STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H)Based on observation, record review and interview; the facility failed to complete an investigation and report the results of the investigation to the State Agency for an injury of unknown origin for 1 (Resident 8) of 2 sampled residents. The facility census was 30.Findings are:A. Review of the facility policy Reporting Abuse to State Agencies and other Entities/Individuals dated 12/1/2017 revealed all suspected violations and all substantiated incidents of mistreatment, neglect, injuries of an unknown source or abuse were to be reported to the Administrator or their designee. In addition, the following agencies or persons were to be notified of the incident:-the State licensing/certification agency.-the ombudsman.-the resident's representative.-Adult Protective Services (APS). -the resident's physician. Notices to the agencies were to be made as soon as possible with the maximum notification within 24 hours and if actual harm, APS was to be notified within 2 hours. The Administrator or designee were to then complete an investigation and then send the results of the investigation to the appropriate agencies within 5 working days. B. Review of Resident 8's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/27/25 revealed the resident was admitted on [DATE]; had severe cognitive impairment; was dependent on staff for toileting cares, bathing cares, upper and lower extremity dressing, repositioning in bed, moving from bed to chair and from chair to bed and all wheel chair mobility; had physical behaviors and other behavioral symptoms not directed at others (hitting or scratching self); had diagnosis of Non-Alzheimer Dementia (a progressive decline in cognition ability that is not caused by Alzheimer's Disease) and Psychotic Disorder. Review of a Nursing Progress Note dated 9/16/25 at 4:01 PM revealed the physician was notified of yellow bruising to the top of the right foot that measured 15 centimeters (cm) by 13 cm with minimal swelling and purple and yellow bruising to the bottom of the right foot that measured 9 cm by 7 cm with minimal swelling noted. Review of the investigation completed by the facility on 9/17/25 revealed the staff determined the resident's foot had potentially bumped into the mechanical lift during a transfer. Further review revealed no staff were interviewed regarding the use of the mechanical lift for the resident or an evaluation was not completed to ensure the staff were transferring the resident safely. An observation on 9/18/25 at 10:35 AM revealed that the resident had yellow bruising to the top of the right foot and the bottom of the foot had yellow/purple bruising with minimal swelling to foot. Resident had no response when asked if the right foot hurt. An interview on 9/22/25 at 1:00 PM with the Director of Nursing and Administrator confirmed that the bruising and swelling to Resident 8's right foot was an injury of unknown origin and that staff failed to complete a thorough investigation to determine the cause of the resident's bruising and swelling to the right foot and no investigation was sent to the Agency.

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