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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemingford Care Center	605 Donald Avenue Hemingford, NE 69348

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Licensed Reference Number 175 12-006.05 (J) Based on observation, interview, and record review, the facility failed to give residents, family members, legal representatives of the resident, visitors, and the public access to the most recent survey results or plan of correction. The facility identified a census of 29 residents.An observation on 4/21/26 at 1:20 PM revealed a 3-ring binder in the lobby of the facility labeled Hemingford Care Center Survey Results.Record review of this survey results book revealed the newest survey results were from from the survey ending December 2024. The book did not include the results of the most recent survey which ended 2/2/26, or the plan of correction written for that survey. Record review also revealed there were no citations related to complaints following the previous survey included the book. An Interview on 4/21/26 at 1:29 PM with the administrator confirmed the required documents were not included in the survey book.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** License Reference Number 175 NAC 12-006.02 (H)Based on record review and interview, the facility failed to report an allegation of abuse or neglect to the State Agency within the required timeframe for 1 (Resident 7) of 3 sampled residents. The facility identified a census of 29. Record review of a facility document titled, Final investigation report dated [DATE], revealed that the Administrator (ADM) received an allegation of neglect on [DATE] from a family member of Resident 7. The document also revealed the family member alleged the facility had caused Resident 7's death through medical neglect.Record review of Nursing Notes dated [DATE] at 3:50 PM revealed the following:Resident 7's family member was in the facility when Resident 7 died.The nurse, Licensed Practical Nurse-C (LPN-C), assessed Resident 7 for signs of life and no heartbeat was detected at 2:39 PM.A provider had ordered a hospice consult for Resident 7, however the consult had not occurred yet.The administrator (ADM) was updated at 3:03 PM on [DATE].The family member used a raised voice throughout the facility, saying the facility had murdered Resident 7, and other residents became distressed.Record review of Nursing Notes dated [DATE] at 4:50 PM revealed the ADM spoke with local law enforcement regarding the family member's allegations and the ADM provided the sheriff with the requested information.A record review of Resident 7's advanced directive signed by the resident on [DATE] revealed the resident desired cardiopulmonary resuscitation (CPR) if their heart stopped beating.A review of Resident 7's physician orders and care plan in Point Click Care revealed CPR was still indicated at the time of Resident 7's death.The facility notified the State Agency of the allegation of neglect on [DATE] at 1:51 PM.An interview on [DATE] at 12:25 PM with the ADM confirmed they did not notify the state agency within 2 hours as required.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (F) (iii) Based on record review and interview, the facility failed to revise Resident 5's 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) to reflect care changes made following Resident 5's grievances. This affected one of three sampled residents. The facility identified a census of 29.Findings are: Record Review of Resident 5's census data revealed the resident was admitted on [DATE]. A record review of Resident 5's diagnoses list revealed a diagnosis of unspecified intracranial injury with loss of consciousness of unspecified duration, sequela (current, long-term complications arising from a past head injury) was added on 5/4/2023. A diagnosis of personal history of traumatic brain injury (a brain injury that is caused by an outside force and affects how the brain works) was added on 5/1/2025. A diagnosis of hemiplegia, unspecified affecting left nondominant side (paralysis of the left arm, leg, and sometimes face caused by damage to the right side of the brain) was added on 5/4/2023. A diagnosis of bipolar disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone) was added on 5/4/2023. A record review of a grievance/complaint report received on 3/29/2026 revealed that Resident 5 was concerned with NA-A not checking on them when they call and is rude and slow to help. In resolution section of report dated 3/31/26, it stated that the grievance/complaint was resolved with this description: Resident 5 reported they wanted NA-A to not provide cares. Explained staffing options, offered 2 hour rounding in pairs: agreed. It is marked that the plan of care was not updated. A record review of a grievance/complaint report received on 4/2/2026 revealed that the concern was described as Resident 5 upset about CNAs waking Resident 5 at night then take too long for clean up. Rude/dismissive when they help. In the section title Documentation of Facility Follow-Up, the date to be resolved by is 4/3/2026. The actions taken to resolve concern included updated care plan. Educated NA-A about tone/approach. Cares in pairs implemented for all noc (night) cares. It was marked yes for plan of care updated and dated for 4/3/2026. The resolution section described the resolution as Resident 5 had previously requested increased checks. Is now upset they are doing the night checks. Resident 5 now wants done only if ?gender' calls. All cares in pairs dated 4/3/2026. Interview with Resident 5 on 4/20/2026 3:05 PM confirmed that they have filed several grievances against NA-A not coming in room and none for them work. NA-A does still come into Resident 5's room. Resident 5 confirmed the facility doesn't do follow ups with grievances. A record review on 4/21/2026 of Resident 5's CCP revealed that the latest revision to the behavior section's interventions was Resident has pattern making accusatory statements regarding ?gender' care needs not being met and then refusing care when assistance is offered. Additionally, resident will make unrealistic demands such as - giving ?gender' ?lots of money' ?right now' but will not express what they need/want. The revision date is 10/20/2025. An interview with Administrator (ADM) on 4/21/26 at 10:36 AM confirmed that the interventions for the behavior section of Resident 5's CCP have not been revised since 2025. ADM confirmed that instead of updating care plan, they wrote progress notes. ADM stated that progress notes about changes to care were put in on 4/6/206, 4/7/2026, and 4/8/2026. ADM reviewed notes during interview and confirmed there were no notes on this topic. ADM stated it was more of a personnel issue and it affected the staff and not Resident 5's plan of care, so there were no changes. ADM stated the changes to care didn't need to be written into the plan of care. ADM confirmed the care concern from the 4/2/2026 grievance was not documented, like the report had revealed. Based on record review of the notes from 4/6/2026, 4/7/2026, and 4/8/2026, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there were no updates based on the updates to staffing during cares. These notes had topics of concern for finances and medications. An interview with Regional Nurse Consultant (RNC) on 4/21/26 at 10:45 confirmed that the CCP for Resident 5 should have been updated for staffing during cares. An interview with Resident 5 on 4/21/2026 at 2:20 PM confirmed that staff have not been doing cares in pairs. An interview with Director of Nursing (DON) on 4/21/2026 at 3:30 PM confirmed that the only staff that have to go into Resident 5's room as pairs is NA-A and young female staff. An interview with Resident 5 on 4/27/2026 at 10:47 AM confirmed that NA-A still goes into Resident 5's room.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10 (D) Based on record review and interviews, the facility failed to ensure a narcotic pain medication was administered as ordered for 1 (Resident 5) of 3 sampled residents. The facility census was 29. Findings Are: A record review of facility policy Administering Medications with a revision date of April 2019 revealed medications were to be administered in accordance with prescriber orders, including any required time frames. A record review of Resident 5's undated Care Plan revealed the resident was admitted to the facility on [DATE] and had diagnoses of intracranial injury with loss of consciousness of unspecified duration, hemiplegia (paralysis of one side of the body), Epilepsy (a brain disorder that causes recurring, unprovoked seizures), Spina Bifida Occulta (a condition where a baby is born with a gap between the vertebrae in their spinal cord), muscle spasms, restless leg syndrome, and a history of a traumatic brain injury. The Care Plan revealed a focus area stating, the resident has an alteration in musculoskeletal status related to contractures of both ankles, right toes, and both hands. The goal for this focus area was for the resident to be free from pain or at a level of discomfort acceptable to the resident. There was also a focus area stating, the resident is at risk for pain related to muscle spasms. The goal for this focus area was for the resident not to have interruptions to their normal activities due to pain and there was an intervention to administer analgesia oxycodone (Percocet) as per orders. A record review of Resident 5's March 2026 Medication Administration Record (MAR) revealed the resident had an order for Percocet (a narcotic pain medication combined with acetaminophen) 5-325 milligrams (MG), 1 tablet to be given every 4 hours for pain. This order had a start date of 8/14/2025. This medication was documented as 9 on March 30th for the 12:00 AM, 4:00 AM, 8:00 AM, and 12:00 PM doses. The MAR revealed 9 was a chart code for other/see progress notes. A record review of Resident 5's Progress Notes dated 3/30/2026 revealed notes at 12:16 AM and 4:17 AM stating the Percocet was not available. There were also notes on 3/30/2026 at 8:20 AM and at 12:10 PM stating the facility was awaiting the Percocet delivery from the pharmacy. A record review of Resident 5's April 2026 MAR revealed the resident continued to have an order for Percocet 5-325 MG, 1 tablet to be given every 4 hours for pain.-This medication was documented as 9 for all 6 administration times on 4/5/2026.-This medication was documented as 9 on 4/6/2026 for the 12:00 AM, 4:00 AM, 8:00 AM, and 12:00 PM administration times.-This medication was documented as 7 on 4/7/2026 at 12:00 AM. The MAR revealed 7 was a chart code for sleeping.-This medication was documented as 9 on 4/26/2026 for the 12:00 PM, 4:00 PM, and 8:00 PM administration times.-This medication was documented as 9 on 4/27/2026 for the 12:00 AM, 4:00 AM, 8:00 AM, and 12:00 PM administration times. A record review of Resident 5's Progress Notes dated 4/5/2026 revealed notes at 12:00 AM and 5:03 AM stating the Percocet medication was not available. There were also notes at 7:47 AM, 12:32 PM, 4:05 PM, 8:17 PM, and 11:35 PM stating the facility was awaiting the Percocet delivery from the pharmacy. A record review of Resident 5's Progress Notes dated 4/6/2026 revealed notes at 3:16 AM, 11:02 AM, and 11:05 AM stating the facility was awaiting the Percocet delivery from the pharmacy. A record review of Resident 5's Progress Notes dated 4/26/2026 revealed notes at 11:45 AM and 4:13 PM stating the Percocet medication was not in stock. There was also a note at 9:15 PM stating the Percocet medication was not in stock. A record review of Resident 5's Progress Notes dated 4/27/2026 revealed notes at 12:46 AM and 4:48 AM stating the Percocet medication was not available. There was also a note at 9:08 AM that facility staff had called the pharmacy and the Percocet medication would be delivered that day. An interview on 4/20/2026 at 3:05 PM with Resident 5 revealed the resident had concerns with not getting their pain medications as ordered, especially at night. Resident 5 also stated the facility had not done anything else to help with their pain. An interview on 4/21/2026 at 3:30 PM with the Director of Nursing (DON) revealed the nurse on duty was supposed to order medications when they were observed to be running low. The DON (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the doses of Percocet were not administered to Resident 5 as ordered for the dates indicated on the March and April 2026 MARs, including 10 consecutive occasions on 4/5/26 and 4/6/26.An interview on 4/27/26 at 2:28 PM with the interim DON confirmed Resident 5 had not received their Percocet as ordered for 3 occurrences on 4/26/26 and 4 occurrences on 4/27/26 and stated I don't know what they did before me as far as reordering the meds. We are doing education now to check on Thursdays to make sure they have enough for the weekend. They ordered it yesterday. An interview on 4/21/2026 at 4:49 PM with the Administrator confirmed Resident 5 had not received their Percocet medication as ordered during the months of March and April 2026.