| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285306 | A. Building<br>B. Wing | 02/02/2026 |

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| Hemingford Care Center | 605 Donald Avenue<br>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.

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Observe each nurse aide's job performance and give regular training.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1) Based on record review and interview, the facility failed to ensure 4 of 5 sampled nurse aides (NA) completed the required 12 hours of ongoing training annually based on their date of hire. This had the potential to affect all residents. The facility identified a census of 33. Findings Are: A record review of the Facility assessment dated [DATE] revealed the in-service training for nurse aides would be sufficient to ensure the continuing competence of nurse aides, provided training must be no less than 12 hours per year. A record review of an Employee Contact List dated 10/26/2026 revealed the following:-NA-I was hired on 10/2/2024,-NA-J was hired on 12/17/2024,-NA-A was hired on 8/30/2024, and-NA-L was hired on 5/8/2022. A record review of NA-I's ongoing training participation from 10/2/2024 through 10/2/2025 revealed the NA had completed 8.25 hours of ongoing training. A record review of NA-J's ongoing training participation from 10/17/2024 through 10/17/2025 revealed the NA had completed 5.75 hours of ongoing training. A record review of NA-A's ongoing training participation from 8/30/2024 through 8/30/2025 revealed the NA had completed 8.75 hours of ongoing training. A record review of NA-L's ongoing training participation from 5/8/2024 through 5/8/2025 revealed the NA had completed 8.75 hours of ongoing training. An interview on 1/29/2026 at 11:15 AM with the Director of Nursing confirmed NA-I, NA-J, NA-A, and NA-L had not completed the required 12 hours of annual ongoing training. |

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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Licensure Reference Number 175 NAC 12-006.11 and 12-006.11(D) Based on observation, interview, and record review, the facility failed to follow recipes to conserve nutritive value, palatability, and proper temperatures of the foods served to the residents. This had the potential to effect all 33 residents served food out of the facility kitchen. Observation of food preparation on 1/27/26 from 10:00 AM to 10:45 AM with Certified Dietary Manager (CDM) revealed the CDM preparing beef tips and gravy and peas with pearled onions. The CDM retrieved the recipes as requested but at no time during preparation, referenced them. The CDM opened 2 bags of peas that were labeled as 2.5 pound bags, there were no pearled onions in these peas. The CDM then cuts open an unknown size bag of beef tips with a scissors and used bare hands to pry open and pour the meat into a pan of water, the CDM touched the bare meat with unclean hands. Interview with the CDM on 1/27/2026 at 10:07 AM revealed that the CDM was preparing enough food for all 33 residents and always made extra about 40 servings. Record review of the beef tips and gravy recipe revealed that the recipe required 10 pounds of meat for 40 portions. The recipe also directed that the meat be browned in a skillet with shortening until internal temperature of product reaches 165 degrees Fahrenheit for 15 seconds. Recipe instructed to add chopped onions to beef tips and simmer for 30 minutes. The meat was cooked in water without any onions and not browned. Record review of the peas and pearled onions recipe required 10 pounds of peas and pearled onions for 50 portions. Recipe also directed that 1/2 teaspoon of black pepper, 3/4 teaspoon of salt, 1 teaspoon basil leaves, and 1/2 cup and 3 tablespoons of margarine be mixed together to add to cooked peas. None of those items were added during food preparation. An additional interview with the CDM on 1/27/26 at 10:15AM confirmed that the peas and pearled onions were ordered but none has come in so the CDM was going to add some onion powder to give it flavor. The CDM confirmed that they were uncertain how much meat was in the bag but thought it was 2 pounds. Observation 1/27/2026 at 10:45 AM revealed the CDM was going to drain the meat from the water without checking an internal temperature to ensure that it reached the required cooking temperature for the recipe, but when asked how they ensure the meat was cooked to the appropriate temperature, the cook responded This? and pointed to the meat. The CDM did obtain the temperature and it read at 194 degrees Fahrenheit (F). The CDM confirmed that only approximately 2 pounds of meat was used when the recipe required 10 and none of the seasonings were added and this could effect palatability and nutritive value. Observation on 1/27/2026 at 11:30 AM revealed the CDM preparing to start serving food to the memory unit without taking temperatures. When cued to take temperatures, the meat temped at 194F, noodles 140F, peas 183F. The CDM did not temp the soup that was being offered as an alternative. The CDM finished plating the trays for the memory unit at 11:44 AM. During the observation, it was noted that many plates only had 4-6 pieces of beef tips, but the CDM did use the appropriate ladle sizes. At 12:04 PM the CDM began plating foods for the rest of the facility. At 12:35 PM the CDM plated the room trays and a test tray and the cart was taken out of the dining room. Further observation on 1/27/2026 at 12:42 PM revealed the test tray arriving to the conference room and the CDM was present. The CDM began checking the temperature of the food delivered from the room tray cart. The beef tips and gravy was temped at 119 degrees F, and the peas temperature was 117 degrees F. The CDM sampled the test tray and confirmed the food was not hot, and would have had better flavor has the recipe been followed, and the beef browned in a skillet with onion. Record Review of the 2022 Food Code, U.S Food and Drug Administration chapter 3, section 501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding.(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5 C (41 F) or less. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 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, interview and record review the facility failed to use or dispose of expired foods, failed to perform hand hygiene and utilize gloves to prevent the potential for food borne illness and cross contamination. The facility also failed to test the sanitizing solution as required for dishwashing and cleaning services. This had the potential to effect all 33 residents that ate food out of the kitchen. Findings are: A Observation during initial kitchen tour on 1/26/2026 from 8:25 AM to 9:20 AM revealed the following: Dish room- There was food splattered on the wall behind the garbage disposal area, beside and behind the sink. There was a black substance behind the loose trim board. The dishwasher had dried white and gray particles all over the top of it. Stove- The lower cover was open and has dark substance build up on it and dry particles of food on it and the front and handles of the oven had a brown build up on it as well. The stove hood- Had a fuzzy grey build up on all of the vents. The prep counter- There were splatters on the wall behind and the storage containers below had dried brown substance and dust on the lids. The second prep counter with the microwave and mixer on top - There was dried brown substance and dust on the shelf below and the shelf above it with all of the spices. The upright refrigerator- had a temperature of 38 degrees F and the temperature log for January had 13 days in the morning where no temperature had been recorded. The evening for January only had one temperature recorded.There was a tote of grape jelly in the refrigerator with a prep date 9/26/2025 with no use-by date.There was a package of pasteurized cheese slices left unsealed with no dates. A ziplock bag of sliced cooked ham that was unsealed with no open date or use-by date. The standup white freezer had biscuits that were expired on 1/23/2026, a package of unlabeled patties with no dates, and egg rolls in blue package with no date. Dry storage room-One package of baking powder not sealed and no date, and five boxes of food on the floor and one box of potatoes on the floor. The refrigerators located in the dining room for resident food, drinks, and snacks- Inside both there was dry yellow and red liquid splattered on all the shelves, underneath the glass on the shelves, and inside the door. There was milk in a small pitcher with no date and no lid, a can of coke open with no name or date. An interview with the Certified Dietary Manager (CDM) at 1/26/26 at 9:05 AM, with the facility administrator present, confirmed the cleanliness concerns in the dish room, stove, and prep counter areas. Also confirmed the concerns with expired and unopened food. The CDM also confirmed that food delivery comes on Tuesdays and Fridays, indicating the food on the floor in the dry storage are had been there since Friday 1/23/2026. The CDM also confirmed that all kitchen staff members are responsible for putting food items away. During the interview the CDM indicated there is a cleaning schedule and that staff were not following the cleaning schedule. The CDM also confirmed that the dishwasher solution was to be checked before each meal, and that the chlorine test for Low Temperature Dish Machine 50 ppm log had 24 empty days for PM testing, and 23 empty days for AM testing. The CDM verified the facility had no food borne illnesses in the last 6 months. Record Review of two separate temperature logs for the fridges and the freezers for the month of January revealed the following:Temp Log for dining room refrigerator and freezer that hold resident foods had 29 blank days, indicating no temperatures were obtained. 1/2/2026 was filled in and 1/7/2026 was filled in. Temp Log for the kitchen refrigerator and freezer had 13 days completed with AM temperatures only. The entire month of January PM temperatures were blank except for one day. B An observation of meal preparation, food service, and temping foods on 1/27/2026 from 10:00 AM to 10:45 AM and 11:30 AM to 12:45 PM revealed the following:The CDM obtains three steam tray pans spraying the inside of each one with cooking spray, and filling each with an unmeasured amount of water. The CDM places two bags of peas into a steam tray pan with water, the CDM with ungloved hands cuts open the package of beef tips and uses bare fingers to finish opening the package touching the meat, then placing the beef tips<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 - Many | into a steam tray pan of water. The CDM then puts half a bag of unmeasured noodles into a steam tray pan with water. At 10:45 AM the CDM was ready to drain the beef tips and was not going to take a temperature to confirm the food was at the required temperature according to the recipe, when cued the CDM took the temperature and it read 194 degreed F. Then the CDM poured the meat and water into a strainer that was located in the middle sink of the 3 compartment sink for dishwashing. The middle sink had hardwater stains and other unknown particles. The CDM then added the drained beef tips to the prepared gravy. An interview with the CDM at 10:55 AM on 1/27/2026 confirmed the middle sink had not been cleansed prior to straining noodles and beef tips in it, and that the cook did not follow the recipe, so the CDM did not use enough meat for 40 servings, nor were any seasonings added. The CDM also confirmed that the chemical solution for wiping down services was changed every 3 hours but that the facility had never tested the solution to ensure that it had the accurate parts per million to ensure sanitization. During the observation of meal service the CDM began to plate foods and when was asked how to know if all of the food maintained required temperature, the CDM stopped to perform the temperatures. The beef tips and gravy temp was 168F, the noodles at 140F, and the peas at 183F. No temperature was taken of the soup that was being served as an alternate. During the plating of the food it was observed that many plates only had 4-6 small pieces of meat. While serving the main dining room, numerous residents chose sandwiches as alternate meals. The CDM took a plate to the prep counter, applied gloves without the benefit of hand hygiene (HH), obtained ham and cheese from the fridge, opened the cheese, took out a large stack of sliced cheese and set it on the outside package of the cheese. The CDM then opened the ham and used the same soiled gloves to take ham out of the bag and then rolled the ham and cheese slices together and removed gloves and performed HH. As the CDM continued to plate food, the meal tickets indicated sandwiches needed to be served so the CDM would stop, obtain a loaf of bread, open the bread with unclean, ungloves hands, take out slices of bread, and then applied gloves without HH and placed ham and cheese slices on the bread and took to the window. This same process occurred three times during meal service. When the main dining room was done [NAME] served, the CDM began making room trays. While making room trays the CDM would use a dirty pen to write names on stickers for the room trays and then touch sandwiches with bare hands. At the end of meal service at 12:37 PM, the CDM was asked how they ensure the food temps held until the end of meal service, the CDM then obtained temperatures and the beef tips and gravy temped at 180F, the noodles 170F, the peas at 170F and the soup at 170F. A room tray was delivered to the conference room at 12:43 PM and the CDM obtained temperatures and they were as follows: Beef tips and gravy with noodles temped 119F, and peas 117F. Record review of 2022, U.S. Food and Drug Administration under chapter 2, section 301.11 states FOOD EMPLOYEES may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. An interview with the CDM at 12:44 PM on 1/27/2026 confirmed the room tray did not hold the required temperature according to the Food Code. The CDM also confirmed that the food tasted cold and was bland in flavor. A record review of the facility food temperature logs for the month of January revealed there were only 7 times that there were partial documentation of food items temped after the meal indicating only one or two items were temped at the end. An additional interview with the CDM on 1/27/2026 confirmed that the facility was not consistent with checking food temperatures after meal service. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A) Based on observation, interview, and record review; the facility failed to ensure the light fixtures throughout all halls of the facility were free of deceased bugs. This had the potential to affect all residents. The facility identified a census of 33. Findings are: A record review of the facility policy Environmental Safety and Infection Prevention Policy dated [DATE] revealed the facility will maintain all resident care areas, common areas, and support spaces in a clean, orderly, and sanitary condition at all times. An observation on [DATE] at 9:40 AM revealed the light fixtures in the hallway outside administrator's office and in common area outside the main dining room had numerous dead bugs in them. An observation on [DATE] beginning at 9:31 AM revealed deceased bugs in the following light fixtures:-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside of the beauty salon,-All of the light fixtures in the common area outside the main dining room,-Three of the light fixtures in the main dining room,-Both light fixtures in the nurse's station,-Both light fixtures outside of the administrator's office,-All of the light fixtures in the entry foyer,-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway outside both laundry room doors,-The light fixture in the hallway outside the employee lounge,-The light fixture in the hallway outside resident room light outside Physical Therapy room,-All of the light fixtures in the Memory Care Unit (MCU) dining room,-The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the hallway between resident rooms [ROOM NUMBERS], -The light fixture in the hallway outside resident room [ROOM NUMBER], -The light fixture in the hallway outside resident room [ROOM NUMBER],-The light fixture in the MCU hallway outside a door labeled assisted living supply, and-The light fixture in the hallway outside resident room [ROOM NUMBER]. An interview on [DATE] at 9:47 AM with the Housekeeper confirmed the light fixtures had bugs in them, housekeeping was not responsible for cleaning the light fixtures, and that this was the responsibility of the maintenance department. An interview on [DATE] at 9:49 AM with Maintenance revealed the light fixtures were cleaned every three months and the last time they were cleaned was in October. Maintenance confirmed the light fixtures needed to be cleaned. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F) Based on record review and interviews, the facility failed to review and revise care plans when necessary for 2 (Residents 11 and 20) of 12 sampled residents, and failed to ensure 1 (Resident 21) of 1 sampled resident representative was able to participate in the development of their care plan. The facility census was 33. Findings Are:<br><br>A record review of the facility policy Care Plans, Comprehensive Person-Centered with a revision date of [DATE] revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.<br><br>A.<br><br>A record review of Resident 11's Baseline Care Plan revealed the resident was admitted to the facility on [DATE].<br><br>A record review conducted on [DATE] of Resident 11's undated Care Plan revealed a focus area dated [DATE] of Advanced Directives which stated that the resident was a full code and the facility was to perform Cardiopulmonary Resuscitation in the event that the resident was found without a pulse or was not breathing. This section also stated the facility was to review the code status with Resident 11's guardian quarterly and as desired.<br><br>A record review of Resident 11's Advance Directives document dated [DATE] revealed the resident did not wish to receive CPR, blood transfusions, tube feedings, or be transferred to an acute care hospital. The document was signed on [DATE] by the resident's guardian and facility Social Services Designee and was signed by the resident's provider on [DATE].<br><br>An interview on [DATE] at 2:47 PM with the Director of Nursing (DON) confirmed Resident 11's Advanced Directive indicated the resident did not want to receive CPR and that their care plan information was not accurate. The DON stated that the MDS Coordinator would be the party responsible for updating this section of the care plan.<br><br>An interview on [DATE] at 9:10 AM with the Minimum Data Set (MDS) Coordinator revealed that the facility's Social Services person was still in training, so this was why the MDS Coordinator was primarily responsible for the advanced directives portion of the care plans. The MDS Coordinator stated they were not aware of Resident 11's code status had changed from CPR to DNR and that they update the care plans when they are made aware of changes.<br><br>B.<br><br>A record review of Resident 20's admission Record revealed the resident was admitted to the facility on [DATE].<br><br>A record review of Resident 20's Level II PASRR dated [DATE] revealed documentation under PASRR Determination:<br><br>-Meets the federal definition of Serious Mental Illness? Yes.<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Meets for Nursing Facility Level of Care? Yes.<br><br>-Days Approved? Unlimited.<br><br>A record review of Resident 20's admission MDS dated [DATE] revealed in Section A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual<br><br>disability or a related condition? contained a response of No. This was signed by the MDS Coordinator on [DATE]. Section A1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions was disabled due to the No response to Section A1500.<br><br>A record review of Resident 20's Care Plan revealed no evidence of the resident's Level II PASRR stating the resident had a serious mental illness or goals and interventions related to this.<br><br>An interview on [DATE] at 9:10 AM with the MDS Coordinator confirmed Resident 20's Level II PASRR indicated they had a Serious Mental Illness and that their admission MDS was not coded accurately. The MDS Coordinator stated that since they were not aware of Resident 20's Level II PASRR result when the MDS was completed, this was the reason for the information also not being on the resident's care plan however, it should have been.<br><br>C.<br><br>Record Review of Resident 21's profile revealed original admission date of [DATE] with a diagnosis of Chronic Heart Failure, Chronic Pain, Displacement of esophageal anti-reflux device.<br><br>Record review of Resident 21's Minimum Data Set (MDS) (a federally mandatory assessment that identifies cares needed for the resident) dated [DATE] revealed the following: Section C The Brief Interview for Mental Status (BIMS) (a brief screener that aids in detecting cognitive impairment) a score of 7, which indicates the resident was moderately cognitively impaired. Section GG indicated the resident is dependent on staff for all activities of daily living, except eating and drinking requires set up and supervision. Section K revealed the resident was on nectar thickened liquids. Section N indicated the resident was on a diuretic.<br><br>Record Review of Resident 21's care plan with a last revision date of [DATE] revealed a problem for fluid balance and a potential risk for fluid deficit related to diuretic use, decreased thirst mechanism, and thickened fluid order. Interventions on the care plan reveal the following: Resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor. Resident will have access to nectar thick liquids of choice whenever possible. An activities problem with an intervention to establish and record interest in activities by talking with family on admission and as necessary.<br><br>Interview with Resident 21's family member on [DATE] at 12:25 PM revealed they only had 3 care plan meetings since the residents admission 7 years ago. Family also states they feel they are not being included in decision making about care, medications, and therapies. The family member also verbalized that they are supposed to have a monthly conference about concerns and that has not been happening.<br><br>Record review of Resident 21's care plan conference summary dated [DATE] revealed that family<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was invited but chose not to attend. The facility did not provide documentation of any other care conference notes for this resident.<br><br>Interview with Social Service Director (SSD) on [DATE] at 11:45 AM revealed that the process is the MDS nurse will give the SSD a list of care plans due two weeks in advance. The SSD will call the families to see if they want to attend. The care conference meetings are now documented on a new form and the SSD confirmed I have no idea when the last care plan meeting was for Resident 21. The SSD also confirmed that the care plan meetings should be quarterly and the last one was done on [DATE].<br><br>Interview with the Administrator (ADM) on [DATE] at 12:20 PM revealed that the previous social services employee did not always document the care plan meetings and the ADM was still looking for documentation for Resident 21. The facility was unable to provide any further documentation on family participation in family care plan meetings for Resident 21.<br><br>Record Review of the facility policy titled Care Planning-Interdisciplinary Team, last revised [DATE] revealed 'The Interdisciplinary Team includes the resident and/or the resident representative The policy goes on to indicate that they will be scheduled at the best time of the day for the resident and family when possible .' |

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| Hemingford Care Center | 605 Donald Avenue<br>Hemingford, NE 69348 |

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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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.08(B) Based on record review and interview, the facility failed to obtain a clinical rationale from the provider to continue as needed (PRN) psychotropic medications beyond 14 days as required for 2 (Residents 6 and 13) of 5 sampled residents. The facility identified a census of 33.<br><br>Findings Are:<br><br>A record review of the facility's Psychotropic Medication Use policy dated July 2022 revealed that for psychotropic medications that are not antipsychotics if the prescriber or attending physician believes it is appropriate to extend the PRN (as needed) order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.<br><br>A.<br><br>A record review conducted on 1/29/2026 of Resident 13's January 2026 Medication Administration Record (MAR) revealed the resident was admitted to the facility on [DATE]. There was an order for lorazepam (an anti-anxiety medication) 0.5 milligrams (MG) to be given every 8 hours as needed for anxiety. The order had a start date of 12/26/2025 and no end date or duration indicated.<br><br>A record review of Resident 13's Progress Note dated 1/8/2026 revealed the resident's provider gave an order to refill the resident's lorazepam 0.5 MG every 8 hours as needed for anxiety. There was no evidence of there being an end date or duration for this medication.<br><br>A record review of Resident 13's electronic medical records conducted on 1/29/2026, 22 days after the refill order was received, revealed no evidence of the provider giving a clinical rationale for continuing Resident 13's as needed lorazepam or of there being an end date or duration for the medication.<br><br>A record review of a medication script provided by the facility revealed the provider had written a script on 1/29/2026 for Resident 13 that stated Continue current PRN (as needed) Ativan (lorazepam) order as prescribed. Re-evaluate 2/12/2026 when provider sees Resident 13. Dx (diagnosis) anxiety.<br><br>An interview on 1/29/2026 at 1:30 PM with the Director of Nursing confirmed there was no clinical rationale to continue the as needed lorazepam nor was there an end date/duration indicated for this medication for Resident 13.<br><br>B.<br><br>Record Review of Resident 6's admission record reveals that resident 6 was admitted [DATE] with diagnosis of unspecified injury of head, diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, obsessive-compulsive personality disorder, other dissociative and conversion disorders, dissociative identity disorder, anxiety disorder, and major depressive disorder.<br><br>Record Review of Resident 6's Comprehensive Minimum Data Set (MDS) (a federally mandated assessment to help guide cares for a resident) dated 10/2/2025 revealed the following: Section C- (continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Brief Interview for Mental Status (BIMS)(a brief screener that aids in detecting cognition impairment) a score of 7 indicating moderate cognitive impairment. Section GG reveals bathing, transfers, and bed mobility require substantial assistance, and eating is set up only. Section D and E show no behaviors. Section N shows the resident is on opioids but none of the psychotropic medications are listed.<br><br>Record review of Resident 6's Care Plan last revised 5/9/2024 revealed a problem of PASSAR level 2, due to anxiety, MDD, and dissociative Identity Disorder, with an intervention of psychiatric consultation and review medication. A behavioral problem related to diagnosis of TBI and psychiatric diagnosis. A psychotropic medication problem related to an order for PRN Lorazepam, scheduled Clonazepam, Seroquel, Gabapentin for diagnosis of anxiety and Belsomra for insomnia.<br><br>Record Review of Resident 6's physician order from Regional [NAME] Medical Center dated 9/29/2025 revealed Lorazepam oral concentration 2milligrams (mg) per milliliter (mL) give 0.5 mL by mouth every eight hours as needed (PRN) for Anxiety.<br><br>Record Review of Resident 6's Progress Notes and Physicians orders from 9/30/2025- 1/28/2026 revealed no documentation about why Lorazepam PRN was continued past 14 days.<br><br>During an interview on 1/29/2026 with the Director of Nursing (DON), when requesting documentation for rationale of continuing Lorazepam PRN, the DON provided a copy of an informed consent dated 12/26/2025. No other documentation provided at that time. The DON returned later in the day with a telephone order from Medical Doctor (MD)-H dated 1/29/2026 at 1:20 PM indicating Lorazepam was for anxiety, and had a note to add a stop date in 14 days.<br><br>A record review of the facility's Psychotropic Medication Use policy dated July 2022 revealed that for psychotropic medications that are not antipsychotics if the prescriber or attending physician believes it is appropriate to extend the PRN (as needed) order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to submit their investigation to the state agency for 1 (Resident 6) of 3 sampled residents within the required 5 working days for Resident 6. The facility reported a census of 33Record review of a facility-provided document titled Initial report revealed that Resident 6 was found to be wearing a brief that was overly wet and soiled at 6:00 AM on 1/2/26. The document further revealed that Nurse Aide-A (NA-A) from the shift prior was suspected of leaving the resident in the soiled brief for an extended period. The document revealed that this incident was reported to the state agency on 1/2/26.Record review of Resident 6's facesheet revealed they were admitted [DATE] and had diagnoses of cancer of the pancreas, rhabdomyolysis (a condition in which muscles break down rapidly and release harmful substances into the body), diabetes mellitus type 2 (a disorder where the body is unable to regulate blood sugar effectively), and a traumatic brain injury.Record review of an undated facility-provided document titled, Summary of Findings Investigation Report, revealed a summary of the findings of the investigation into the allegation of neglect that occurred on the night shift of 1/1/26 PM to 1/2/26 AM.A record review of a facility policy titled, Abuse, neglect, exploit or misappropriation - Reporting and investigating, last revised September 2022, revealed that the facility administrator will provide a follow-up investigation report within 5 business days.Record review of an email exchange provided by the facility's Administrator (ADM) revealed that a final investigation report was not submitted to the state agency within 5 working days as required.An interview with the ADM on 1/28/2026 at 3:30 PM confirmed no investigative report was submitted by the facility within the 5 working days as required. |

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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>Based on record review and interview, the facility failed to notify 1 (Resident 1) of 1 sampled resident and their representative in writing regarding the reason for their transfers to the hospital. The facility identified a census of 33.Findings Are: A record review of Resident 1's Progress Notes dated 1/2/2026 revealed the resident was transported to the emergency room at 3:11 PM and the facility confirmed at 5:14 PM the same day that the resident had been admitted to the hospital. A record review of a Bed Hold Agreement for Resident 1 confirmed the resident was placed on a bed hold on 1/2/26. A record review of Resident 1's Progress Note dated 1/19/2026 revealed the resident was sent to the emergency room at 7:10 PM. A record review of Resident 1's Progress Note dated 1/20/2026 confirmed the resident had been admitted to the hospital. A record review of a Bed Hold Agreement for Resident 1 confirmed the resident was placed on a bed hold on 1/19/2026. A record review of Resident 1's electronic medical records revealed no evidence of a written notice of the reason for transfer being provided to the resident or their representative related to Resident 1's hospital admissions on 1/2/2026 and 1/19/2026. An interview on 1/29/26 at 11:28 AM with the Administrator confirmed that the reason for Resident 1's transfers to the hospital on 1/2/26 and 1/19/26 were not provided in writing as required to the resident or their representative. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview, the facility failed to ensure the admission 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) was accurately coded in relation to the Level II Pre-admission Screening and Resident Review (PASRR, a process which requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have Serious Mental Illness or Intellectual Disability) for 1 (Resident 20) of 1 sampled resident. The facility identified a census of 33.Findings Are: A record review of Resident 20's admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident 20's Level II PASRR dated 10/28/25 revealed documentation under PASRR Determination:-Meets the federal definition of Serious Mental Illness? Yes.-Meets for Nursing Facility Level of Care? Yes.-Days Approved? Unlimited. A record review of Resident 20's admission MDS dated [DATE] revealed in Section A1500 Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? contained a response of No. This was signed by the MDS Coordinator on 11/9/2026. Section A1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions was disabled due to the No response to Section A1500. An interview on 1/29/26 at 9:10 AM with the MDS Coordinator confirmed Resident 20's Level II PASRR indicated they had a Serious Mental Illness and that their admission MDS was not coded accurately. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident 11) of 12 sampled residents. The facility identified a census of 33.Findings Are: A record review of the facility policy Care Plans, Comprehensive Person-Centered with a revision date of March 2022 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. A record review of Resident 11's admission 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 9/29/2025 revealed in Section F, the following activities that were very important to the resident:-Being around animals, such as pets.-Keeping up with the news.-Going outside to get fresh air when the weather is good.-Participating in religious services or practices.In addition, Resident 11 indicated the following activities were somewhat important to them:-Doing things with groups of people.-Doing their favorite activities. A record review conducted on 1/27/2026 of Resident 11's undated Care Plan revealed no evidence of the resident having a focus area or goals related to their activities preferences. An interview on 1/28/26 at 2:47 PM with the Director of Nursing (DON) confirmed Resident 11's Care Plan did not contain a section related to their activities preferences and that the MDS Coordinator would be the person responsible for updating this in the care plan. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide peri-cares as required to Resident 3 and failed to ensure Resident 21's lab work was obtained as ordered by the provider. The facility reported a census of 33.<br><br>Findings are:<br><br>A.<br><br>Record review of Resident 3's face sheet revealed they were admitted to the facility on [DATE] with urinary tract infection, mood disorder, paralytic syndrome (loss of motor function, generalized muscle weakness, neurogenic bowel (an impaired ability to control bowel movements due to damage of the nervous system), and diabetes mellitus type 2 (a disorder where the body is unable to regulate blood sugar effectively).<br><br>An interview with Resident 3 on 1/26/26 at 11:08 AM revealed the resident was upset about being left waiting for assistance to on prior occasions. Resident 3 revealed that on several prior occasions, they had been left to wait in their room for staff to help them with incontinence care. Resident 3 stated staff had answered their call light, said they were going to return with the required 2nd staff member, then Resident 3 had waited for 30 minutes to 2 hours to have their continence products removed and changed. Resident 3 stated this made them feel helpless and that they were inconveniencing the staff.<br><br>Continuous observation on 1/28/26 revealed the following:<br><br>At 9:03 AM, Resident 3 was in their wheelchair in the TV area near the nurse's desk and reported to the charge nurse they needed to be changed and they were returning to their room.<br><br>At 9:05 AM, Resident 3 was in the hallway near the activity room. Nurse Aide-N (NA-N) asked the resident where they were going and helped them return to their room. Resident 3 told NA-N they needed to be changed. NA-N left the resident's room,<br><br>At 9:06 AM, Resident 3 turned on their call light.<br><br>At 9:07 AM, Nurse Aide-O (NA-O) entered Resident 3's room, the call light was turned off, then NA-O exited the room.<br><br>An interview with Resident 3 at 9:14 AM revealed they were still waiting for help in their room. The interview also revealed they had asked NA-N and NA-O for assistance but that they each needed a second person to help with the mechanical lift. Resident 3 stated that it was difficult to get two staff to be available at the same time.<br><br>At 9:28 AM two nurse aides who were not NA-N or NA-O wheeled a resident out of the activity room and into the room to the left of Resident 23's room. One of the nurse aides brought the mechanical lift into that resident's room and shut the door.<br><br>At 9:35 AM Resident 3 was still waiting in their room for assistance.<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 9:38 AM Resident 3 wheeled themselves into the hallway outside their room. A housekeeper walked by, and Resident 3 stated to the housekeeper they needed assistance being changed because they had a meeting at 10:00 AM.<br><br>At 9:40 AM Resident 3 was still out in the hallway, and NA-N walked up to the resident and asked what they needed, and Resident 3 stated they needed to be changed because they had a meeting at 10, and reiterated they had been waiting since 9 AM. NA-N pushed Resident 3 in their wheelchair into their room and exited shortly afterward.<br><br>At 9:42 AM NA-N and Nurse aide-P (NA-P) entered Resident 3's room with the mechanical lift, returned to the hall to put on protective clothing, then re-entered the room and shut the door.<br><br>At 10:06 AM NA-N and NA-P exited Resident 3's room, and NA-P carried a red plastic bag of trash that smelled like a bowel movement out of the room and into a utility room across the hall. Resident 3 exited the room at 10:07 AM in their wheelchair.<br><br>The continuous observation ended at 10:13 AM.<br><br>An interview with NA-P on 1/28/26 at 10:13 AM revealed Resident 3 had an incontinent bowel movement.<br><br>An interview with NA-N on 1/28/26 at 1:16 PM confirmed Resident 3 required the use of the mechanical lift and two staff members for assistance.<br><br>An interview with the Director of Nursing (DON) at 1:33 PM revealed that nursing staff are expected to assist the resident with toileting needs within approximately 10 to 15 minutes of requesting assistance, and that included Resident 3. The DON confirmed that sitting in a dirty brief would be a concern for Resident 3's skin integrity and infection control for Resident 3's catheter.<br><br>B.<br><br>Record review of Resident 21's clinical census sheet indicated resident went to the hospital on 1/13/2026 and returned to the facility on 1/15/2026 with a diagnosis of Influenza A and hypoxia, a history of essential hypertension, Chronic kidney disease stage 3, unspecified urinary incontinence, and urinary tract infections. Resident also was admitted to the hospital 4/18/2025 with a diagnosis of Altered Mental Status (AMS) and had numerous labs drawn, with hemoglobin being low at 10.3, (normal range 12.0-16.0) red blood cells being low at 2.96 (normal being 4.20-5.40).<br><br>Record review of Resident 21's Minimum Data Set (MDS) (a federally mandatory assessment that identifies cares needed for the resident) dated 11/15/2025 revealed the following: Section C The Brief Interview for Mental Status (BIMS) (a brief screener that aids in detecting cognitive impairment) a score of 7, which indicated the resident was moderately cognitively impaired. Section GG indicated the resident is dependent on staff for all activities of daily living, except eating and drinking requires set up and supervision. Section I shows a diagnosis of heart failure, anemia, Non-Alzheimer's Dementia, Hypokalemia (low Potassium). Section K revealed the resident was on nectar thickened liquids. Section N indicated the resident was on a diuretic.<br><br>Record Review of Resident 21's care plan with a last revision date of 7/23/2025 revealed a problem for fluid balance and a potential risk for fluid deficit related to diuretic use, decreased thirst<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mechanism, and thickened fluid order. Interventions on the care plan revealed the following: Resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor; to obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Resident will have access to nectar thick liquids of choice whenever possible. Also revealed a problem for Vitamin B12 deficiency anemia, another problem for history of Congestive Heart Failure and hypokalemia; an intervention to monitor potassium levels.<br><br>Record Review of Resident 21's orders revealed new orders for labs on 1/8/2026 at 1:04 PM; Basic Metabolic Panel and Hemoglobin A1c ( BMP and Hgb A1c). Record Review of Resident 21's progress note on 1/9/2025 revealed no tubes available for lab draw.<br><br>Interview with Licensed Practical Nurse (LPN)-C on 1/28/2026 at 12:15 PM confirmed there was an order to draw a BMP and Hgb A1c on 1/9/2025 and it was not done. LPN-C also confirmed there is no progress note showing the MD was notified that the lab order was not completed. The facility did not provide a policy on Lab draws. |

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement interventions to prevent and alleviate the formation and worsening of pressure injuries for Resident 23. The facility identified a census of 33. A record review of Resident 23's face sheet revealed they were admitted to the facility on [DATE] with diagnoses of traumatic brain injury, dementia, chronic obstructive pulmonary disease, and congestive heart failure.A record review of Resident 23's nursing progress notes revealed the following:On 12/11/25, Resident 23 had a peeling skin/small open area to coccyx (tailbone). The area was cleaned and a nurse aide was educated to apply barrier cream with each brief change, and staff should attempt to reduce pressure to buttocks while in bed.On 12/15/25, the same area to Resident 23's coccyx split open and measured 3.2 x 0.5 centimeters (cm). Treatment and dressing were applied, and the resident's primary care provider was notified.On 12/20/25, the open area measured 2.4 by 0.2 cm.On 12/25/25, a progress note revealed the wound appeared shorter during a dressing change.On 12/31/25 during a dressing change, purulent drainage (thick, miik-like discharge which frequently indicates infection) was noted from the wound.On 1/8/26 during a dressing change, redness was documented at the site of the wound with minimal drainage.On 1/15/26 during a dressing change, the wound was documented as grey and light pink, no drainage or bleeding, 1.5 inches (in) long x 0.5 in wide, and 0.5 cm deep.No progress notes were charted for the wound from 1/16/26 through 1/19/26.On 1/20/26 at 1:36 PM during Resident 23's dressing change, the dressing was noted to have green/brown drainage with foul odor, was darker in color, and the surrounding area was reddened. The provider was notified and a referral was made to the wound care clinic. Resident 23 was placed on a turning schedule every 2 hours for the nurse aides to document.On 1/21/26 at 5:45 PM during Resident 23's dressing change the wound measured 5.5 by 3 by 1 (no measurement units given), wound bed was light pink and grey with a large amount of purulent drainage, peeling skin, and foul odor but better than it was on 1/20. The primary care provider's office was contacted again regarding the wound clinic referral.On 1/22/26 at 2:38 PM the provider's office was contacted to notify of Resident 23's new skin integrity issues including soles of feet, left scapula (shoulder blade), right heel, and to ensure the wound clinic referral had been sent. At 4:51 PM the facility contacted the wound clinic to ask if the nurse practitioner (NP) could come to the facility to see Resident 23.On 1/23/26, progress notes stated the wound clinic's NP came to the facility and looked at Resident 23's wounds. The NP gave recommendations for wound treatments and recommended sending Resident 23 to the hospital for intravenous antibiotics and surgical debridement (removal of dead or infected tissue to promote healing). Resident 23 was sent to the emergency department at the hospital and was later admitted for intravenous antibiotics and a surgical consult.A record review of Resident 23's provider orders revealed the following interventions related to their coccyx wound:On 2/13/2025 an order was entered for barrier cream to be applied every shift to the coccyx and buttocks for a preventative treatment.On 12/22/25 an order to administer sugar free Prostat (an oral protein supplement) two times a day.On 1/21/26 an order was entered to complete weekly wound assessments on 5 separate areas of resident's body including gluteal cleft (the groove separating the two buttocks).On 1/21/26 an order was entered to monitor open area to gluteal cleft.On 1/22/26 an order was entered to ensure Resident 23 was repositioned every hour and to keep them off their buttocks as much as possible.A record review of Resident 23's care plan revealed the following items related to their coccyx wound:Initiated on 3/24/25, Resident 23 required 1 to 2 people for bed mobility.Initiated on 3/24/25 and revised on 11/21/25, to leave a sling under Resident 23 while they are up in their wheelchair.Initiated on 3/24/25, to clean Resident 23's peri-area with each incontinence episode, apply house barrier, and check 2-3 hours and as required for incontinence.Initiated on 1/26/26, maintain enhanced barrier precautions while providing direct resident care.Initiated on 1/26/26, to assess and document wound healing every week until resolved, (continued on next page) |

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| | 285306 | A. Building<br>B. Wing | 02/02/2026 |

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

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and report changes to the provider.Record review of an untitled facility document dated 1/23/26 revealed the wound clinic NP performed a wound assessment on that date of Resident 23's wounds. The document also revealed the NP removed the dressing from the lower sacrum (near the coccyx) which was saturated. The open wound had a foul odor and was covered with eschar (dead tissue), and the edges of the wound did not show growth of new tissue. The subcutaneous tissue (lowest level of the skin) was liquefied and a thin layer of tissue remained. A wound culture was taken for lab testing. The wound was estimated at 5 cm long by 2 cm deep and 2 cm wide with undermining (made a pocket in the wound) 1.5 cm long and called sacral pressure injury that is effectively Stage 4. The note also stated that Resident 23 needed to go to the ER or primary care office, the sacral wound was heavily draining and obviously deeply infected.Record review of a website for the National Institute of Health, National Library of Medicine, National Center for Biotechnology Information (https://www.ncbi.nlm.nih.gov/books/NBK553107/) revealed pressure injuries develop due to prolonged pressure exerted over specific areas of the body. Stage 4 was described as full-thickness skin loss through the fascia (connective tissue that connects structures in the body) with considerable tissue loss, with possible muscle, bone, tendon, or joint involvement.An interview on 2/2/26 at 12:30 PM with Licensed Practical Nurse-C (LPN-C) confirmed additional interventions were added to Resident 23's care plan on 1/22/26 the day before Resident 23 went to the hospital.An interview on 2/2/26 at 12:35 PM with the director of nursing (DON) revealed that there were no additional interventions besides the repositioning and wound dressing changes. The interview also revealed Resident 23 was still in the hospital. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(J)(iii)Based on observation, record review, and interview, the facility failed to ensure one (Resident 21) of one sampled resident received adequate fluid according to dietary recommendations based on resident weight and medication orders. The facility identified a census of 33. Findings are:Record review of Resident 21's clinical census sheet indicated the resident went to the hospital on 1/13/2026 and returned to the facility on 1/15/2026 with a diagnosis of Influenza A and hypoxia (low oxygen levels). A history of essential hypertension. Chronic kidney disease stage 3, unspecified urinary incontinence, and urinary tract infections.Record review of Resident 21's Minimum Data Set (MDS) (a federally mandatory assessment that identifies cares needed for the resident) dated 11/15/2025 revealed the following: Section C The Brief Interview for Mental Status (BIMS) (a brief screener that aids in detecting cognitive impairment) a score of 7, which indicated the resident was moderately cognitively impaired. Section GG indicated the resident is dependent on staff for all activities of daily living, except eating and drinking requires set up and supervision. Section K revealed the resident was on nectar thickened liquids. Section N indicated the resident was on a diuretic.Record Review of Resident 21's care plan with a last revision date of 7/23/2025 revealed a problem for fluid balance and a potential risk for fluid deficit related to diuretic use, decreased thirst mechanism, and thickened fluid order. Interventions on the care plan reveal the following: Resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor. Resident will have access to nectar thick liquids of choice whenever possible.Record Review of Resident 21's dietary assessment dated [DATE] revealed the resident is on two diuretics, nectar thickened liquids, and requires 2,062 milliliters (mL) daily, encourage intake in the dining room, and promote fluid intake.Record review of Resident 21's daily fluid intake revealed the following:1/16/2026 240mL total1/17/2026 780mL total1/18/2026 0mL total1/19/2026 720mL total1/20/2026 30mL total1/21/2026 780mL total1/22/2026 550mL total1/23/2026 810mL total1/24/2026 1060mL total1/25/2026 960mL total1/26/2026 1600mL total1/27/2026 720mL totalObservations of Resident 21 revealed the following:1/26/2026 at 11:11 AM, Resident 21 sitting in the commons area in wheelchair without any fluids available.1/27/2026 at 7:30 AM, Resident 21 sitting in wheelchair in commons area sleeping, no fluids available.1/27/2026 at 7:54 AM, Resident 21 sitting in wheelchair in commons area asking repeatedly for water, licking lips and smacking mouth. Staff obtain water after several minutes.1/27/2026 at 8:00 AM Resident 21 taken to the dining room with the fluids requested earlier, no other fluids offered.1/27/226 at 8:15 AM, Resident 21 served pureed food on a separated plate, this was set to the left of the resident and no silverware was provided. Staff obtained silverware a few minutes later.1/27/2026 at 8:20 AM, Resident 21 having difficulty feeding self, dropping food on self and table, scooping food off table and off resident arm and licking hands. No additional fluids are offered.1/27/2026 at 2:29 PM, Resident 21 sitting in recliner room with a water pitcher on the opposite side of room out of reach.1/28/2026 at 7:00 AM, Resident 21 sleeping in wheelchair in commons are with no fluids available.1/28/2026 at 8:10 AM, Resident 21 in the dining room at the table, no fluids available. 1/28/2026 at 8:15 AM, Resident 21 has food on the table in front of them, sleeping, no fluids available.1/28/2026 at 8:25 AM, staff member sits down to assist Resident 21 with eating, no fluids available.1/28/2026 8:37 AM, Resident 21 had food in front of them for over 25 minutes being fed by staff and no fluids available. Interview with Dietary Aid B on 1/28/2026 at 8:37 AM confirmed that liquids are passed at meals per the resident request. No water is passed because The residents get that in their pitchers daily in their room. They can ask for drinks at meals. Dietary aid also confirmed that Residents 21 did not have any fluids in front of them at this time and had been served their meals at 8:15 AM. Interview with the Registered Dietician (RD) on 1/28/2026 at 1:05 PM confirmed that the expectation is the residents will have at least two glasses of liquids with meals. The RD also confirmed that Resident 21's fluid intake is very<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | important because of diagnosis of Congestive Heart Failure, and the resident takes diuretics (Medication to encourage the increased production of urine, and to remove fluid from the body).Record review of facility policy titled Hydration-Clinical Protocol last revised September 2017 revealed ?The staff will provide supportive measures such as supplemental fluids.' |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure 1 (Resident 6) of 5 sampled residents was seen by a primary care physician as required by the federal regulation, which is every 120 days when alternating visits with a non-physician practitioner (NPP). The facility identified a census of 33. Record Review of Resident 6's admission record reveals that resident 6 was admitted [DATE] with diagnosis of unspecified injury of head, diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, obsessive-compulsive personality disorder, other dissociative and conversion disorders, dissociative identity disorder, anxiety disorder, and major depressive disorder. Record Review of Resident 6's Minimum Data Set (MDS) (a federally mandated assessment to help guide cares for a resident) dated 10/2/2025 revealed the following: Section C- Brief Interview for Mental Status (BIMS)(a brief screener that aids in detecting cognition impairment) a score of 7 indicating moderate cognitive impairment. Section GG reveals bathing, transfers, and bed mobility require substantial assistance, and eating is set up only. Record Review of Resident 6's Provider visit notes revealed only two provider visit notes from a Primary Care Physician; MDH; dated 9/30/2025 and 10/3/2025. Resident 6 was seen only by Advanced Practice Registered Nurse (APRN)-D,APRN-G, Doctor of Podiatric Medicine (DPM)-E, Physicians Assistant-Certified (PA-C)-F, and Hospice RN on all other dates from 1/17/2025-1/20/2026. On 11/4/2025 Resident 6 was readmitted to hospice. Provider visit notes are as follows: 1/17/2025 60 Day review APRN-D2/20/2025 Podiatry3/26/2025 APRN-D4/8/2025- APRN-D4/24/2025 DPM-E5/15/2025 APRN-D7/10/2025 DPM-E7/24/2025 APRN-D9/18/2025 APRN-G9/23/2025 APRN-D9/30/2025 APRN, MD-H10/3/2025 MD-H10/7/2025 Hospice RN10/10/2025 Hospice RN10/17/2025 Unidentified signature, no name or title written in identifier box10/21/2025 Unidentified signature, no name or title written in identifier box12/2/2025 Unidentified signature, no name or title written in identifier box12/23/2025 Unidentified signature, no name or title written in identifier box Interview with the facility Administrator (ADM) on 1/29/2026 at 12:15 PM confirmed inability to provide provider notes for physician visits during dates outlined above. ADM confirmed following a Center for Medicare/ Medicaid Services (CMS) guideline from 2024 that separated Med A and Medicaid provider visits by payer source. Per Federal regulation, provider visits are not separated by payer source. ADM confirmed existing physicians are overwhelmed with patients Record review of facility policy- Physician Services last revised 2/2021 states 'The medical care of each resident is supervised by a licensed physician'. Policy states 'Supervising the medical care of residents includes (but is not limited to) .conducting routine required visits'. Policy states 'Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and facility policy' |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.08 Based on record review and interview, the facility failed to ensure the provider reviewed and documented what, if any, actions had taken place to address the pharmacist recommendations made during their monthly medication regimen review for 2 (Residents 6 and 13) of 5 sampled residents. The facility identified a census of 33.Findings Are:<br><br>A record review of the facility policy Medication Utilization and Prescribing- Clinical Protocol with a revision date of July 2016 revealed in the Treatment/Management section that the physician and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions and risks.<br><br>A record review of the facility policy Tapering Medications and Gradual Drug Dose Reduction with a revision date of July 2022 revealed that periodically the staff and practitioner will review the continued relevance of each resident's medications.<br><br>A.<br><br>A record review of Resident 13's January 2026 Medication Administration Record revealed the resident was admitted to the facility on [DATE].<br><br>A record review of Resident 13's Pharmacy Consultant Progress Notes revealed the following:<br><br>-On 10/26/2025 the pharmacist wrote if Resident 13 hadn't used their PRN (as needed) Zofran (an anti-emetic medication) in the last 90 days, can we discontinue it?<br><br>-11/25/2025 the pharmacist wrote if Resident 13 hadn't used their PRN Benzonatate (a cough suppressant capsule) in the last 90 days, can we discontinue it?<br><br>-On 12/23/2025 the pharmacist wrote if Resident 13 hadn't used their PRN Zofran in the last 90 days, can we discontinue it?<br><br>A record review of Resident 13's electronic medical records revealed no evidence of the resident's medical provider documenting that the recommendations had been reviewed and what, if any, action had taken place to address them.<br><br>An interview on 2/2/26 at 2:20 PM with the Administrator confirmed there were no medical provider responses documented in related to the pharmacist recommendation made for Resident 13 on 10/26/2025, 11/25/2025, and 12/23/2025.<br><br>B<br><br>A record review of the facility policy Medication Utilization and Prescribing- Clinical Protocol with a revision date of July 2016 revealed in the Treatment/Management section that the physician and staff will adjust existing medications based on their efficacy and the continued presence of relevant conditions and risks<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident 6's admission record revealed that Resident 6 was admitted [DATE] with diagnosis of unspecified injury of head, diffuse traumatic brain injury with loss of consciousness of 30 minutes or less, obsessive-compulsive personality disorder, other dissociative and conversion disorders, dissociative identity disorder, anxiety disorder, and major depressive disorder. Record review of Resident 6's Comprehensive Minimum Data Set (MDS) (a federally mandated assessment to help guide cares for a resident) dated 10/2/2025 revealed the following: Section C- Brief Interview for Mental Status (BIMS) (a brief screener that aids in detecting cognition impairment) a score of 7 indicating moderate cognitive impairment. Section D and E show no behavior. Section N shows the resident is on opioids but none of the psychotropic medications are listed. Record review of Resident 6's Care Plan last revised 5/9/2024 revealed a problem of PASSAR level 2, due to anxiety, Major depressive disorder (MDD), and Dissociative Identity Disorder, with an intervention of psychiatric consultation and review medication if needed. A behavioral problem related to diagnosis of TBI and psychiatric diagnosis. A psychotropic medication problem related to an order for PRN Lorazepam, scheduled Clonazepam, Seroquel, and Gabapentin for diagnosis of anxiety and Belsomra for insomnia.<br><br>Record review of Resident 6's progress notes revealed that there is no review or note from a physician regarding pharmacy recommendations for mediation changes from:<br><br>6/27/2025 at 7:32 PM Per CMS guidelines, can we get a stop date on the Clonazepam? (It can then be restarted)<br><br>8/28/2025 at 9:24 PM If patient no longer has a cough, can we DC (discontinue) the PRN Benzonatate Record review from 9/12/2025 at 3:59 PM revealed Pt has PRN tesselon [NAME], but refused-saying 'It's more than just a cough'. Any recommendations?.<br><br>11/27/2025 at 12:11 AM Based on kidney function, consider decreasing gabapentin to 100mg BID at 12:10 AM Since patient is on hospice consider discontinuing the Myrbetriq<br><br>An Interview with Licensed Practical Nurse (LPN)-M on 2/2/2026 at 11:00 AM revealed that the steps for changing medications after pharmacy recommendation depends on what kind of med. The MDS nurse has been sending emails and faxes to providers about either getting a stop date or a visit, or whatever we need for whatever med it is. Interview also revealed that if physician does not respond to recommendations made by pharmacy usually we will just keep faxing and calling until we get a response from them. LPN-M confirmed they were unable to locate and provide follow up documentation from provider about pharmacy recommendations listed above. |