achieved the manufacturer designated temperature during the rinse cycle to ensure sanitization of dishes used by the residents and kitchen staff. This had the potential to affect all the residents' receiving food from the kitchen. The facility census was 46.Findings are:Review of a document titled [NAME] Service dishwasher Manual revealed hot water sanitization wash cycle temperature of 150 degrees Fahrenheit and rinse temperature 180 degrees Fahrenheit. In an observation completed on 12/22/2025 at 8:36 AM of the facility dishwashing machine the following was observed.-Activation of a washing cycle wash cycle temperature was 152 degrees Fahrenheit. The rinse cycle temperature was 172 degrees Fahrenheit.-In the bottom right hand corner of the dish machine clearly visible was a manufacturer label stating wash temperature of 150 degrees Fahrenheit and rinse temperature of 180 degrees Fahrenheit.A review of a facility document titled Dish Machine Temperature Log Thermal Sanitizing dated December 2025 revealed temperature is to be based on federal, state and manufacturer's guidelines for the dish machine. Enter and follow the strictest guidelines and the following documentation.-On December 4th the rinse temperature was recorded as 172 degrees Fahrenheit on the Morning shift, 178 degrees Fahrenheit on the Noon shift, and 153 degrees Fahrenheit on the Evening shift. In the action taken column there is nothing written indicating an action was taken to correct the temperature not meeting manufacturer recommendations. -On December 8th for the Evening shift there is no temperatures recorded for the dish machine.-On December 13th for the Evening shift the rinse temperature was recorded as 159 degrees Fahrenheit. In the action taken column there is nothing written in the column indicating an action was taken to correct the temperature not meeting manufacturer recommendations. -On December 15th for the Evening shift the rinse temperature was recorded as 160 degrees Fahrenheit. In the action taken column there is nothing written in the column indicating an action was taken to correct the temperature not meeting manufacturer recommendations. -On December 19th for the Evening shift the rinse temperature was recorded as 160 degrees Fahrenheit. In the action taken column there is nothing written in the column indicating an action was taken to correct the temperature not meeting manufacturer recommendations. -On December 21st for the Evening shift the rinse temperature was recorded as 160 degrees Fahrenheit. In the action taken column there is nothing written in the column indicating an action was taken to correct the temperature not meeting manufacturer recommendations. In an observation completed on 12/22/2025 at 8:40 AM of the facility dishwashing machine the following was observed.-Activation of a washing cycle wash cycle temperature was 152 degrees Fahrenheit. The rinse cycle temperature was 178 degrees Fahrenheit.In an interview completed on 12/22/2025 at 8:40 AM with the Dietary Manager (DM), the DM confirmed that the facility dishwashing machine should reach a temperature of 180 degrees Fahrenheit during the rinse cycle. The DM confirmed that the observed reading of 178 degrees Fahrenheit did not reach the manufacturers recommended temperature for sanitization. The DM confirmed the documentation of the temperatures recorded on the Dish Machine Temperature Log Thermal Sanitizing that were below 180 degrees should have had a action taken documented reflecting what was done to ensure the temperature of 180 degrees Fahrenheit was achieved prior to washing the dishes and was not and that there was a missing entry in the log.In an observation completed on 12/30/2025 at 10:17 AM Cook-C placed soiled dishware items into the facility dish washing machine and activated the dishwashing cycle. The [NAME] then returned to the main kitchen area out of site of the facility dishwashing machine. The [NAME] did not observe the dishwashing machine for temperatures during the washing and rinse cycle. In an observation completed on 12/30/2025 at 10:18 AM the dishwashing machine rinse cycle was observed to be 172 degrees Fahrenheit.In an interview completed on<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/30/2025 at 10:19 AM with the DM the DM confirmed that the dishwashing machine did not achieve the manufacturers recommended temperature of 180 degrees for sanitization and the [NAME] did not observe this ensuring the dish ware items were sanitized by the dish machine. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175 NAC 1-005.06(D)Licensure Reference Number 175 NAC 1-005.06(F)Licensure Reference Number 175 NAC 12-006.18Based on observation, record review, and interview the facility failed to ensure that staff performed disinfection of mechanical lifts between resident use to prevent cross-contamination, failed to ensure that staff performed hand hygiene (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) before putting on gloves and after removing gloves, and failed to perform hand washing to prevent the potential for cross contamination for 1 resident (Resident 22) during resident transfers and cares. The facility census was 46.Findings are:A.Record review of the facility policy titled Safe Resident Handling Program dated 7/7/25 revealed that there are basic responsibilities for every employee to ensure that the work environment is safe. Staff follow infection control practice to clean lifts after each use. Record review of the facility Standard, Enhanced Barrier, and Transmission-Based Precautions dated 7/7/25 revealed the purpose is to prevent the spread of infection and communicable diseases. The section titled Enhanced Barrier Precautions (EBP) revealed that the use of gown and gloves during high contact resident care activities prevent opportunities for transfer of multidrug-resistant organisms to staff hands and clothing. High contact resident care activities include transfers, dressing, bathing, providing hygiene, changing briefs or assisting with toileting, changing linens, indwelling medical device care, and wound care. Record review of the facility policy titled Hand Hygiene dated 11/13/25 revealed that the purpose is to guide compliance for hand hygiene with Centers for Disease Control (CDC) and World Health Organization (WHO) hand hygiene recommendations and establish hand hygiene as the single most important factor in preventing the spread of disease-causing organisms to residents and staff. Hand hygiene should be performed after glove removal. The section titled Washing with soap and water revealed to wet the hands and apply soap. Rub hands together briskly for 15-20 seconds. Rinse hands with water and dry thoroughly. Record review of the current care plan for Resident 14 dated 12/22/25 revealed that Resident 14 is dependent on staff for transfers with 2 staff and the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own). The care plan revealed that Resident 14 requires Enhanced Barrier Precautions. Staff are to use gown and gloves when transferring the resident. Observation on 12/29/25 at 1:13 PM outside the room of Resident 14 revealed that a visitor exited the room of Resident 14. Enhanced Barrier Precautions signs (required use of gown and gloves during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organisms and residents at increased risk) were posted on the door of the resident room. A white container outside of the resident room contained personal protective equipment (gowns and gloves). Nurse Aide-G (NA-G) and Nurse Aide-H (NA-H) were in the room of Resident 14 with the resident and the mechanical total body lift. The visitor closed the room door and stood by the commons area outside the resident room. NA-G opened the resident room door at 1:27 PM. The visitor re-entered the room. Resident 14 was now seated in the motorized wheelchair in the center of the room. The mechanical total body lift was parked beside the resident bed between the bed and the resident wheelchair. NA-H exited the resident room. Licensed Practical Nurse-B (LPN-B) entered the room of Resident 14. NA-G and LPN-B adjusted the resident oxygen tank and applied the oxygen to Resident 14. NA-G exited the room with the mechanical total body lift (the lift had not been disinfected) and pushed it into the room of Resident 22. Resident 22 sat in a wheelchair in the room. NA-H entered the room of Resident 22. NA-G and NA-H put on gloves (no hand hygiene was performed prior to putting the gloves on). NA-G and NA-H hooked the lift sling to the mechanical total body lift and lifted Resident 22 from the wheelchair and transferred Resident 22 onto the bed. NA-H removed the gloves and exited the room to get more wipes (NA-H did not perform hand hygiene after removing the gloves). NA-G removed the resident's shoes and pulled down the resident's pants to the ankles.<br>(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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | NA-G unhooked the brief soiled with bowel movement (BM) and began to wipe the BM from the skin of Resident 22 with the gloved hands and disposable wipes. The time was now 1:38 PM and NA-H returned into the room. NA-H put on gloves (NA-H did not perform hand hygiene prior to putting on the gloves). Resident 22 was rolled onto their left side and NA-G continued to clean BM from the resident. NA-G then removed the gloves and went into the resident's bathroom. NA-G performed hand washing by wetting the hands and applying soap. NA-G scrubbed the hands together with soap for a total of 10 seconds and then rinsed and dried the hands (NA-G did not scrub the hands with soap for 15-20 seconds as required). NA-H placed a new brief under the resident. NA-G put on gloves and assisted to hook the brief. NA-H removed the gloves and did not perform hand hygiene. NA-H got a new pair of pants to replace the soiled pair on Resident 22. NA-G removed the gloves and began to gather the trash bag of soiled wipes and the soiled brief. (NA-G did not perform hand hygiene after removing the gloves). NA-G put on a pair of gloves and picked up the soiled left sling and soiled pad from the bed and placed them into a plastic bag. NA-G exited the resident room with the bag of trash and the bag with the soiled lift sling. NA-G returned to the resident room with a clean lift sling. NA-G and NA-H placed the sling underneath Resident 22. NA-G moved the mechanical total body lift to the bedside and NA-G and NA-H hooked the lift sling to the lift. NA-G lifted Resident 22 from the bed with the mechanical total body lift and transferred the resident into the wheelchair. NA-G and NA-H removed their gloves and tucked the lift sling straps into the wheelchair (NA-G and NA-H did not perform hand hygiene after removing the gloves). NA-H assisted Resident 22 to remove their shirt and replaced it with a button up shirt. NA-H exited the resident room and performed hand sanitization with alcohol based hand sanitizer. NA-G exited the room with the mechanical total body lift. NA-G performed hand sanitization with alcohol based hand sanitizer. NA-G parked the mechanical total body lift outside the room and removed disinfectant wipes from the bag on the lift. NA-G used the wipes to disinfect the lift. The time was now 1:50 PM. Interview on 12/29/25 at 1:50 PM with NA-G confirmed that the mechanical lifts are to be disinfected between residents. NA-G confirmed that the mechanical total body lift was not disinfected after it was used for Resident 14. NA-G confirmed that the mechanical total body lift was not disinfected before it was used to transfer Resident 22. NA-G revealed that they do not always have time to disinfect the lifts between residents. NA-G confirmed that staff are supposed to perform hand hygiene before putting on gloves and after removing gloves. Interview on 12/30/25 at 12:10 PM with the facility Infection Preventionist (IP) confirmed that hand hygiene is to be performed prior to putting on gloves and after taking off gloves. The IP confirmed that staff are expected to disinfect the mechanical lift on exit from the resident room prior to next use. The IP confirmed that the expectation for hand washing with soap and water is to scrub the hands with soap for 15-20 seconds before rinsing and drying the hands. |