STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28A065	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carl T Curtis Health Education Center Nursing Home	923 Senior Circle Macy, NE 68039

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to conduct ongoing reviews for antibiotic stewardship and ensure that medical criteria was used for infection surveillance. This had the potential to affect all residents that resided in the facility. The facility census was 23.Findings are:Review of a facility policy Infection Prevention and Control Program with a revised date of October 2018, Section 8 revealed: Antibiotic Stewardship a. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. b. Medical Criteria and standardized definitions of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews. Review of a policy Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes with a revised date of December 2016 revealed: Policy Statement Antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic resident antibiotic prescribing practices and facility-wide antibiotic stewardship. 1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: a. resident name and medical record number; b. unit and room number; c. date symptoms appeared; d. name of antibiotic (see approved surveillance list); e. start date of antibiotic; f. pathogen identified (see approved surveillance list); g. site of infection; h. date of culture: i. stop date; j. total days of therapy; k. outcome; and l. adverse events. Record review of an untitled and undated document/spreadsheet, reported by the Director of Nursing and Infection Preventionist to be the antibiotic stewardship spreadsheet, did not include total days of antibiotic therapy, outcome or adverse events. An interview with the Infection Preventionist RN, on 1/29/26 at 8:56 AM confirmed the facility did not have medical criteria and standardized definitions of infections that were used to help recognize and manage infections and while the electronic medical record generated a spreadsheet for antibiotics, there was not a formal system for the infection preventionist or designee to review.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G) Based on record review and interview, the facility failed to identify and monitor specific target behaviors for the use of antipsychotic medications [a group of medications used to treat symptoms of psychosis, such as hallucinations and delusions] for 2 (Residents 4 and 20) of 5 residents reviewed for unnecessary medications. The facility census was 23. Findings are:A.Record review of a facility policy entitled Behavioral assessment, Intervention and Monitoring dated 2001 revealed the following information: Policy statement: Behavioral symptoms will be identified using facility approved behavioral screening tools and the comprehensive assessment. General Guidelines:1.Behavior is the response of an individual to a wide variety of factors. These factors may include medical, physical, functional, psychosocial, emotional, psychiatric or environmental causes. a. Behavior is regulated by the brain and is influenced by experiences, personality traits, environment, and interactions with other people.b. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort, or express thoughts that cannot be articulated. Assessment:2. As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and caregivers, review of medical record and general observations:a. the residents' usual patterns of cognition, mood and behavior;b. the residents' usual method of communicating things like pain, hunger, thirst, and other physical discomforts;c. the residents' typical or past responses to stress, fatigue, fear, anxiety, and depression.Management:1.The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. 7. Interventions will be individualized and part of an overall care environment that supports physical, functional, and psychological needs, and strives to understand, prevent and relieve the residents distress or loss of abilities. 8. Interventions and approaches will be based on a detailed assessment of physical , psychological and behavioral symptoms and their underlying causes. The care plan will include, as a minimum: a. a description of the behavior symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations; b. targeted and individualized interventions for behavioral and psychological symptoms; c. the rationale for the interventions and approaches; d. specific and measurable goals for targeted behaviors e. how the staff will monitor for the effectiveness of the interventions. 10: When medications are prescribed for behavioral symptoms, documentation will include: e. Specific target behaviors and expected outcomes; h. Monitoring for efficacy and adverse consequences; B.Record review of Resident 4's current Face Sheet dated 1/27/26 revealed that Resident 4 was admitted to the facility on [DATE] and included a diagnosis of generalized anxiety disorder, major depressive disorder, recurrent, in partial remission, personal history of traumatic brain injury and vascular dementia, mild, with anxiety. Record review of Resident 4's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's plan of care) dated 12/23/25 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 4. The MDS rating for scores 0-7 indicate severe cognitive impairment. The MDS identified that Resident 4 exhibited no behaviors, was dependent with activities of daily living and used antipsychotic medications daily with indications for use. Record review of Resident 4's current Physician Orders dated 1/27/26 revealed a physician order for Quetiapine [an antipsychotic medication used to treat symptoms of psychosis, such as hallucinations and delusions] 50 mg 2 times per day for major depressive disorder, recurrent, in partial remission with indications for use: anxiety. The medication had been started on 4/29/25 and changed to the current dose on 1/15/26. The orders included an order for Rexulti [an antipsychotic medication used to treat agitation associated with dementia] 2 mg tab every day by mouth with indications for use: agitation. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication had been started on 4/29/25. Record review of Resident 4's current Physician Orders dated 1/27/26 revealed an order written on 2/21/25 to monitor antipsychotic medications for dry mouth, constipation, blurred vision, disorientation / confusion, difficulty urinating, hypotension [low blood pressure], dark urine, yellow skin, nausea / vomiting, lethargy, drooling, extrapyramidal symptoms such as tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue. The orders did not identify specific target behaviors to monitor for the use of the antipsychotic.Record review of Resident 4's Medication Administration Record [MAR], which included December 2025 and [DATE], revealed that Resident 4 received Quetiapine 50 mg 2 times per day and Rexulti 2 mg once per day.Record review of Resident 4's Comprehensive Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) did not identify resident specific target behaviors to be monitored for the use of antipsychotic medicationsRecord review of Resident 4's Electronic Medical Record revealed that no specific target behaviors had been identified and no monitoring for specific target behaviors had been completed. Interview on 01/28/2026 at 1:50 PM with the Director of Nursing [DON] confirmed there were no specific target behaviors identified to monitor for the use of the Rexalti and the Quetiapine for Resident 4. The DON confirmed there were no specific target behaviors identified in the care plan. The DON confirmed that the orders to monitor were for side effects, not specific target behaviors for Resident 4. C.Record review of Resident 20's admission Face Sheet dated 1/26/26 revealed that Resident 20 was admitted to the facility on [DATE] and included a diagnosis of generalized anxiety disorder, other recurrent depressive disorders, agoraphobia [a specific anxiety about being in a place or situation where escape is difficult, embarrassing or where help may not be available] and Schizophrenia [a psychotic disorder characterized by hallucinations, delusions [fixed beliefs], disorganized thinking or behavior and flat, inappropriate affect]. Record review of Resident 20's quarterly MDS dated [DATE] revealed a BIMS score of 14, which indicated intact cognition. The MDS identified that Resident 4 exhibited verbal behaviors directed toward others 1 - 3 days per week and rejected cares 1 - 3 days per week. The MDS identified that Resident 20 was independent with activities of daily living and used antipsychotic medications daily with indications for use. Record review of Resident 20's active Physician Orders dated 1/26/26 revealed a physician order for Rexulti 2 mg tab -1 tablet by mouth at bedtime for Schizophrenia with indications for use: agitation. The medication had been started on 5/07/25. Record review of Resident 20's active Physician Orders dated 1/26/26 revealed orders written on 5/23/25 to monitor antipsychotic medications for dry mouth, constipation, blurred vision, disorientation / confusion, difficulty urinating, hypotension [low blood pressure], dark urine, yellow skin, nausea / vomiting, lethargy, drooling, extrapyramidal symptoms such as tremors, disturbed gait, increased agitation, restlessness, involuntary movement of mouth or tongue. The orders did not identify specific target behaviors to monitor for the use of the antipsychotic. Record review of Resident 20's Medication Administration Record [MAR], which included December 2025 and [DATE], revealed that Resident 20 received Rexulti 2 mg 1 tablet by mouth at bedtime. The order started on 5/7/25. Record review of Resident 20's Comprehensive Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) did not identify resident specific target behaviors to be monitored for the use of antipsychotic medications. Record review of Resident 20's Electronic Medical Record revealed that no specific target behaviors had been identified and no monitoring for specific target behaviors had been completed. Interview on 01/28/2026 at 1:50 PM with the Director of Nursing [DON] confirmed there were no specific target behaviors identified to monitor for the use of the Rexalti for Resident 20. The DON confirmed there were no specific target behaviors identified in the care plan. The DON confirmed that the orders to monitor were for side effects, not specific target behaviors for Resident 20.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide a written reason for the transfer to the hospital for Resident 24. The facility census was 23. Findings are:Record review of Resident 24's Discharge Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a residents functional capabilities and helps nursing home staff identify health problems) dated 12/19/25 identified the facility re-admitted Resident 24 on 12/9/25 with diagnoses of Peripheral Vascular Disease (PVD), Diabetes Mellitus (DM), acquired absence of right leg above knee, pressure-induced deep tissue damage of sacral region, infection following a procedure, unspecified, initial; acquired absence of left leg below knee. The MDS identified that Resident 24 had moderately impaired cognition. Functional abilities were noted as independent with eating, dependent with toileting hygiene, bathing, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. Record review of the Clinical Census for Resident 24 revealed the resident was sent to the hospital on [DATE] and 12/29/25. Record review of the facility Bed-Hold Notice dated 12/16/25 revealed no reason for transfer was identified on the form. The facility was unable to locate or provide a form for the 12/19/25 transfer to the hospital. Interview on 1/28/2026 at 3:00 PM with the facility Administrator confirmed that the reason for transfer was not filled out for Resident 24 when (gender) left to go to the hospital on [DATE] and the facility was unable to locate a Bed-Hold / Transfer Notice for discharge on [DATE]. The Administrator confirmed that the reason for transfer should have been documented on the bed hold / transfer form.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. License Reference Number 175 NAC 12-006.18(D)Based on record review, observation and interview, the facility failed to ensure a staff member performed hand hygiene before donning gloves (putting on) and failed to clean the rubber stopper on an insulin flex pen (a pre-filled disposable device used to inject insulin) prior to administering insulin for Resident 5. The facility had a census of 23.Findings are:A record review of the facility Handwashing/Hand Hygiene policy from the Nursing Services Policy and Procedure Manual for Long-Term Care, 2001 MED-PASS, Inc. revealed the following:Administrative Practices to Promote Hand HygieneAll personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.Indications for hand hygiene.Hand washing is indicated: Immediately before touching a resident.Before performing an aseptic (free from contamination caused by harmful bacteria, viruses or other microorganisms) task, for example, placing an indwelling device (a medical instrument inserted into the body to remain for a time, such as a catheter) or handling an invasive medical device (an instrument that fully or partially penetrate the body, either through the skin or a bodily orifice, for diagnostic or therapeutic purposes).After contact with blood, body fluids, or contaminated surfaces.After touching a resident.After touching the resident's environment.The use of gloves does not replace hand washing/hand hygiene.Applying and removing glovesPerform hand hygiene before applying non-sterile gloves.A record review of the manufacturers' instructions provided by the facility for the use of a prefilled insulin pen contained the following:Wash your hands with soap and water before you start to prepare your injection. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from a disposable needle. Screw the needle tightly to your Flex pen (a pre-filled disposable device used to inject insulin).An observation of insulin administration on 1/27/2026 at 9.45 AM by Registered Nurse (RN) A to Resident 5 revealed RN A removed the cap from Resident 5's insulin Lantus (Glargine) flex pen and attached a disposable needle to it. RN A turned the dial on the pen to prepare 2 units of insulin, depressed the pen to flush the 2 units through the needle, and then prepared 10 units of insulin for administration. RN A used hand sanitizer and took the insulin pen and an alcohol wipe to the residents room. RN A knocked on the door with and opened it using their bare hand on the handle. RN A donned gloves without washing their hands or using hand sanitizer, used an alcohol swab to wipe Resident 5's left arm and then pressed the insulin pen to the sanitized area and administered the insulin.An interview on 1/27/2026 at 9:45 AM with RN A confirmed RN A did not use hand sanitizer before donning gloves and should have done so. RN A confirmed they (gender) did not use an alcohol swab to clean the rubber stopper of the insulin flex pen before administering insulin and should have done so. RN A confirmed these 2 actions were an infection control breach.An interview on 1/28/2026 at 1:10 PM with the Director of Nursing (DON) confirmed RN A should have performed hand hygiene before donning gloves and should have cleaned the rubber stopper of the insulin flex pen with an alcohol swab before attaching a needle and administering insulin.