STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28E257	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gordon Countryside Care	500 East 10th Street Gordon, NE 69343

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 accuracy of the 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) related to an active diagnosis for Resident 14 and weight loss for Resident 1. The sample size was 12 and the facility census was 33.Findings Are: A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated October 2024 revealed in Chapter 3 coding instructions for Active Diagnoses that diseases should be coded that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Chapter 3 also revealed that the definition of a physician-prescribed weight-loss regimen included planned diuresis. A.A record review of Resident 14's Quarterly MDS dated [DATE] revealed the resident was admitted to the facility on [DATE]. In section I, the MDS indicated the resident had an active diagnosis of Pneumonia (an infection that causes inflammation in the lungs, leading to fluid or pus filling the air sacs). A record review of Resident 14's active diagnoses, conducted on 9/22/2025, revealed no evidence of a pneumonia diagnosis. A record review of Resident 14's Progress Notes from 4/21/2025 through 7/22/2025 revealed no evidence of the resident being diagnosed with or treated for pneumonia. A record review of Resident 14's Medication Administration Records for the months of April, May, June, and July 2025 revealed no evidence of the resident being treated for pneumonia. An interview on 9/23/2025 at 8:19 AM with the MDS Coordinator (MDSC) revealed Resident 14 had been admitted to the facility with a diagnosis of pneumonia that never got resolved. MDSC confirmed that the diagnosis of pneumonia should not have been included on the MDS that was completed on 7/8/2025. B.A record review of Resident 1's quarterly MDS dated [DATE] revealed the resident was admitted to the facility on [DATE]. Section K of the MDS indicated that the resident had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a prescribed weight-loss regimen. A record review of Resident 1's weights revealed the following:-On 1/7/2025 the resident weighed 119 pounds,-On 6/10/2025 the resident weighed 118.5 pounds,-On 7/1/2025 the resident weighed 119 pounds,-On 7/15/2025 the resident weighed 127 pounds,-On 7/22/2025 the resident weighed 121.5 pounds, and-On 7/25/2025 the resident weighed 118 pounds. A record review of Resident 1's Progress Note dated 7/16/2025 revealed the resident was seen by their provider that date. The provider noted the resident did not return to the facility from their hospitalization with an order for Bumex (a diuretic medication), which they had been on prior to the hospitalization. The resident was having edema (swelling) to the lower extremities from not being on the diuretic. The resident received a new order for Bumex 1 milligram daily. A record review of Resident 1's Progress Notes revealed a quarterly nutrition assessment documented on 7/28/2025. This note revealed the resident had been hospitalized earlier in the month for pneumonia and upon returning to the facility, did not have an (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for a diuretic. The resident's weight was up to 127 pounds on 7/15/2025 when re-admitted to the facility but had trended back down with re-initiation of the diuretic. An interview on 9/23/2025 at 8:20 AM with MDSC confirmed Resident 1's MDS dated [DATE] indicated the resident had an unplanned weight loss and should not have since the resident had a planned diuresis upon return from their hospitalization.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number 175 NAC 12-006.09(H)(iv) Based on record review and interview, the facility failed to follow their bowel protocol to prevent constipation for 1 (Resident 4) of 5 sampled residents. The facility census was 33.Findings Are: A record review of facility policy Bowel Management Policy dated 8/1/2024 revealed all residents will have a bowel management plan tailored to their individual needs, preferences, and medical conditions. In the Documentation section the policy states staff are to document absence of bowel movements for 3 days or more and initiate appropriate action. In the Intervention Protocol for Constipation section the policy states that on Day 1 staff are to monitor and encourage natural bowel movement and offer fluids and dietary fiber. On Day 2, staff are to administer prescribed stool softener or laxative. On Day 3, staff are to reassess and consider use of a suppository if no bowel movement, and on Day 4+ staff are to notify the physician and consider enema or other medical interventions. A record review of Resident 4's quarterly 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 9/2/2025 revealed the resident was always continent of bowels and required substantial assistance from staff for their toileting hygiene. A record review of Resident 4's undated Care Plan revealed the resident had a history of constipation and staff were to monitor and document the resident's bowel movements. The staff were also to administer medications as ordered by the physician. A record review of Resident 4's physician's orders revealed the following:-An order for Milk of Magnesia (a laxative medication), give 30 milliliters every 12 hours as needed for constipation. This order had a start date of 5/11/2025.-An order for Miralax (a laxative medication), give 17 grams every 24 hours as needed for constipation. This order had a start date of 10/23/2024. A record review of Resident 4's Task: B&B- Bowel Elimination for 8/1/2025 through 9/22/2025 revealed:-No bowel movements from 8/10/2025 through 8/13/2025, which was 4 days.-No bowel movements from 9/5/2025 through 9/9/2025, which was 5 days. A record review of Resident 4's Progress Notes from 8/1/25 through 9/22/25 revealed no evidence of assessments or interventions related to their bowels during the timeframes when they had no bowel movements. A record review of Resident 4's Medication Administration Records for August and September of 2025 revealed no usage of their as needed Milk of Magnesia or Miralax. An interview on 9/23/2025 at 10:07 AM with the Director of Nursing confirmed there were no interventions implemented for Resident 4's constipation that occurred in August and September 2025.

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F 0689 Level of Harm - Minimal harm or potential for 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 175 NAC 12-006.09(I) Based on record review, observation, and interview, the facility failed to ensure developed interventions were implemented to prevent falls for 1 (Resident 19) of 3 sampled residents. The facility identified a census of 33.Findings are: A record review of the facility's policy, Falls - Clinical Protocol (dated March 2018) revealed the facility would monitor and document a resident's response to interventions intended to reduce falls or their consequences. A record review of Resident 19's undated Care Plan Report revealed Resident 19 was at risk for falls due to deconditioning, knee pain, and occasional incontinence. Additionally, it revealed on 8/29/2025, the resident had fallen when attempting to get up from their bed unassisted and on 9/16/2025 had fall from their bed and received a bruise to the center of their forehead. On 9/16/2025, an intervention was added to place a fall mat beside the bed when the resident was in bed. An observation on 9/18/2025 at 11:00 AM revealed Resident 19 had been resting in bed. Resident 19's floor mat had been tucked underneath the bed. An observation on 9/18/2025 at 11:25 AM revealed Resident 19 continued to be resting in their bed and was beginning to become restless, yelling out for help. Resident 19's floor mat had been tucked underneath the bed. An observation on 9/18/2025 at 11:30 AM revealed Resident 19 continued to be resting in their bed and continued to be restless. Resident 19's floor mat had been tucked underneath the bed. An interview on 9/18/2025 at 11:35 AM with Nurse Aide (NA) - I confirmed Resident 19's floor mat was tucked underneath the bed and that, as part of the resident's fall interventions, it should be placed beside the bed when the resident is in the bed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Licensure Reference Number 175 NAC 12-006.11(D) Based on record reviews, observations, and interviews, the facility failed to ensure staff followed proper glove use of hand hygiene practices prior to food preparation or between tasks in accordance with the food code and Center for Disease Control (CDC) guidelines during meal service to prevent the potential for cross-contamination. This had the potential to affect 1 resident who resided within the facility. The facility identified with a census of 33. Findings are: A review of the Nebraska food code (last revised 2017, 3.301.11, Section (A3) and (F)) revealed staff are required to perform hand hygiene during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. Before donning (put on) gloves to initiate a task that involves working with food. A CDC guideline titled Clinical Safety: Hand Hygiene for Healthcare Workers (dated 2/27/2024) revealed gloves are to be changed between tasks and after contact with potentially contaminated surfaces or residents. - An observation on 9/23/2025 at 11:53 AM revealed the Certified Dietary Manager (CDM) entered the kitchen AM and advised [NAME] -A that CDM would take care of the grilled cheese sandwich ordered. The CDM walked to the walk-in refrigerator grabbed a loaf of bread and a pack of cheese and butter. Placed the items on the preparation table. CDM grabbed a frying pan placed on stove and turned on gas. CDM opened the bread and butter and without wearing gloves or performing handwashing and proceeded to butter two pieces of bread, grabbed one slice of cheese, placing the cheese between the two slices of bread and placing the sandwich into the frying pan with bare hands. - CDM began washing down the counter where sandwich had been made. - CDM took a spatula from a drawer and turned the sandwich. - At 11:58 PM Grilled cheese sandwich plated and covered with a clear plastic wrap, placed on counter and notified [NAME] A sandwich was ready. CDM washed hands and left the kitchen. An interview on 9/23/2024 9:30 AM CDM in the kitchen, revealed CDM was aware of [gender] error in touching the food with bare hands stated it was too late to start over had already started the process of making the grilled cheese sandwich, but admitted that gloves should have been worn and bare hands should not have touched the food.