STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285296	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saunders Medical Center	1760 County Rd J Wahoo, NE 68066

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 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. Licensure Reference Number 175 12-007.04 (D) The facility failed to ensure resident bathroom ventilation was functional in eight resident rooms (rooms 102, 105, 107, 114, 119, 121, 204, and 206) out of eight resident rooms sampled. The facility census was 53 at the time of the survey. Findings are: An observation on 4.13.2026 during the initial screening at 8:00 AM, the resident bathroom ventilation was not functioning in rooms 102, 105, 107, 114, 119, 121, 204, and 206 when checked with a one-ply tissue. An observation on 4.14.2026 at 8:10 AM, the resident bathroom ventilation was not functioning in rooms 102, 105, 107, 114, 119, 121, 204, and 206 when checked with a one-ply tissue. During the environmental tour on 4.14.2026 at 10:55 AM with the Facilities Manager (FM), the resident bathroom ventilation was not functioning in rooms 102, 105, 107, 114, 119, 121, 204, and 206 when checked with a one-ply tissue. In an interview on 4.14.2026 at 10:55 AM with the FM, it was confirmed the resident bathroom ventilation was not functioning in rooms 102, 105, 107, 114, 119, 121, 204, and 206 when checked with a one-ply tissue. In an interview on 4.14.2026 at 12:00 PM with the FM, it was confirmed the facility does not have a policy to check the resident bathroom ventilation for functionality or a preventative maintenance program for the Heating, Ventilation, and Air Conditioning (HVAC) system. In a record review of the facility's HVAC Service Checklist dated 2026 revealed the filters are checked with no mention of the resident bathroom ventilation system checks. In an interview on 4.14.2026 at 2:20 PM with the Director of Nursing (DON), it was confirmed the facility does not have an HVAC policy or preventative maintenance program.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number 175 NAC 12.006.09(B)(iii)Based on record review and interviews, the facility failed to accurately code a Minimum Data Set (MDS- a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) reflected that antipsychotic (medication used to manage psychosis including hallucinations, delusions and agitation) was being given. This affected 1 (Resident 41) out of the five sampled residents. The facility census was 53 at the time of survey.Findings are:Record review of Resident 41's Quarterly MDS dated [DATE] revealed the following:-resident was admitted on [DATE]-Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scores from 0-15, the higher the score, the higher the cognitive function) score of 6 which indicated severe cognitive impairment-resident had delusions-no behaviors were indicated.-Antipsychotic medication use was not indicated in section N.Record review of Resident 41's admission physician visit dated 9/30/25 revealed a diagnosis of Dementia with psychosis.Record review of Resident 41's Comprehensive Care plan date initiated 10/15/2025 revealed the following:-Psychotropic Medication use-AIMS (Abnormal Involuntary Movement Scale) testing to be completed quarterly and as needed.-Behavior committee to review quarterly and as needed.-Pharmacy review every month and as needed.-Medications to be given as ordered.Record review of Resident 41's physician order revealed an order for Risperdone (antipsychotic medication) to be given every evening was dated 9/30/2025.Record review of Resident 41's Informed Consent for Antipsychotic medication was dated 10/10/2025.During an interview on 04/14/2026 at 10:52 AM Registered Nurse (RN) - A, the MDS nurse, confirmed the following:-MDS was coded wrong and that the antipsychotic medication was coded as an antianxiety because it was used for anxiety. -the RAI manual is used to ensure MDS accuracy. -no one audits the MDS's or care plans for accuracy.During an interview on 04/14/2026 11:08 AM RN - B, the Education Coordinator, confirmed that nursing is supposed to complete the AIMS assessment for those residents taking an antipsychotic medication. During an interview on 04/14/2026 11:10 AM RN - C, the Quality Control nurse, confirmed that the behavior committee did not notice the AIMS was not completed for Resident 41 and should have. Review of the Behavior Committee notes dated 1/7/26 and 3/26/26 revealed that risperidone was used by the resident. Target behaviors and nonpharmacological interventions identified. Recommendations did not include to complete an AIMS assessment. Review of Drug Regimen Reviews dated 10/23/25, 11/18/25, 12/11/25, 1/27/26, 2/18/26, and 3/17/26 did not reveal a recommendation to complete an AIMS assessment for the use of an antipsychotic medication. Review of pharmacy communication dated 3/26/26 revealed the resident was on an antipsychotic medication and was having hallucinations and delusions.During an interview on 04/14/2026 11:43 AM the Pharmacist confirmed that (gender) does not look for the AIMS assessments because nursing has always done that. Review of the facility policy titled Psychotropic Drug Use last reviewed 10/2025 revealed the following:- residents on antipsychotic medications will have an AIMS assessment completed quarterly- the Behavior Committee will evaluate changes in the residents function - Medication Management Review will be performed monthly and will include medication monitoring During an interview on 04/15/2026 at 9:40 AM Director of Nursing (DON) confirmed the following:-no job duty list, policy or expectations for the behavior committee.-there was not an AIMS assessment completed for Resident 41 and there should have been one because the resident is on an antipsychotic medication- it was coded wrong on the MDS.