STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 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. Licensure Reference Number 175 NAC 12-006.05 (G)Based on record review and interview, the facility failed to ensure medications were used per the manufacture approved recommendations for 2 of 5 sampled residents (Residents 16 and Resident 17). The facility census was 58.Findings are: Record review of a facility supplied document titled Use of Psychotropic Medications and dated 08/2025 revealed adequate indications for use means that the medication administered is consistent with the manufacturer's recommendations. A.Record review of a document titled Remeron (mirtazapine) (which is an antidepressant medication) and dated 2009 revealed under indications and usage the medication is indicated for the treatment of major depressive disorder.Record review of an admission Record revealed the facility admitted Resident 16 on 07/06/2022 with diagnoses of dementia (which is a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), major mood disorder (which is a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies, insomnia (which is the inability to sleep), restlessness and agitation, and anxiety (which is an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it). Record review of Resident 16's Electronic Medical Health Record (EMHR) revealed that Resident 16 had orders to receive Mirtazapine tablet 15 milligrams one time a day for insomnia. In an interview completed on 01/14/2026 at 4:17 PM with the facility Director of Nursing (DON), the DON confirmed that insomnia was an off-label use of the medication and not the approved indication or use of the medication. B.Record review of a document titled Risperdal (which is an antipsychotic medication) and dated 01/2020 revealed under indications and usage that the medication is indicated for the treatment of schizophrenia, acute manic or mixed episode associated with bipolar one disorder, and treatment of irritability associated with autistic disorder.Record review of an admission Record revealed the facility admitted Resident 17 on 03/29/2024 with diagnoses of dementia (which is a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), anxiety (which is an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it) and Alzheimer's Disease (which is a degenerative brain disease of unknown cause that usually starts in late middle age or in old age, that results in progressive memory loss, impaired thinking, disorientation, and changes in personality and mood). Record review of Resident 17's Electronic Medical Health Record (EMHR) revealed that Resident 17 had orders to receive Risperdal 0.5 milligrams one time daily for Alzheimer's disease. In an interview completed (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
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 01/14/2026 at 4:17 PM with the DON, the DON confirmed that Alzheimer's was not an approved indication for the use of the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 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** Licensure Reference Number 175 NAC 12-006.09(G)(i)Based on record review and interview the facility failed to complete a recapitulation of stay (a concise summary of the resident's stay and course of treatment in the facility) for 2 of 2 sampled discharged residents (Resident 67 and 63) as required. The facility census was 58.Findings are: Record review of the facility policy titled Discharge of a Resident and dated 01/2025 revealed that the purpose was to ensure accurate documentation upon discharge of a living resident to another location. Nursing will print off the Transfer/Discharge Record that includes medical diagnoses, Advance Directives, and other pertinent information. Medications are also listed and last dose and time given needs to be documented. A. Record review of an admission Record revealed that the facility admitted Resident 67 on 06/21/2025 an discharged from the facility on 07/05/2025. Record review of Resident 67's Progress Notes revealed documentation that on 07/05/2025 at 1:47 AM Resident 67's body was released to their mortuary of choice. There was no further documentation in the progress notes for Resident 67. Record review of a facility supplied document titled Discharge Plan and dated 06/21/2025 revealed that Resident 67 was admitted to the facility for dementia and planned to stay in the facility long term. The residents responsible party and provider agreed with this plan. The resident's choice of pharmacy, that the resident would only like to be asked about discharge on their comprehensive assessment, that the resident passed away at the facility and that the social services designee checked in with the residents responsible party were also documented on the document. There was no recapitulation of the residents stay present in Resident 67 medical health record. In an interview completed on 01/20/2025 with the facility Director of Nursing (DON), the DON confirmed that the facility did not complete a recapitulation of stay or discharge summary for Resident 67. B. Record review of the facility policy titled Discharge of a Resident dated 1/2025 revealed that the purpose was to ensure accurate documentation upon discharge of a living resident to another location. Nursing will print off the Transfer/Discharge Record that includes medical diagnoses, Advance Directives, and other pertinent information. Medications are also listed and last dose and time given needs to be documented. Record review of the admission Record dated 1/14/26 for Resident 63 revealed Resident 63 admitted into the facility on [DATE]. The admission Record revealed that Resident 63 discharged from the facility on 11/26/25. Record review of the progress note for Resident 63 dated 11/26/25 at 9:00 AM revealed that Resident 63 discharged to home against medical advice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Discharge Instructions to Resident and/or Family dated 1/20/26 at 9:17 AM in the electronic medical record for Resident 63 revealed the date of discharge as 11/26/25. The form revealed that Resident 63 discharged to home by car accompanied by family. The section titled Therapy Needs revealed that no information was documented in the section. The section titled Nursing contained no information documented in the box for special instructions and no information documented in the box for Explanation of medications and treatments provided to. Record review of the facility provided Discharge Instructions to Resident and/or Family dated 1/20/26 for Resident 63 revealed that Resident 63 discharged home by car accompanied by family. The section titled Therapy Needs contained the information that the Resident left AMA (against medical advice) The section titled Nursing contained the box for special instructions. The special instructions box contained the information Resident left AMA. The box titled Explanation of medications and treatments provided to contained the information NA (Not Applicable). Record review of the medical record for Resident 63 revealed that it contained no required recapitulation of the resident's stay. The medical record contained no required reconciliation of the resident's medications. Interview on 1/20/26 at 1:33 PM with the facility Director of Nursing (DON) confirmed that the facility did not have a recapitulation of stay for Resident 63 as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2)Based on observation, record review, and interview the facility failed to monitor resident pressure ulcers (a localized wound of the skin and/or underlying tissue, usually over a bony area. A bedsore.) per professional standards for 1 of 1 resident reviewed (Resident 4). The facility census was 58.Findings are: A.Record review of the facility policy titled General Wound Care dated 1/2023 revealed that the guidelines are designed to assist the nursing staff in deciding how to care for skin problems. Measure the wound size (length, width, depth). If the wound fails to show signs of healing, re-evaluate the treatment plan and consult the physician. Record review of the facility policy titled Wound Documentation dated 1/2024 revealed that the guidelines are to assist nursing staff in deciding how to care for skin problems as well as where to record their findings and treatments. Document the size, location, drainage, color, stage, and dressing used. The facility wound nurse documents weekly wound assessments of pressure ulcers and significant wounds.Record review of the facility policy titled Pressure Sore Treatment dated 1/2025 revealed that staff are to document the location, stage, length, width, and depth, color, treatment, progress, and the condition of the wound. Perform treatment on the wound as ordered. Inform the physician of changes and treatments. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 5/15/25 for Resident 4 revealed Resident 4 admitted into the facility on 3/25/22. The assessment revealed that Resident 4 did not have any pressure ulcers.Record review of the care plan for Resident 4 dated 1/13/26 revealed Resident 4 was at risk for impaired skin integrity. Record review of the progress note for Resident 4 dated 10/19/25 at 9:04 PM revealed Resident 4 had a large water blister to the right heel and a left heel blister has opened. Record review of the progress note for Resident 4 dated 10/20/25 at 3:25 PM revealed Resident 4 was seen in wound clinic related to the heel blisters. A treatment for silicone bordered foam dressings to both heels was ordered for the resident. A Iodosorb (a sterile antimicrobial wound dressing that absorbs drainage, dead tissue, and debris while releasing iodine to kill bacteria) was ordered for the left heel and to have a padded cushions while in bed or chair. Record review of the care plan for Resident 4 dated 1/13/26 revealed Resident 4 had an intervention to change the dressing to the bilateral heels as ordered initiated on 10/24/25. The care plan revealed Resident 4 required Enhanced Barrier Precautions (gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug resistant organism and residents at increased risk due to wounds or indwelling medical devices) due to pressure ulcers to both heels. Record review of the MDS assessment for Resident 4 dated 11/13/25 revealed Resident 4 had three stage 2 pressure ulcers (a stage 2 pressure ulcer involves damage to the skin that results in the loss of the outermost skin layer and exposure of the inner layer of skin) that were not present on admission to the facility.Observation on 1/14/26 at 10:01 AM in the room of Resident 4 revealed that Nurse Aide-A (NA-A) was in the room to change the resident's clothing. Resident 4 was barefoot and no wound was observed on the left heel. The red wound bed on the right heel was approximately 1.3 centimeters (cm) in length and 2.5 cm in width per visual measurement and did not have drainage. NA-A applied the compression stockings to the right foot/leg and then to the left foot/leg. Interview on 1/15/26 at 11:38 AM with the facility Director of Nursing (DON) revealed the DON was the wound nurse and does the weekly assessments of resident wounds for the facility. Record review of the Weekly Wound Assessment (the facility record of the wound assessment performed by the facility wound nurse) for Resident 4 dated 10/24/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The date acquired was documented as 10/20/25. The documentation revealed that this was the first observation of the wound by the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound nurse. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 10/31/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/7/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/14/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/21/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound.Record review of the Weekly Wound Assessment for Resident 4 dated 11/24/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/4/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 20 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/12/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 20 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/19/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 20 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/22/25 revealedthe assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 20 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/31/25 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 20 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 1/9/26 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 15 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 1/16/26 revealed the assessment was for the stage 2 pressure ulcer on the right heel. The section titled Wound Measurements revealed a length of 15 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Interview on 1/20/26 at 12:52 PM with Licensed Practical Nurse-B (LPN-B) revealed the wound dressing on the right heel of Resident 4 was changed by LPN-B on 1/20/26. LPN-B revealed the right heel wound was open and had clear drainage. LPN-B reported the wound was oval shaped and approximately 1.5 cm in length and 2.5 cm in width. LPN-B revealed that there is no measurable depth of the wound.Record review of the resident record for Resident 4 revealed no measurements of the length and width of the pressure (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ulcer on the right heel. Interview on 1/20/26 at 11:36 AM with the facility Director of Nursing (DON) confirmed that Resident 4 had pressure ulcers on the right heel and the left heel. The DON confirmed that the DON performs weekly wound assessments. The DON revealed that weekly the DON completes assessment of each pressure ulcer and puts the assessment findings into the Weekly Wound Assessment in the electronic health record for the resident. The DON confirmed that the weekly assessment includes measurements, any changes with drainage, change in pain with dressing changes, and any signs or symptoms of infection. The DON confirmed that the length and width of the wounds were not measured as required.B.Record review of the progress note for Resident 4 dated 10/19/25 at 9:04 PM revealed that Resident 4 had a large water blister to the right heel and a left heel blister has opened. Record review of the progress note for Resident 4 dated 10/20/25 at 3:25 PM revealed Resident 4 was seen in wound clinic related to the heel blisters. A treatment for silicone bordered foam dressings to both heels was ordered for the resident. A Iodosorb (a sterile antimicrobial wound dressing that absorbs drainage, dead tissue, and debris while releasing iodine to kill bacteria) was ordered for the left heel and to have a padded cushions while in bed or chair. Record review of the Weekly Wound Assessment (the facility record of the wound assessment performed by the facility wound nurse) for Resident 4 dated 10/24/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel with a acquired date documented as 10/20/25. The documentation revealed this was the first observation of the wound by the wound nurse. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 10/31/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/7/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/14/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 11/21/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound.Record review of the Weekly Wound Assessment for Resident 4 dated 11/24/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 30 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/4/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 25 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/12/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 25 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/19/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 25 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment for Resident 4 dated 12/22/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 25 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 12/31/25 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Wound Measurements revealed a length of 25 millimeters (mm). The section contained no measurement of the width or any depth of the wound. Record review of the Weekly Wound Assessment for Resident 4 dated 1/9/26 revealed the assessment was for the stage 2 pressure ulcer on the left heel. The section titled Overall Impression revealed that the wound was healed. Record review of the resident record for Resident 4 revealed no measurements of the length and width of the pressure ulcer on the left heel. Interview on 1/20/26 at 11:36 AM with the facility Director of Nursing (DON) confirmed that Resident 4 had pressure ulcers on the right heel and the left heel. The DON confirmed that the DON performs weekly wound assessments. The DON revealed that weekly the DON completes assessment of each pressure ulcer and puts the assessment findings into the Weekly Wound Assessment in the electronic health record for the resident. The DON confirmed that the weekly assessment includes measurements, any changes with drainage, change in pain with dressing changes, and any signs or symptoms of infection. The DON confirmed that any change of treatment order and any special interventions is documented on the Weekly Wound Assessment. The DON confirmed that the DON uses a paper or see through ruler to measure the vertical (length) and horizontal (width) at the largest parts of the wound. The DON revealed that the DON measures a diameter measurement for regular shaped wounds. The DON revealed that irregular shaped wound measurements are the length and width. The DON confirmed that the measurements of the pressure ulcers on Resident 4's right and left heels were a diameter. The DON confirmed that the length and width of the wounds were not measured as required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285216	A. Building B. Wing	01/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT Carmel Home - Keens Memorial	412 West 18th Street Kearney, NE 68845

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.12 (D)The facility filed to ensure medications were labeled in compliance with professional standards of practice and or manufacturer instructions for 2 of 5 sampled Residents (Resident 51 and 57). The facility census was 58.Findings are:Record review of a facility supplied document titled Medication storage and labeling and dated 01/2023 revealed drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principals including the expiration date when applicable. A.Record review of a document titled Carboxymethylcellulose sodium solution (a lubricating eye drop) dated 06/2022 revealed to discard the multiuse vial 90 days after opening of the vial.In an observation completed on [DATE] at 8:13 AM Licensed Practical Nurse C (LPN-C) removed a multi dose clear vial with a white lid from the medication cart. The vial was labeled with a pharmacy label including Resident 51 name, medication name, dose, and frequency to administer the medication on the label. There was no date written on the multi dose bottle indicating the date the bottle was opened or when the bottle should be discarded 90 days from being opened. The LPN proceeded to administer the prescribed eye drop medication to Resident 51 and then return to the medication cart.In an interview completed on [DATE] at 9:09 AM with LPN-C, LPN-C confirmed there was no open date or date indicating 90 days after opening for the bottle to be discarded. The LPN confirmed that this should be written on the bottle so staff knew when the medication was no longer good and should be discarded.B.Record review of a document titled Humalog highlights of prescribing information and dated 03/2013 revealed multi dose vials stored at room temperature should be discarded after 28 days.In an observation completed on [DATE] at 8:45 AM LPN-C removed a white box containing a multi dose insulin vial from the medication cart and placed it on top of the medication cart. The LPN then checked Resident 57 orders. The LPN stated that due to the resident's blood sugar level the resident would not receive the insulin at this time. The vial of insulin was labeled with a pharmacy label including Resident 57 name, medication name, dose, and frequency to administer the medication on the label. A yellow sticker was located on the vial with an Open date written as 12/13 and an EXP (expiration date) of 01/10.In an interview completed on [DATE] at 9:09 AM with LPN-C, LPN-C confirmed that Resident 57 insulin expired 5 days ago on [DATE] and should have been discarded and a new vial obtained. The LPN confirmed that the vial of insulin should not be on the medication cart and was.