STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285082	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Continental Springs, LLC	3200 G Street South Sioux City, NE 68776

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 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.19(A)Based on observations, record reviews, and interviews; the facility failed to maintain the cleanliness and condition of resident rooms/bathrooms in 3 (Rooms 206, 505 and 509) of 45 occupied rooms. This had the potential to affect 3 residents who resided in those rooms. In addition, the facility failed to clean and maintain bathhouses, and the windows, flooring and walls in corridors and the dining room. The total sample size was 17 and the facility census was 46. Findings are: A. Review of the undated Maintenance and Housekeeping Policy revealed the purpose of the policy was to ensure the facility was maintained in a safe, clean, functional, and hygienic condition through effective maintenance and housekeeping practices, thereby supporting operational efficiency, safety, and compliance with applicable standards and regulations. This applied to all buildings, infrastructures, equipment, utilities, common areas, and external premises of the facility. The following objectives were identified:-obtain a clean, safe, healthy environment.-prevent equipment and infrastructure deterioration.-ensure compliance with safety, health and environmental regulations.-minimize downtime and maintenance related risks.-promote accountability and continuous improvement.The following roles and responsibilities were identified for the maintenance team -perform preventative corrective and breakdown maintenance.-maintain records of inspections and repairs and servicing.-ensure safe operation of equipment and utilities.The following roles and responsibilities were identified for the housekeeping team:-maintain cleanliness of all designated areas per schedule. High touch and high risk areas were to receive priority cleaning. -use approved cleaning agents and equipment. -follow waste segregation and disposal guidelines.B. Review of the Deep Clean Check Off List revealed the following areas in the residents' rooms which were to be cleaned with documentation when cleaning was completed: -pull out the beds and sweep/vacuum under, wipe down the bed frames and springs.-pull out the dresser and sweep/vacuum underneath, wipe down sides.-dust and wipe down televisions. -clean ceilings, vents, and light fixtures.-clean windowsills and inside of windows.-clean and wipe down heater/radiator units, remove trash from inside of units. -clean and wipe down pictures/prints on the walls.-clean and wipe down garbage cans inside and out.-clean and wipe down all walls (clean out corners with scrapers if needed). -clean and wipe down doors, door jams, and door frames.-clean and wipe down closets and shelving inside and out.-clean and wipe down all tables, nightstands and rolling tables.-clean and wipe down all chairs. -clean and wipe down baseboards/edges.-clean and disinfect floors.-clean and disinfect toilets.-clean and disinfect vents (check for trash inside of vents).-clean and disinfect any wheelchairs in the rooms.inspect curtains for spills or damage and alert management to replace if needed. -clean and disinfect outside of refrigerators.-clean and disinfect phones, remotes, and anything else belonging in room. C. Environmental observations of the residents' rooms on 1/11/26 during the initial pool from 9:00 AM to 2:00 PM revealed the following:-resident room [ROOM NUMBER], the (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathroom trash receptacle contained several pre-moistened cleansing cloths and an incontinent brief which were soiled with feces and the room had a feces odor. The window next to the resident's bed was covered with plastic and the window frame was paint chipped.-resident room [ROOM NUMBER], with a urine odor to the room. The mattress on the bed had brown discoloration, and an outline of a urine stain. The bed frame and headboard with heavy layer of dust/debris. The wheelchair in the room had brown spots which covered the wheels and handles of the chair. The vanity underneath the handwashing sink in the resident's room was missing the baseboard to the left side. In addition, there were brown colored stains on the ceiling which extended down the wall directly above the light fixture over the vanity/handwashing sink.-resident room [ROOM NUMBER], personal fan which blew directly across the resident's bed with heavy layer of dust/debris. The baseboard heater in the resident's room behind and to the side of the bed was missing the outside cover. The baseboard underneath the handwashing sink/vanity was still intact but portions were pulled away from the wall. Observations of the facility shower/bathhouses on 1/12/26 at 9:25 AM revealed the following:-300 hall shower room, the ceiling directly above the shower chair had a 5 by 7 centimeter (cm) area of paint which had peeled away from the ceiling and was hanging. The remainder of the ceiling with areas of chipped paint.-500 hall whirlpool room, panel on the lower wall opposite of the tub with a heating/cooling unit. Two prongs extended from the panel which were to hold knobs for adjusting the temperature of the room. The panel with areas of brown discoloration which appeared to be rust. A window directly next to the whirlpool tub was covered with plastic and was secured with 2-3 inch blue masking tape around the perimeter of the window. A ceiling vent above the tub with a heavy layer of dust/debris. Interview with Bath Aide (BA)-A and BA-B on 1/12/26 at 9:35 AM verified the concerns related to the ceiling of the shower room. BA-A and BA-B confirmed the following regarding the whirlpool room:-there were no knobs for the heating/cooling unit in the whirlpool room. The staff would have to get someone from maintenance to come with pliers to adjust the temperature of the room. -the window did not close completely and the plastic wrap and tape helped to keep the cold out.-the ceiling vent above the whirlpool needed to be cleaned. During an environmental tour with the Assistant Social Service Director (SSD) /previous Administrator on 1/13/26 from 10:30 AM to 11:17 AM revealed the following:-room [ROOM NUMBER], the window frame remained paint chipped and was covered with plastic.-desk at the Nurse's Station between the 300 and the 500 corridors, with a wood veneer finish which was faded and worn completely away in areas. -the windows to bilateral sides of the corridor between the dining room and the 500 halls were spotted/soiled and required cleaning. The wall cover was peeled away on bilateral sides of the hall between the fire doors and the windows.-floor of the commons area leading to the 300 hall was scuffed with areas worn away/missing. -floor to the dining room with several scuffed areas underneath the residents' tables/chairs and at the entrance of the dining room by the 300 halls. During an interview on 1/13/26 at 11:20 AM the Assistant SSD/previous Administrator reported the following:-was aware on 1/11/26 the bathroom trash in room [ROOM NUMBER] contained soiled items and there was an odor in the room. The housekeeping staff were instructed to clean the room and remove the trash.-performed a daily check of the resident's room temperature and if a significant drop in temperature from the entrance of the room to the window, would then instruct the maintenance staff to cover the windows with plastic.-replaced the mattress in room [ROOM NUMBER] on 1/12/26 when notified of the strong urine odor.-the windows in the corridor required cleaning and indicated they had not been cleaned since the spring/summer months and the wall covering needed to be repaired. -flooring in the dining room and the hallways needed to be replaced.-desk at the Nurses' Station needed to be repaired. An interview with the Maintenance Supervisor on 1/14/26 at 8:00 AM confirmed the ceiling needed to be (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repaired in the shower room and knobs needed to be replaced on the heating/cooling unit of the whirlpool room. In addition, the baseboards needed to be repaired in rooms [ROOM NUMBERS] and the baseboard heater in room [ROOM NUMBER] needed a new cover. Interview with the head of House keeping on 1/14/26 at 8:30 AM confirmed the housekeeping staff were to clean the resident's bed frames, personal fans and the ceiling vents in the resident's rooms and the bath houses. If the housekeeping staff notice a resident's wheelchair was soiled then the staff should wipe down and notify nursing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(iii)(3)Based on observations, record review, and interview; the facility failed to thoroughly assess bruising and to implement interventions to prevent ongoing bruises for Resident 52. The sample size was 2 and the facility census was 46 Findings are: A. Review of a facility policy titled Pressure Ulcers and Skin Policy with a reviewed date of 8/22 revealed the nursing staff were to examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. When bruising was observed, staff were to ensure appropriate clinical assessment occurred. The assessment was to include the general location, appearance, resident comfort, reported concerns and any reasonable contributing factors. Documentation was to support continuity of care and demonstrate bruising was recognized and addressed with ongoing observation and appropriate follow-up when indicated. Additional follow-up may occur when there was a change in condition, increased bruising, resident concern, or other clinical indicators. B. Review of Resident 52's Nursing Admission/Screening History dated 1/6/26 at 9:27 AM revealed no skin issues were noted.Review of the resident's current Care Plan dated 1/7/26 revealed the resident was admitted [DATE] with diagnoses of spinal stenosis, atrial fibrillation, repeated falls, history of Transient Ischemic Attacks (brief interruption of blood flow to the brain leading to temporary symptoms like those of a stroke), anxiety, and depression. The resident was identified at risk for skin breakdown related to fragile skin and side effects from blood thinner medications. Interventions included the following:-avoid scratching, keep fingernails short and avoid excessive moisture to body parts.-identify/document potential causative factors and eliminate/resolve where possible.-encourage the resident to wear shirts with long sleeves or geri-sleeves (sleeves made with breathable material that contours to the shape of the arm which protects skin from bruising and skin irritation). -keep skin clean and dry, apply lotion to dry skin. Review of a Nursing Progress Notes revealed the following:-1/7/26 at 2:00 AM the resident was found seated on the floor of the resident's room. The resident was barefoot and the right great toenail was bleeding. No further areas of skin breakdown were identified.-1/8/26 at 9:20 AM the resident's skin without bumps, bruises or redness noted. Right great toe with no further bleeding.-1/8/26 at 5:00 PM the resident's skin was without any new bumps, bruises, or redness. The bump to the resident's temple had subsided.-1/8/26 at 9:40 PM the resident was observed laying on the floor of the resident's room. The resident reported striking head and a small bump was noted above/beside the left eye.-1/9/26 at 8:20 PM the resident's skin is without any new bumps, bruises or redness noted. Area above the left eye continues with bruising to small bump.-1/11/26 at 5:45 AM the resident was up all night, repeatedly attempting to get up out of the wheelchair and yelling/hitting at staff. -1/11/26 at 10:59 AM resident noted to have bruises scattered on bilateral arms from fall and bumping items from being active up and down all night. During an observation on 1/11/26 at 11:02 AM, the resident was seated by the Nurse's Station in a tilt-n-space wheelchair (chair which allows the entire seating system to tilt backward while maintaining the user's hip, knee, and ankle angles). Resident 52 was picking things out of the air and attempted to reach down to the floor to pick up items. Resident 52 was wearing a short sleeved shirt and pants were pulled up to the resident's mid shins. The resident had dark purple bruising visible to bilateral arms from mid-bicep to the wrist, bilateral lower legs from the resident's ankle to the mid shin area and a bruise was noted above the resident's left eye. No protective sleeves or long sleeves were observed on the resident's arms. Review of Nursing Progress Notes on 1/12/26 at 8:17 AM revealed a late entry for 1/10/26 (no time) which indicated the resident had been up throughout the day with increased anxiety and multiple attempts to exit seek. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was unbalanced and would run into doors/hand railings and was resistive with cares. Several discolored areas were noted to the residents' arms. During an observation on 1/12/26 at 10:38 AM, Nurse Aide (NA)-D and NA-C approached the resident who was seated in a recliner in the front commons area. The resident was wearing gripper socks, a sleeveless night gown and a short sleeved t-shirt. No arm protectors or long sleeves were in place. A gait belt was placed on the resident who was then transferred into a wheelchair and assisted to the resident's room for cares. During an interview on 1/12/2026 at 11:48 AM, Registered Nurse (RN)- AA reported the direct care staff were to notify the Charge Nurse of any new areas of skin breakdown and then the Charge Nurse was responsible for completing and documenting an assessment. The RN further reported typically measuring any new areas of breakdown, including bruising so that the staff can define if the areas are healing or not. Review of a Facsimile (Fax) Communication Sheet dated 1/13/26 at 1:31 PM revealed the resident's Primary Care Provider was notified the resident had scattered bruising to bilateral arms and requested a review of the resident's current medications. Further review of the fax revealed no evidence the bruising to the resident's left eye or bilateral lower legs being identified. During an interview with the Director of Nursing (DON) on 1/12/26 at 11:51 AM, the DON confirmed the Charge Nurses were responsible for completing assessments of any areas of skin breakdown. The DON indicated Resident 52's bruising was extensive and would not expect the staff to measure the areas but would expect to have documentation of all areas of breakdown with descriptions regarding exact location, color, and extent of the bruising to measure if bruises were healing. The DON did verify the resident's care plan identified use of long sleeves or geri-sleeves to be placed on the resident's arms to protect the resident's skin and to potentially prevent further bruising.