STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285297	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone View	850 Laurel Parkway Drive Broken Bow, NE 68822

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Licensure Reference Number 175 NAC 12-006.05(S) Based on observation, record reviews and interviews, the facility failed to ensure the resident environment was free of soiling and debris and cleaned consistently with facility practices for 1 resident (Resident 7) of 1 resident sampled. The facility census was 53. Findings are: A record review of an admission Record dated 6/3/2026 for Resident 7 revealed an admission date of 7/10/2019. A record review of the undated Care Plan for Resident 7 revealed the following for the resident:-The resident required extensive assistance with personal hygiene,-The staff were to keep their environment clean, and -The staff were to ensure an environment conducive to comfort. An observation on 6/1/26 at 11:37 AM with Resident 7 revealed the resident's wheelchair was found to have food in between the wheelchair frame, seat and armrest. The resident also had eggs and crumbs sitting in the lap crease of their shirt. An observation on 6/1/26 at 1:46 PM with Resident 7 revealed the wheelchair was still found to have food in between the wheelchair frame, seat and armrest. The resident also had eggs and other food items sitting in the lap crease of their shirt. An observation on 6/2/26 at 11:25 AM with Resident 7 revealed the wheelchair was found to have food in between the wheelchair frame, seat and armrest. The resident was also observed to have unknown food items sitting in the lap crease of their shirt. An observation on 6/2/26 at 11:30 AM with Resident 7 revealed their shirt had been cleaned but the wheelchair continued to have food in between the wheelchair frame and armrest. An interview with Nurse Aide (NA)-E on 6/2/26 at 4:00 PM revealed that cleaning wheelchairs was a part of night shift duties and the list and schedule was located in a binder titled, Nightshift. In the binder NA-E revealed several forms, one titled, Night Shift Checklist with a date, hall, and initials. Categories for the checklist reveal resident supplies stocked with a list of supplies, nightly infection control with duties listed including that wheelchairs are cleaned per schedule and personal protective equipment (PPE)/isolation stocked. A second form titled, Night Shift - Performed Task, policies and procedures and an area for a date, staff member initials, and room number. Another form found was titled, Wheelchair and [NAME] Cleaning Schedule for 100/200/300/400 (hall). All rooms per hall were listed for the day in correspondence to clean the wheelchair or walker and a night correlating the room and initials, with a date of the week of 7 days. A binder in the nurses station titled Nightshift revealed a record review of a form titled, Wheelchair and [NAME] Cleaning Schedule for 300 hall revealed:-The form for dates 6/1-6/7 no document was found,-The form for dates 5/25-5/31 no document was found,-The form for dates 5/18-5/24 no document was found,-Date: 5/11-5/17, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed a line through it,-The form for dates 5/8-5/10 no document was found,-Date: 5/1-5/7, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed a blank spot,-The form for dates 4/27-4/30 no document was found,-Date: 4/20-4/26, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed a blank spot,-Date: 4/13-4/19, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed an (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initial,-Date: 4/6-4/12, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed a blank spot, and-Date: 3/30-4/5, Resident 7 room number revealed the night of the week to clean wheelchair was listed as Thursday and an initial for completion of the duty revealed a blank spot. An interview on 6/2/26 at 11:36 AM with the Director of Nursing (DON) revealed it was the expectation of the facility that the cleaning of all resident wheelchairs to be done weekly and as needed when visibly soiled. An interview with the DON on 6/2/26 at 4:30 PM revealed the missing forms for weekly cleaning schedules had not been located at the time. A record review conducted on 6/3/2026 of additional forms titled Wheelchair and [NAME] Cleaning Schedule for 300 hall for dates:-6/1-6/7 was found the following day and left for review which revealed Resident 7 room number on the night of the week to clean the wheelchair is listed as Thursday and an initial for completion of the duty revealed an initial.-5/25-5/31 was found the following day and left for review which revealed Resident 7 room number on the night of the week to clean the wheelchair is listed as Thursday and an initial for completion of the duty revealed an initial.-5/18-5/24 was found the following day and left for review which revealed Resident 7 room number on the night of the week to clean the wheelchair is listed as Thursday and an initial for completion of the duty revealed an initial.-The form for dates 5/8-5/10, no document was found.-The form for dates 4/27-4/30, no document was found. An interview on 6/4/26 at 8:00 AM with the DON revealed the facility had deep cleaned Resident 7's wheelchair, and had initiated newly scheduled daily checks on Resident 7's wheelchair along with continued nightshift scheduled cleanings.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify a resident's responsible party of bed hold at the time of the resident's transfer from the facility for 1 (Resident 1) of 2 sampled residents, and failed to notify the ombudsman in writing of a resident's transfer from the facility as required for 1 (Resident 57) of 2 sampled residents. The facility census was 53. Findings are:A.Record review of a facility supplied document titled Notice of Bed Hold Policy and not dated revealed when a resident requires hospitalization or therapeutic leave, the facility advises the resident and the family of the bed hold policy in writing. In the case of an emergency transfer the notice is provided to the family within 24 hours of the transfer. Record review of Resident 1's Progress Notes revealed documentation on 12/29/2025 at 2:11 PM that Resident 1 was transferred out of the facility to the local emergency room and a copy of the facility's bed hold policy was sent with the resident. On 12/30/2026 the Social Service Director (SSD) documented that they mailed the bed hold to the resident's family/responsible party for them to return and sign the document. Record Review of a facility supplied document titled Resident Transfer Record -V2 dated 12/29/2025 revealed documentation that the bed hold policy was given to the resident. There was no documentation present reflecting the resident's family/responsible party was notified of the bed hold at the time of the resident's transfer. In an interview completed on 06/02/2024 at 3:15 PM with the facility Social Service Director (SSD), the SSD stated that the facility process is to give the Notice of Bed Hold Policy document to the resident at the time of the transfer and the SSD on the next business day following the transfer will mail the Notice of Bed Hold Policy document to the residents responsible party. The SSD confirmed that there was no documentation present in Resident 1's Electronic Health Record (EHR) indicating that the resident's responsible party/family was notified of the Notice of Bed Hold Policy for Resident 1's admission to the hospital on [DATE]. In an interview completed on 06/03/2026 at 2:00 PM with the Regional Administrator (RA), the RA confirmed that there was no documentation prior to the SSD documentation that the Notice of Bed Hold Policy was mailed to the resident's responsible party/family indicating that they were notified at the time of the transfer of the resident's bed hold. B.Record review of Resident 57's Progress Notes revealed on 03/23/2026 at 5:37 PM the facility was notified that Resident 57 was being admitted to the hospital. On 03/27/2026 the resident's family members came to the facility and picked up the resident's belongings to be taken to the resident's new care facility. Record review of a facility supplied document titled Action Summary and dated 04/06/2026 with a date range listed as 03/01/2026 to 03/31/2026 revealed no listing of Resident 57's transfer from the facility and admission to the hospital. In an interview completed on 06/02/2026 at 3:15 PM with the facility SSD, the SSD confirmed that the document titled Action Summary was the document that was sent once a month to the ombudsman and served as the notification to the ombudsman of the residents that had transferred out of the facility during the the designated date range. The SSD confirmed that Resident 57 was admitted to the hospital and then discharged from the facility due to being admitted to another care facility from the hospital. The SSD confirmed that the resident's transfer or discharge from the facility was not listed on the report supplied to the ombudsman and should have been.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iv) Based on record review, observation, and interview the facility failed to perform catheter cares in a manner to prevent the potential of cross contamination and infection for 1 (Resident 48) of 1 sampled resident. The facility census was 53. Findings are:A record review of Resident 48's undated Care Plan revealed the resident was admitted to the facility on [DATE], had a foley catheter (a tube that is inserted into the bladder to aide in draining urine), and was at risk for infection due to the history of Urinary Tract Infection. The Care Plan also contained an intervention for the staff to provide catheter care every shift with proper technique. In an observation completed on 06/03/2026 from 7:35 AM to 7:56 AM of catheter cares being provided to Resident 48 by Nurse Aide B (NA-B) the following was observed:-NA-B placed a package of disposable wipes, an incontinence product, and a box of disposable gloves on the foot of Resident 48's bed without first placing a clean barrier on the bed. -Resident 48 had been incontinent of a bowel movement. NA-B obtained a wipe from the disposable wipe container and used it to begin cleansing the resident's skin. NA-B used the same soiled, gloved hand to obtain additional wipes from the container and finished cleansing the BM from the resident's skin. -Without first changing gloves and without the benefit of hand hygiene, NA-B then grasped the resident's catheter with their gloved hand and used a disposable wipe to cleanse the tubing. NA-B repeated this action twice with the same disposable wipe. -NA-B then concluded assisting the resident with their needs. In an interview completed with NA-B on 06/03/2026 at 1:30 PM, NA-B confirmed that they were trained to use the disposable wipes for catheter care. The NA confirmed that they placed the supplies (package of disposable wipes, brief, and box of gloves) directly on the foot of Resident 48's bed and did not place a clean barrier between the items and the resident's bed. The NA confirmed that they did not change their gloves after cleansing the resident's visible soiling and prior to obtaining new, clean disposable wipes from the package. The NA confirmed that they were unsure if it was acceptable to use the same area of the disposable wipe when wiping down the catheter tubing. In an interview completed on 06/03/2026 at 2:50 PM with the facility Infection Control Nurse (ICP), the ICP confirmed that the NA should have provided a clean barrier between the supplies and the resident's bed and did not, and confirmed that the NA should have removed their gloves and completed hand hygiene after cleansing the resident's visible soiling and obtaining new clean disposable wipes. The ICP confirmed that a separate area of the disposable cloth or a new cloth should have been used for each wipe down the catheter.