STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285219	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southlake Village Rehabilitation & Care Center	9401 Andermatt Drive Lincoln, NE 68526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.05(H)(vi)(3)(g)Based on record review and interview, the facility failed to ensure that valid and appropriate Power of Attorney (POA - a legal document that allows someone to act on another person's behalf) and advance directive documentation (a legal document that states a person's wishes about medical care if they can no longer make decisions) were maintained for Resident 9, who had severe cognitive impairment (a condition where thinking, memory, and decision-making abilities are significantly reduced). This affected 1 of 4 sampled residents. The facility census was 123. Findings are:Record review of Resident 9's admission Social Services Review dated [DATE] said no advance directives or POA were on file. Documentation showed a call was made to the daughter regarding POA, but no response was received. The record also showed a Brief Interview for Mental Status (BIMS - a test used in nursing homes to measure thinking ability, scored 0-15) with a score of 2, which indicates severe cognitive impairment, confirming inability to make legal or medical decisions.Record review of Resident 9's Quarterly Social Services Review dated [DATE] said no POA was on file and that staff had not received responses from the daughter regarding follow-up care needs.Record review of progress notes through [DATE] revealed no documentation of POA acquisition. On [DATE], the facility produced a faxed copy of a General Power of Attorney form dated [DATE], obtained from a prior facility. The document designated the daughter as attorney-in-fact (a person allowed to act under a POA) but was a general POA only and did not designate medical (health care) or financial authority.Record review of Resident 9's Do Not Resuscitate (DNR - a legal order not to perform CPR if breathing or heartbeat stops) form showed two signatures: one by the resident and a second entry showing the daughter's name written with a forward slash beside it. The daughter's name appeared as though she signed in place of the resident, despite not holding medical or financial POA authority.Record review of the Clinical Resident Profile dated [DATE] showed the resident's code status listed as DNR/Do Not Attempt Resuscitation. The profile documented POA invoked for resident: No. The daughter was listed only as Emergency Contact #1 and Responsible for Trust, but not as medical or financial POA. This conflicted with the General Power of Attorney document faxed to the facility on [DATE], which was limited to general powers and did not authorize medical or financial decision-making.An interview with the Social Services Coordinator on [DATE] at 10:48 AM confirmed that the facility tracks POA status during quarterly assessments (reviews of care done every three months) and attempts outreach (phone calls or emails) when documentation is missing. The Social Services Coordinator stated the only documented outreach for Resident 9 was on [DATE], with no follow-up documentation until the general POA was received via fax to the current facility on [DATE] from a previous facility where Resident 9 had resided. The Social Services Coordinator confirmed the POA form on file is general only and does not grant medical or financial authority.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Licensure Reference Number 175 NAC 12-006.11 Based on observations, record reviews and interviews, the facility failed to follow the menu when preparing food for residents on pureed diet. This had the potential to affect 6 residents who receive a pureed diet. The facility census was 123. A record review of residents receiving pureed diets revealed that there are six residents receiving pureed diets.A record review of the recipe for Pureed Beef Stroganoff Casserole revealed: A recipe for 5 servings:Beef, Stroganoff entree, 1 quart 2 cups, Beef Broth 2 cupsPlace prepared stroganoff casserole and broth in a food processor, blend until smooth. Add any food thickener as needed. Portion size 2- #8 scoops. A observation on 9/29/25 at 7:00 AM revealed that the Production [NAME] (PC) was preparing pureed Beef Stroganoff Casserole. PC was wearing a skull cap with hair on the back of her neck/ears/and bangs being exposed. PC had a 1 quart container of noodles already cooked and PC then poured the noodles into the food processor. PC then went to the refrigerator and pulled a pan of beef tip and gravy out and placed on the counter. PC took out a spatula and did 2 spatulas scoops of the beef tips and placed in the food processor with the noodles. PC had 2 cups of beef broth in a measuring cup and poured a little at a time into the blender till PC got the consistency of applesauce. Approximately 1/2 cup of the beef broth was left in the measuring cup. PC then placed the pureed mixture into metal pans and then covered the pans with lids and placed in oven. A record review of the Policy: Standardized recipes are used when preparing menu items with no dated revealed: Cooks are trained and expected to use and follow the recipes provided. An interview on 09/29/2025 8:50 AM with the Registered Dietician (RD) confirmed that PC should of used a scoop that has measurements on them instead of a spatula. RD confirmed that PC should of followed the recipe and PC did not follow the recipe.

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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(E) Based on observations, record reviews and interviews, the facility failed to contain hair while preparing meals for the residents. This had the potential to affect all residents in the facility. The facility census was 123. An observation on 9/24/25 at 8:00 AM in the kitchen revealed that Production cook (PC) was wearing a skull cap. PC had bangs hanging out of skull cap, and hair hanging on both ears and hair hanging out of the skull cap down to the neckline. PC was preparing the lunch meal.An observation on 9/25/25 at 9:30 AM revealed that PC was wearing a skull cap. PC had bangs hanging out of skull cap, and hair hanging on both ears and hair hanging out of the skull cap down to the neckline. PC was preparing the lunch meal. An observation on 9/29/25 at 7:00 AM revealed that PC was preparing pureed Beef Stroganoff Casserole. PC was wearing a skull cap with hair on the back of her neck/ears/and bangs being exposed. An observation of Culinary Chef (CC) was wearing a skull cap with hair hanging down on ears and back of neck and forehead. CC was putting food away from delivery in the freezers. An observation of PC (wearing the skull cap with bangs hanging out of skull cap, and hair hanging on both ears and hair hanging out of the skull cap down to the neckline) had a 1-quart container of noodles already cooked and poured the noodles into the blender. PC then went to the refrigerator and pulled a pan of beef tip and gravy out and placed it on the counter. PC took a spatula and did 2 scoops of the beef tips and placed the beef tips in the blender with the noodles. PC had 2 cups of beef broth in a measuring cup and poured a little at a time into the blender till cook 1 got the consistency of applesauce. PC then placed the pureed mixture into metal pans and then covered the pans with lids and placed it in the oven. A record review of the Policy: Satellite Kitchen responsibility with no date revealed:Clock in, place on hair covering, wash hands. A review of the food code 2-402 Hair Restraints 2-402.11 EffectivenessFood employees shall wear hair restraints such as hats, hair covering or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food. An interview on 9/29/25 at 9:30 AM with the Dietician confirmed that the hair is restraint but not completely covered. The dietician confirmed that all the hair should be covered and the hair is not.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. Licensure Reference Number 175 NAC 12.007.04(D) ventilation systemBased on observation, interview, and record review, the facility failed to have functional bathroom ventilation in six resident rooms (rooms 302, 309, 312, 313, 316, and 418) out of 30 rooms surveyed. The facility census was 123.Findings: An observation on 9/24/2025 during the initial tour, it was revealed rooms (302, 309, 312, 313, 316, and 418) bathroom vents were not functioning when tested with one ply tissue. An observation on 9/29/2025 at 7:23 AM revealed rooms (302, 309, 312, 313, 316, 414, and 418) bathroom vents were not functioning when tested with one ply tissue. On 9/29/2025 at 7:46 AM during a tour with maintenance, it was revealed the bathroom vents in rooms (302, 309, 312, 313, 316, and 418) were not functioning. In an interview on 9/29/2025 at 7:46 AM, maintenance confirmed the bathroom vents were not functioning in rooms (302, 309, 312, 313, 316, and 418) during the tour. It was confirmed that the preventative maintenance is performed quarterly, and the filters were due to be changed soon, and there was possibly dust build up. In a record review of the Facility's undated Logbook Documentation titled Inspect exhaust fans for proper operation and clean if necessary revealed the inspection of the vent fans include proper functioning and cleanliness. In a record review of the Facility's Logbook Documentation dated 6/19/2025, 7/16/2025, 8/1/2025, and 9/17/2025 revealed the vent inspections were marked as being completed on-time but did not reveal the status of the inspections. In an interview on 9/29/2025 at 12:53 PM with maintenance confirmed when the inspections are completed, a note is placed in the system regarding the status of the inspection. In a record review on 9/29/2025 at 12:56 PM of the Facility's Work History Report dated for the past 12 months revealed the exhaust fans were inspected and functional as of 6/30/2025. The monthly inspections dated 7/31/2025, 8/31/2025, and 9/30/2025 were marked as completed but did not indicate the status of the inspection. In an observation on 9/30/2025 it was revealed the bathroom vents were not functioning in rooms (302, 306, 309, 316, and 418).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(B)(ii)1Based on record review and interviews, the facility failed to ensure 1 out of 5 Nursing Assistant (NA) sampled nurse aides had completed at least 12 hours ongoing training, including abuse prevention and dementia management training annually based upon their employment date as required and the facility failed to ensure 1 (NA) out of 5 sampled NA's had a performance review at least once every 12 months as required. This had the potential to affect all residents who reside within the facility. The facility had a census of 123 at the time of survey. Findings are:Record review of the facility's Facility Assessment with a revision date of 8/1/2025 revealed a facility must develop, implement and maintain an effective training program for all new and existing staff.Review of undated facility policy, titled NetLearning enrollment and Completion Tracking revealed:-all team members are expected to complete their assigned NetLearnings prior to annual review date.-this ensures that all team members are current on all required education as part of their performance evaluation process. -NetLearning generates weekly email notifications to leadership and department supervisors and supervisors are expected to meet with team members one-on-one to discuss outstanding NetLearnings and provide a printed copy of the conversationReview of the facility Employee Handbook dated 1/2024 revealed that several years ago a team met to redesign the Performance Evaluation and that team members will have the opportunity to discuss their job and performance improvement annually. The facility provides the opportunity for the supervisor and team member to discuss the team members strengths and future growth plans. Department supervisors are responsible for conducting the discussion. A record review of an undated facility provided list of staff names and dates of hire revealed that NA - B was hired on 11/22/2022.A record review of NA - B's NetLearning Transcript as of 9/2025 revealed no course transcript for the last year.A record review of the staffing schedule dated 8/24/25 through 9/25/25 revealed that NA - B worked the floor on 8/24, 8/30, 8/31, 9/6, 9/7, 9/13, 9/14, 9/20, and 9/21/25. During an interview on 09/25/2025 at 2:24 PM with NA - C (staffing scheduler) confirmed that NA-B did work the floor on 8/24, 8/30, 8/31, 9/6, 9/7, 9/13, 9/14, 9/20, and 9/21/25. During an interview on 09/25/2025 at 12:55 PM the Director of Nursing (DON) confirmed that (gender) does the annual review for nursing staff and reviews their NET learning.During an interview on 09/25/2025 at 1:40 PM Licensed Practical Nurse (LPN) - A confirmed that all staff need to have 12 hours of training each year. During an interview on 09/25/2025 at 1:44 PM Clinical Support Liaison (CSL) confirmed that NA - B hasn't had their required education for the past 2 years. Last year NA - B was not in compliance and did not have any abuse prevention or dementia management training. During an interview on 09/25/2025 at 2:31 PM the DON confirmed that NA - B did not complete the paperwork or meet criteria for [DATE] and she did not get an evaluation. During an interview on 09/25/2025 at 2:35 PM CSL confirmed that the Building the Best of the Best (BBB) program does not believe the annual evaluation is about the past mistakes, it is supposed to focus on the future. All staff members are in a constant evaluation.A record review of NA - B's personal file revealed there was not a PIP (performance improvement plan) in place regarding continuing education and that there was not a performance evaluation.Record review of NA - B's nurse aide/med aide competency check off dated 7/22/25 revealed skills reviewed. It did not reveal performance evaluation or continuing education. During an interview on 9/25/2025 at 2:41 PM CSL also confirmed that NA - B was not on a performance improvement plan and her training/education had been acknowledged but was not addressed.During an interview on 09/25/2025 at 3:29 PM the Administrator (Adm) confirmed that NA - B had not had a performance evaluation in over a year. The last documented addressed concern with (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NA - B was dated January of 2024. The Adm also confirmed there was no facility policy regarding performance evaluations.