STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285307	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Prairie Commons Care Center	3490 Ewoldt Street Grand Island, NE 68803

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Licensure Reference Number 175 NAC 12-006.09(I)Licensure Reference Number 175 NAC 12-006.09(I)(i)(1)Licensure Reference Number 175 NAC 12-006.09(I)(i)(3)Based on observation, record review, and interview the facility failed to provide and implement interventions to protect residents from sunburn injury for 1of 3 residents (Resident 1). This caused Resident 1 to experience sunburn injury requiring treatment. The facility census was 27.Findings are:Record review of the undated facility Elder Abuse Prevention Program revealed that the facility will not tolerate any form of elder abuse. Neglect is a failure of the facility, its employees, or service providers to provide goods and services to an elder necessary to avoid physical harm, pain, mental anguish, or emotional distress. The section titled Indicators that must be reported and investigated revealed that burns, bruises, all injuries of unknown source, and fractures of unknown origin must be reported and investigated. Record review of the facility policy titled Change of Condition dated 2/10/26 revealed that a nurse will promptly contact the provider and the resident/responsible party of a resident's acute illness, serious accident, or death. The provider will be notified as soon as an assessment is conducted and the resident's responsible party will be notified as soon as possible of an accident involving a resident that results in injury and has the potential for requiring provider intervention. Record review of the facility Resident Handbook dated 4/5/23 revealed that the facility staff will implement the plan of care and assist with activities of daily living including eating, bathing, dressing, toileting, ambulation, and transfers. Assistance from the nursing staff may be obtained by pushing the call button on the call light and/or pendant. The resident has the right to a safe, clean, comfortable, and homelike environment and supports for daily living safely. The resident has the right to be free from abuse and neglect. Record review of the facility procedure titled Vulnerable Adult-Nebraska dated 2/17/26 revealed that all staff, residents, and families are required to report suspected abuse or neglect. The Director of Nursing or designee shall be responsible for maintaining a log of any suspected or actual cases of abuse or neglect. They shall verify that the report to the proper officials has been made and that appropriate intervention has been taken. Record review of the admission Record for Resident 1 dated 6/3/26 revealed that Resident 1 admitted into the facility on 6/17/24 with diagnoses of Hemiplegia (severe or total paralysis; inability to move on one side of the body that can affect the arms, legs, and facial muscles) and Hemiparesis (mild to moderate muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following a stroke that affect the resident's right dominant side; lack of coordination; and arthritis. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 2/28/26 for Resident 1 revealed that Resident 1 required a wheelchair for mobility and was dependent on staff for toilet hygiene, transfers from sitting to standing, toilet transfers and chair to bed transfers. Resident 1 required staff to do more than half the effort for upper body and lower body dressing. Record review of the Care Plan Report dated 6/3/26 for Resident 1 revealed that Resident 1 had a self-care deficit related to stroke with right hemiplegia. Resident 1 needed assistance to get to activity functions. Staff were to encourage Resident 1 to use the bell to call for assistance. Resident 1 needed a safe environment with a working and reachable call light. The care (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 0689 Level of Harm - Actual harm Residents Affected - Few	plan revealed that Resident 1 was considered a vulnerable adult due to placement in the skilled nursing facility and the facility was to adhere to resident rights in the provision of services. The care plan revealed that Resident 1 was at risk for injuries to the skin. An intervention dated 6/17/24 revealed to educate resident/family/caregivers of causative factors and measures to prevent skin injury. The care plan contained an intervention dated 6/17/24 to monitor and document the location, size, and treatment of skin injury. Interview on 6/3/26 at 4:48 PM with Medication Aide-D (MA-D) revealed that MA-D did not work the day Resident 1 got the sunburn. MA-D revealed that MA-D did work the next day and MA- D and Licensed Practical Nurse-B (LPN-B) noticed the sunburn. MA-D revealed that since Resident 1 was already scheduled to see the physician that day, LPN-B requested something for the sunburn. Record review of the Provider Communication Form (a form with written information from the facility sent with the resident to the physician visit) for Resident 1 dated 5/27/26 revealed that LPN-B noted that Resident 1 had a sunburn from the day prior and requested an order for Aloe (a hydrating gel with soothing and ant-inflammatory properties for sunburns). The physician response on the form revealed an order for Aloe to sunburn three times daily until healed. Record review of the Physician Visit Notes for Resident 1 dated 5/27/26 revealed notation that the day prior Resident 1 had been sitting outside in the sun for 2 hours in the afternoon. Resident 1 had a bit of a sunburn. The physician was to send a prescription for aloe for the sunburn. The patient instructions include Aloe to sunburn three times a day. Observation on 6/3/26 at 8:43 AM in the room of Resident 1 revealed that Resident 1 wore a pair of charcoal gray athletic shorts. The right and left legs were reddish in color from just below the knees to mid-thigh. A distinct line was noted at the top of the reddish area on each thigh where the redness ended and pinkish skin began. Interview on 6/3/26 at 8:43 AM with Resident 1 revealed that Resident 1 had a sunburn on the top of both thighs. Resident 1 revealed that Resident 1 got the sunburn when left sitting outside for too long. Resident 1 revealed that the resident did not have a call light accessible to summon staff while outside. Resident 1 revealed that the facility did not have portable call lights or pendants. Resident 1 stated that staff put something on the sunburn after visiting the doctor. Record review of the Medication Administration Record (MAR, a legal record of the medications administered to a resident at a facility by a health care professional) for May 2026 revealed Aloe Vera Gel- Apply to bilateral knees, thighs, and arms topically three times a day for sunburn treatment was administered in the PM (evening) on 5/27/26, and three times daily on 5/28/26, 5/29/26, 5/30/26, and 5/31/26. Record review of Resident 1's MAR for June 2026 revealed administration of aloe vera three times daily on 6/1/26 and 6/2/26 and the AM (morning) administration documented on 6/3/26. Interview on 6/3/26 at 11:57 AM with MA-C revealed that Resident 1 was outside after lunch 1 day last week. MA-C confirmed that MA-C unlocked the door for Resident 1 to go out. MA-C revealed that it was a warm day and that MA-C checked on the resident a few times. MA-C was unable to recall the length of time between checks on the resident. MA-C revealed that MA-C brought Resident 1 in after about 30 minutes. MA-C revealed that MA-C had clocked out and left but was coming back to get something that they forgot and they brought Resident 1 into the facility after they were clocked out. MA-C revealed that Resident 1's legs were red from fresh sunburn and MA-C had told the charge nurse. Interview on 6/3/26 at 12:02 PM with MA-D revealed that Resident 1 got a sunburn from being outside too long. MA-D revealed that when residents are outside they can get in by ringing the doorbell for staff to let them in. MA-D revealed that staff were to check on the residents every 10-15 minutes while they were outside. MA-D revealed that the staff had to check with residents as to when they wanted to come in. Interview on 6/3/26 at 12:58 PM with Resident 1 revealed that Resident 1 was unable to get themself back into the building from outside and staff had to bring the resident in. Interview on 6/3/26 at 1:58 PM with the Facility Administrator (FA) revealed that it was a charge nurse decision on whether it was safe for a resident to go outside based on the weather conditions. Staff were to check on residents outside every 15 minutes. Interview on 6/3/26 at 2:05 PM with LPN-B revealed that the facility doors were locked so staff had to let the residents out of the facility and then let them back (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	in. LPN-B revealed that staff check on residents every 15 minutes. LPN-B revealed that Resident 1 had not gone outside on any shift LPN-B had worked. Interview on 6/3/26 at 2:43 PM with the FA revealed that the FA got a call last Friday (5/29/2026) that Resident 1 had gone to the doctor and was found to have a terrible sunburn. Resident 1 had told the doctor that the resident was left outside for hours and had a terrible sunburn. The FA stated that Resident 1 was not a reliable historian. The FA revealed that the facility Director of Nursing (DON) assessed Resident 1 and the skin was pink but had no blisters. The FA revealed that the DON was told Resident 1 wasn't outside for more than 15 to 20 minutes. The FA revealed that the floor staff assigned to the resident's area was responsible for monitoring the residents. Record review of the Brief Interview for Mental Status (BIMS) evaluation (a brief screening tool that aids in detecting cognitive impairment) dated 5/21/26 for Resident 1 revealed that Resident 1 had a BIMS score of 14. A BIMS score of 14 indicated that Resident 1 was cognitively intact. (BIMS scoring: 13-15: Cognitively intact; 8-12: Moderately impaired; 0-7: Severely impaired). Record review of the Progress Note dated 5/29/26 at 5:26 PM for Resident 1 revealed that the nurse went and assessed Resident 1 at 10:31 AM that day. Redness was noted to the left and right knee area to the upper thigh (area above where ted hose end and the resident's shorts begin). No blistering was noted and no open areas were noted. The area on the left leg measured 17 centimeters by 13 centimeters. The area on the right measured 22 centimeters by 18 centimeters. The nurse spoke to the resident's Power of Attorney (POA) at 5:26 PM and they were aware of the resident's condition. No additional concerns were noted. The POA is aware that the aloe came in and was being used. Interview on 6/3/26 at 3:10 PM with the FA confirmed that it was last Tuesday, 5/26/26 around lunch when Resident 1 got sunburned. The FA revealed that the FA just visited with LPN-A about the incident. The FA revealed that LPN-A was the charge nurse on duty when the resident was sunburned. The FA revealed that Nurse Aide-E (NA-E), MA-C, and NA-F were the floor staff working on 5/26/26. The FA revealed that LPN-A did not say anything about Resident 1 being sunburned. Interview on 6/3/26 at 3:16 PM with LPN-A revealed that there were 3 floor staff working the day Resident 1 got the sunburn. LPN-A revealed that LPN-A was not sure which staff member let Resident 1 out the locked door to go outside. LPN-A revealed that Resident 1 wheeled themselves in the wheelchair to the middle of the sidewalk and began to sun themselves. LPN-A revealed that all the staff were in the dining room and watching Resident 1. LPN-A revealed that staff went to request Resident 1 to come back in after 5 to 10 minutes but the resident refused. LPN-A revealed that MA-C told Resident 1 only a few more minutes. LPN-A revealed that MA-C brought Resident 1 back into the facility about 5 minutes later. LPN-A revealed that staff did not say anything about a sunburn. LPN-A revealed that LPN-A did not observe any burn on the resident's skin. LPN-A stated that Resident 1's skin was always pink and that LPN-A couldn't tell the resident had a sunburn even after the resident returned from the doctor visit on 5/27/26. LPN-A confirmed that no sunscreen had been offered to Resident 1. LPN-A revealed that sunscreen was not available in the facility until after Resident 1 got sunburned. Record review of the Medical Record for Resident 1 revealed no documentation of any checks on Resident 1 while they were outside and no documentation of how long Resident 1 was outside on 5/26/2026. Observation on 6/3/26 at 4:11 PM in the room of Resident 1 with the facility Director of Nursing confirmed the presence of the visible sunburned areas on the right and left leg of Resident 1 from just below the knee to the line of the resident's shorts at mid-thigh. Interview on 6/3/26 at 4:21 PM with the FA revealed that the FA was unsure of any new interventions to prevent a recurrence of sunburn for Resident 1. The FA consulted with the DON and then told this surveyor that interventions to prevent sunburn for Resident 1 were to encourage Resident 1 to stay under the cover of the patio when outside. The FA confirmed that no prevention interventions had been added to the care plan for Resident 1. The FA confirmed that the facility was required to monitor residents when outside to prevent accidents or injury. Record review conducted on 6/3/2026 of Resident 1's Care Plan Report revealed no new interventions had been added to protect Resident 1 from recurrence of sunburn. Record review conducted on 6/3/26 of Resident 1's MAR revealed no orders for sunscreen. (continued on next page)

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