| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285102 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanton Health Center | 301 17th Street<br>Stanton, NE 68779 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to report, investigate, and submit a completed investigation report related to an allegation of potential abuse to the State Agency within the required time frame for Residents 3 and 39. The sample size was 5 and the facility census was 49. Findings are: A. Record review of the facility policy Abuse, Neglect, or Misappropriation of Property last revised 1/23/24 revealed the facility had a zero tolerance policy and mandated employees to immediately report any allegations/suspicions of:-any type of crime committed against a resident,-Resident abuse,-willful resident neglect, -misappropriation of resident property, and-exploitation of a resident. The Administrator, Director of Nursing (DON), or designee would interview the person reporting, any witnesses, the resident and the charge nurse, review the residents medical record, interview all staff members that had contact with the resident, interview the roommate, family members and visitors if possible,-the Administrator or designee would report to law enforcement and the State Agency within 2 hours after forming a suspicion of serious bodily harm and 24 hours in all other cases, and-the Charge Nurse/Department Supervisor must report to the Administrator/DON immediately. For Resident-to-Resident incidents without injury, the facility would:-investigate, -implement and document necessary precautions/interventions to prevent further occurrence,-notify the responsible parties of all residents involved,-notify the physicians of the residents involved, and -document the finding that validate the conclusion of isolated, not preventable, or unforeseeable incidents. B. Record review of Resident 3's Minimum Data Set (MDS- a federally mandated assessment tool used in developing Care Plans) dated 6/25/25 revealed the resident had moderate cognitive impairment; required assistance with dressing and hygiene, and was dependent with toileting; had diagnoses of Alzheimer's Disease, dementia, anxiety and depression and had no behaviors. Record review of Resident 3's Care Plan last reviewed 6/25/25 revealed the resident had a cognitive deficit with diagnoses of Alzheimer's Disease, dementia, anxiety, and depression; had a history of making sexual comments and/or suggestions towards staff with inappropriate touching; and required assistance with bed mobility, dressing, oral cares, personal hygiene, toileting, and transfers. Record review of Resident 3's Progress Notes revealed the following entries:-on 3/20/25 at 1:00 PM a Behavior Note revealed it was reported to a nurse that Resident 3 was caught pulling out another Resident's (unnamed) shirt from the neckline and looking down their shirt. Resident 3 was stopped and told that was inappropriate. -on 6/3/25 at 4:59 AM a Behavior Note revealed Resident 3 was found in the Dining Room after the evening meal sitting next to Resident 39 holding their hand. Resident 3 was reminded not to touch other residents and stated I can touch whoever I want. Resident 39 was removed from the dining room and taken to the solarium. Resident 3 followed and sat away from Resident 39. An aide took Resident 39 down the hallway (where Resident 39's room was) and Resident 3 followed but was intercepted and assisted to the hallway where Resident 3's room was located. C. Record review of Resident 39's MDS dated [DATE] revealed the resident had severe<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285102 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanton Health Center | 301 17th Street<br>Stanton, NE 68779 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cognitive impairment; exhibited physical and verbal behaviors; was dependent with oral hygiene, toileting, dressing, and personal hygiene; and had diagnoses of Alzheimer's Disease, non-Alzheimer's dementia, anxiety, depression, and a psychotic disorder (a mental disorder characterized by a disconnection from reality. Record review of Resident 39's Care Plan last reviewed 6/25/25 revealed the resident required substantial assistance with bed mobility and transfers, and was dependent with dressing, oral cares, personal hygiene, and toileting; had the potential to be physically aggressive; was combative during cares; had impaired cognition; and had diagnoses of Alzheimer's Disease, dementia, delusional disorder, anxiety and depression. Record review of Resident 39's Progress Notes reviewed no evidence of the incident with Resident 3 on 6/3/25. D. Record review of the Facility Reported Incidents for the last 12 months revealed no evidence that the incident on 3/20/25 or the incident on 6/4/25 were reported to the State Agency. E. An interview on 7/9/25 at 3:25 PM with the Administrator and the Director of Nursing (DON) confirmed the incidents documented in Resident 3's Progress Notes on 3/20/25 and 6/4/25 were not reported to the State Agency and they should have been reported. Further interview revealed the management staff were not able to determine who the other resident was in the note from 3/20/25. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285102 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanton Health Center | 301 17th Street<br>Stanton, NE 68779 |

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 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** Licensure Reference Number 175 NAC 12-006.09Based on interview and record review; the facility failed to complete neurological assessments (assessment of motor and sensory skills, hearing, speech, vision, coordination, and balance to determine a potential injury or change in status) after unwitnessed falls for 1 (Resident 46) of 4 sampled residents. The facility identified a census of 49.Findings are:Record review of the facility policy Resident Fall Assessments with a revision date of 8/24 revealed after an unwitnessed fall or a fall in which a head injury was identified, the staff were to complete a neurological assessment per policy:-every 15 minutes for 1 hour,-every hour for 4 hours, and-every 4 hours for 19 hours. Record review of Resident 46’s Minimum Data Set (MDS-a comprehensive assessment tool used to develop a resident's care plan) dated 5/15/25 revealed the resident was admitted on [DATE] with diagnoses of non-traumatic brain dysfunction, heart failure, diabetes, Alzheimer's dementia, anxiety, and depression. The following was assessed regarding Resident 46:-short- and long-term memory loss with severely impaired decision-making needs,-physical behaviors directed at others,-dependent on staff for assistance with transfers, bed mobility, toileting, and personal hygiene,-always incontinent of bowel and bladder, and-impaired balance.Record review of an Incident Report dated 1/21/25 at 11:45 PM revealed Resident 46 had been seated in the corridor in the resident's wheelchair. The staff heard something crash and observed the resident on the floor next to the chair. No injuries were identified. Record review of a Neurological Assessment Flow Sheet revealed on 1/22/25 at 1:30 AM, 2:30 AM, 3:30 AM, 4:30 AM, and at 4:30 PM the staff failed to document neurological assessments and/or vital signs and instead documented Resident 46 was sleeping. In addition, there was no evidence neurological assessments were completed on 1/22/25 at 8:30 PM and on 1/23/25 at 12:30 AM, 4:30 AM and at 8:30 AM to assess for a potential head injury. Record review of an Incident Report dated 1/28/25 at 9:15 AM revealed Resident 46 was found on the floor after sliding out of the wheelchair. No injuries were identified. Record review of a Neurological Assessment Flow Sheet revealed of 1/28/25 at 10:00 PM and on 1/29/25 at 2:00 AM and at 6:00 AM neurological assessments and/or vital signs were not completed as Resident 46 was sleeping. Record review of an Incident Report dated 6/17/25 at 9:45 PM revealed Resident 46 was on the floor in the resident's room next to the bed. The resident appeared unharmed. Record review of a Neurological Assessment Flow Sheet revealed on 6/18/25 at 6:30 PM neurological assessments and/or vital [NAME] were not completed to assess Resident 46 for potential injury as the resident was sleeping. During an interview on 7/10/25 at 9:35 AM, Registered Nurse (RN)-U confirmed if a resident had an unwitnessed fall, the charge nurse was to complete neurological assessments and vital signs every 15 minutes for 1 hour, every hour for 4 hours and then every 4 hours for 19 hours to determine the potential for injury. These scheduled assessments should not be omitted unless the resident was out of the building. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285102 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanton Health Center | 301 17th Street<br>Stanton, NE 68779 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175 NAC 12-006.18(B)Based on observations, record review and interview; the facility failed to ensure respiratory care equipment was cleaned and stored in a sanitary manner to prevent the potential for cross contamination for Resident 6. The sample size was 1 and the facility census was 49. Findings are: Record review of the facility policy Respiratory Equipment Storage and Sanitation with a revision date of 7/1/24 revealed the purpose of the policy was to ensure respiratory equipment was stored and sanitized in a manner that prevented cross contamination, protected the resident's health and complied with infection prevention and control standards. Nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) equipment was to be dissembled and thoroughly rinsed after use, set out to dry on a clean dry surface and disinfected per policy using an approved disinfectant or sterilization method. Once the equipment was dry and ready for storage, it was to be placed in a clean, labeled, anti-microbial storage bag assigned to the individual resident. Equipment and supplies were not to be stored on the floor or in a high-moisture area. Record review of Resident 6's current undated Care Plan revealed the resident had shortness of breath and decreased lung expansion related to Chronic Obstructive Pulmonary Disease (COPD), intermittent asthma, and obstructive sleep apnea. The following interventions were listed:-keep the head of the bed elevated at least 30 degrees while lying flat,-maintain a clear airway by encouraging the resident to clear own secretions with effective coughing,-education resident/family/caregivers regarding side effects and overuse of inhalers and nebulizers,-encourage prompt treatment of any respiratory infections, and-give nebulizer treatments as ordered. Record review of Resident 6's Order Summary Report revealed the following orders with the date of initiation:-8/19/24 Albuterol Sulfate (medication used to treat or prevent breathing problems) aerosol solution 2 puffs every 6 hours as needed for wheezing.-12/31/24 Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) 1 vial orally as needed for shortness of breath twice a day.-3/11/25 Ipratropium-Albuterol inhalation solution 0.5-2.5 (3) mg/3ml 1 vial orally four times a day for shortness of breath. -1/16/25 Pulmicort inhalation suspension 0.5 mg/2ml 1 vial inhale orally twice a day for asthma. Record review of Resident 6's Nursing Progress Notes for January of 2025 revealed the following:-1/10/25 at 2:25 PM the resident received Ipratropium-Albuterol inhalation solution 0.5/2.5 (3) mg/3ml as needed for shortness of breath.-1/16/25 at 2:43 PM the resident requested the Ipratropium-Albuterol inhalation solution 0.5/2.5 (3) mg/3ml as needed for shortness of breath. -1/16/25 at 3:46 PM the resident was seen by the Primary Care Provider (PCP) and a new order was received for Z-pack (antibiotic used to treat bacterial infections) as directed and Medrol dose pack (medication used to treat inflammation) as directed. Record review of Resident 6's Nursing Progress Notes for March of 2025 revealed the following:-3/11/25 at 2:01 PM the resident received Albuterol Sulfate aerosol solution 2 puffs orally as needed for wheezing. -3/11/25 at 2:04 PM a note was sent to the PCP regarding the resident's increased pulmonary conditions. The resident had experienced increased shortness of breath and wheezing related to periods of activity.-3/20/25 at 1:20 PM the PCP ordered Breo (medication used to control asthma symptoms by improving breathing prevent wheezing) inhalation 1 puff a day.-3/20/25 at 4:04 PM the resident was seen by the PCP with a new order for a Prednisone(medication used to treat inflammation) taper.-3/21/25 at 10:28 AM the resident with wheezing lung sounds and a non-productive dry cough. -3/23/25 at 1:35 PM the resident's lung sounds were coarse with wheezes throughout. -3/28/25 at 11:57 AM the resident with wheezing sounds to all lung fields. Record review of Resident 6's Nursing Progress Notes for May of 2025 revealed the following:-5/22/25 at 3:24 PM the resident was seen by the PCP and had complaints about shortness of breath. A new order was received for Z-pack 30 mg for 3<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285102 | A. Building<br>B. Wing | 07/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stanton Health Center | 301 17th Street<br>Stanton, NE 68779 |

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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | days, then 20 mg for 3 days and 10 mg for 3 days then discontinued. In addition, the resident was started on Azithromycin (antibiotic used to treat bacterial infections) for an upper respiratory infection.-5/26/25 at 1:23 PM the resident continued to have shortness of breath of breath, wheezing and a cough. During an interview with Resident 6 on 7/7/25 at 9:54 AM, the resident confirmed repeated upper respiratory infections and reported the nebulizer machine was always left by the staff in the seat of the resident's recliner. Observations of Resident 6's room on 7/7/25 at 12:45 PM, 7/8/25 at 9:23 AM and 12:01 PM, and on 7/9/25 from 9:12 AM to 11:30 AM and at 2:08 PM revealed a nebulizer machine positioned in the seat of the resident's recliner. The tubing/mouthpiece and chamber were attached to the machine, uncovered, and not dated. Droplets of moisture were visible to the inside surface of the chamber. An incontinence pad with a light brown stain was in the seat of the recliner and directly underneath the nebulizer machine. There was no black antimicrobial bag seen in the resident's room. During an interview on 7/9/25 at 11:24 AM, Registered Nurse (RN)-T identified if a resident is on routine nebulizer treatments, the staff are to pull the components of the nebulizer equipment apart and then they are to be rinsed out and placed on a barrier to dry. Once the equipment was air dried, it was to be placed in a black antimicrobial bag for storage until the next treatment. In addition, the tubing and the mouthpiece were to be replaced weekly and labeled with the date they were changed out. |