STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.04(F)(i)(5) Based on record review and interviews, the facility failed to notify the provider of a change in condition for 3 (Residents 2, 6, and 14) of 6 sampled residents and failed to notify the provider of the inability to follow provider orders for diabetic care for 3 (Residents 14, 7, and 17) of 3 sampled residents. The facility census was 25.A record review of the facility's policy Change in a Resident's Condition or Status (dated February 2021) revealed the nurse would notify the resident's attending physician or physician on call when there has been a significant in the resident's physical/emotion/mental condition or the need to alter the resident's medical treatment significantly within 24 hours. A. A record review of Resident 6's admission Record revealed the facility admitted Resident 6 on 12/11/2018. Resident 6 had diagnoses of dementia and generalized muscle weakness. A record review of Resident 6's quarterly MDS with a date of 8/12/2025 revealed Resident 6 required moderate assistance with rolling left and right, substantial assistance with sitting to lying, and was fully dependent on staff for all other transfers and movements. Additionally, the MDS identified Resident 6 at risk for the development of pressure ulcers. Under skin and ulcer/injury treatments, a pressure reducing device for the chair and application of ointments/medication other than to the feet was identified. A record review of Resident 6's Treatment Administration Record (TAR) from October 2025 revealed an order to complete a skin assessment and document finding in a weekly skin assessment under the assessment tab every Thursday for skin integrity with a start date of 8/14/2025. The order had been documented as completed on 10/2/2025, 10/9/2025, and 10/16/2025. There was no evidence that this had been completed on 10/23/2025 or 10/30/2025 as ordered. A record review of Resident 6's assessments under the assessment tab for Weekly Skin Assessment revealed assessments had been completed on 10/2/2025, 10/9/2025, 11/6/2025, and 11/13/2025. There was no evidence that a skin assessment had been completed on 10/16/2025. A record review of Resident 6's Weekly Skin Assessment with a date of 10/9/2025 revealed the resident's skin was intact. A record review of Resident 6's Weekly Skin Assessment with a date of 11/6/2025 revealed resident skin was intact, except for their sacral area where a dressing was intact. (continued on next page)

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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Skin Assessment and Bathing Documentation forms for Resident 6 revealed the following: - On 10/6/2025, Nurse Aide (NA)-G had written pick marks on chest. - On 10/12/2025, Medication Aide (MA) – F had circled wound on the form, circling areas of the resident's left chest and sacral area. Registered Nurse (RN) – A had additionally signed the form. A record review of Resident 6's note from their visit with the Nurse Practitioner (NP) on 10/13/2025 revealed no evidence the NP had been made aware of the resident's new skin wound. A record review of Resident 6's note from their visit with the NP on 10/21/2025 revealed Resident 6 presented with an unstageable sacral pressure injury. The wound was non-blanchable with a black/dark purple center. An order for wound care was provided to the facility. An interview on 11/17/2025 at 9:50 AM with MA-F confirmed they had found an open wound on Resident 6's sacral area on 10/12/2025. MA-F was unable to recall if [gender] had notified the charge nurse but had provided the Skin Assessment and Bathing Documentation form for RN-A to sign. An interview on 11/17/2025 at 9:52 AM with RN-A confirmed they had signed the Skin Assessment and Bathing Documentation form on 10/12/2025 but was unable to recall if they had completed a skin assessment or notified the provider and family. RN-A confirmed documentation of the skin assessment and notification to the family and provider should have been documented in the resident's medical record if it had been completed. An interview on 11/17/2025 at 9:55 AM with the DON confirmed there had been no documented skin assessment completed between 10/9/2025 and 10/21/2025, when the wound had been documented as being found in the resident's medical record. Additionally, the DON confirmed there was no evidence the facility had notified the physician prior to 10/21/2025 or had notified the family. B. A record review of the facility's policy, Wound Care (dated December 2011) in preparation for wound care, assembled all equipment and supplies needed. A record review of an admission Record revealed the facility admitted Resident 2 on 1/20/2017. Resident 2 had diagnoses of dementia (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), Chronic Inflammatory Demyelinating Polyneuritis (CIPD, a rare autoimmune disorder where the body's immune system attacks the myelin sheath, the protective covering of the nerves, primarily in the peripheral nervous system which can lead to progressive weakness and sensory changes in the arms and legs) and a Stage 4 Pressure Ulcer (a severe, open wound with full-thickness tissue loss that extends through the skin and into underlying muscle, tendon, or bone.) A record review of Resident 2's Care Plan Report revealed a focus area for skin integrity and pressure ulcer/injury with a last revised date of 9/3/2025. The area revealed Resident 2 was at risk for skin integrity impairment and pressure ulcer development due to impaired mobility, suprapubic catheter, bowel incontinence, and occasional moist skin folds due to obesity. Resident 2 had a stage (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pressure Ulcer to [gender] coccyx/sacrum. An intervention of Cleanse wound with Anasept cleanser, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound and cover with border dressing twice a day and as needed with a last revised date of 10/16/2025 had been added. A record review of Resident 2's TAR for October 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. Additional review of the TAR order revealed on 10/31/2025, the order was documented as held with reason of Other/See Progress Note. A record review of Resident 2's Progress Notes revealed on 10/31/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Treatment not done, unable to find the anasept cleanser. A record review of Resident 2's TAR for November 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. The order had been documented as held with reason of Other/See Progress Note on 11/1/2025 night shift. A record review of Resident 2's visit notes with the NP from 11/3/2025 revealed Resident 2 was seen again on 11/3/2025 per the staff request for wound concerns. The note revealed the wound was significantly worse with an increase in length, width, and depth since the last evaluation on 10/30/2025. The note also revealed the current order to cleanse the wound with Anasept spray, but at the time of the assessment was unavailable. An interview on 11/13/2025 at 2:25 with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) revealed the facility had been out of the Anasept spray as of 10/31/2025 and confirmed there was no documentation that the physician had been notified of the facility being out of Anasept spray and the inability to complete Resident 2's wound treatment as ordered. C. A record review of the facility policy Diabetes- Clinical Protocol with revision date of December 2020 revealed in the Monitoring and Follow Up section that the staff will identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia. A record review of Resident 14's admission Record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of Type I Diabetes Mellitus with Diabetic Polyneuropathy (diabetes of a form that usually develops during childhood or adolescence and is characterized by a severe deficiency of insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency toward ketoacidosis). A record review of Resident 14's September 2025 Medication Administration Record (MAR) revealed the resident had an order to monitor blood glucose levels four times a day and PRN (as needed) with a start date of 9/2/2025. The order also stated to notify the provider if the resident's blood sugar was less than 80 or greater than 400, or if resident was symptomatic. Further review of the (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation for this order revealed the resident had the following blood glucoses done in the morning that were below 80: -On 9/3/25 their blood glucose was 61, -On 9/5/25 their blood glucose was 70, -On 9/7/25 their blood glucose was 64, -On 9/14/25 their blood glucose was 50, -On 9/15/25 their blood glucose was 44, -On 9/19/25 their blood glucose was 48, and -On 9/20/25 their blood glucose was 50. A record review of Resident 14's September 2025 Medication Administration Record (MAR) revealed the resident had an order for Glucagon Emergency Kit 1 milligram (MG), inject 1 dose intramuscularly every 4 hours as needed for BS (Blood Sugar) below 60 and unable to consume oral. This order had a start date of 4/29/2024. Further review of this order revealed it had been documented as given on 9/8/2025 at 6:16 AM for a BS of 54, on 9/15/2025 at 7:08 AM for a BS of 44, and on 9/16/2025 at 5:56 AM for a BS of 46. A record review of Resident 14's September 2025 Medication Administration Record (MAR) revealed the resident had an order for Glutose 15 Gel 40 %, give 1 dose orally every 8 hours as needed for signs and symptoms of hypoglycemia. This order had a start date of 4/29/2024 and there was no evidence of this being administered or attempted during the month of September. A record review of Resident 14's Progress Notes for the month of September 2025 revealed a note on 9/8/2025 at 6:26 AM stating the resident had a blood glucose of 54, glucagon injection had been administered, and the practitioner had been notified. There was no documentation stating the resident had been unable to consume oral medication that morning. Further review of the Progress Notes revealed no evidence of the provider being notified by the facility of any other blood glucose readings that were below 80 or of the resident requiring a glucagon injection on 9/15/2025 and 9/16/2025. An interview on 11/13/25 at 11:10 AM with the Nurse Practitioner (NP) revealed the NP was not aware of the resident requiring the use of the glucagon injections for their low blood glucose levels on 9/15/2025 and 9/16/2025 until the pharmacist reached out to them about it on 9/19/2025. The NP also stated that Resident 14 was a very fragile diabetic, and they would have expected the facility to notify them of the need to utilize glucagon injections. An interview on 11/13/25 at 12:20 PM with the DON confirmed the injectable glucagon was given to Resident 14 three times in September. The DON confirmed there was no evidence of the provider being notified of this on 9/15/2025 or on 9/16/2025. An interview on 11/17/2025 at 2:15 PM with the administrator confirmed that when a nurse notifies the provider of a concern related to the residents, the nurse should then enter a progress note in the resident's medical record regarding what they notified the provider about. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. A record review of Resident 14's October 2025 MAR revealed the following orders: -Insulin (medication used to treat diabetes) Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (milliliter), inject as per sliding scale: if blood glucose is 201 - 225 = 2; 226 - 250 = 3; 251 - 299 = 4; 300 - 350 = 5; 351 - 375 = 6; 376 - 400 = 7; 401 - 402 = 8 and call provider. Give one time a day before supper. This order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the dose on 10/21/2025. -Tresiba (medication used to treat diabetes) FlexTouch Subcutaneous Solution Pen injector 100 UNIT/ML, inject 25 unit subcutaneously one time a day. The order had a start date of 9/20/2025. The blood glucose and insulin were documented as NA on 10/22/2025. -Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML, inject as per sliding scale: if blood glucose is 176 - 200 = 3; 201 - 225 = 4; 226 - 250 = 5; 251 - 299 = 7; 300 - 350 = 8; 351 - 375 = 9; 376 - 400 = 10; 401 - 402 = 12 call provider. Give two times a day. The order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the midday dose on 10/21/2025 and for the AM dose on 10/22/2025. -Monitor blood glucose levels four times a day and PRN. Notify provider if blood sugar is less than 80 or greater than 400 or if the resident is symptomatic. This order had a start date of 9/02/2025. The blood glucose was documented with an X on the 10/21/2025 midday, PM, and HS (hour of sleep) administration times and for the AM administration time on 10/22/2025. The midday time on 10/22/2025 revealed a blood glucose of 528. A record review of Resident 14's Progress Notes for October 2025 revealed no progress notes documented by the facility staff related to notifying the provider about the resident not receiving blood glucose checks or insulin the evening of 10/21/2025 and morning of 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, therefore Resident 14's blood glucose level had not been obtained since the previous morning, and the resident had not received any of their scheduled insulin doses. NP revealed the facility could not provide justification for why no one had notified the NP about the blood glucose monitoring strips not arriving the evening prior. NP stated the strips arrived prior to lunchtime on 10/22/2025 and at that time Resident 14's blood glucose was 528 and the NP had to order an extra dose of insulin to help lower the level. NP stated Resident 14 was a very fragile diabetic and needs their blood glucose checked frequently due to unpredictable and erratic levels. NP also stated that missing blood glucose checks, and insulin doses could have easily caused Resident 14 significant harm. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available and that the facility did not attempt any other method (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of obtaining strips, which resulted in Resident 14 not having their blood glucose level checked for four consecutive scheduled times. The DON also confirmed that Resident 14 did not receive their scheduled insulin doses during that timeframe. The DON confirmed the facility did not reach back out to the NP after being unable to obtain the strips the evening of 10/21/2025. E. A record review of Resident 7's admission Record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus without complications (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). A record review of Resident 7's October 2025 MAR revealed the following orders: - Insulin Glargine Subcutaneous Solution Pen injector 100 UNIT/ML, inject 20 unit subcutaneously one time a day, to be given at HS. The order had a start date of 10/21/2025. There was documentation of the medication being administered on 10/21/2025 but the associated blood glucose was documented as NA. - Insulin Glargine Subcutaneous Solution Pen injector 100 UNIT/ML, inject 50 unit subcutaneously one time a day, in the AM. The order had a start date of 10/22/2025. There was documentation of the medication being administered on 10/22/2025 but the associated blood glucose was documented as NA. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, Resident 7 wanted to speak with them. NP stated that Resident 7 reported their blood glucose had not been checked the evening prior or that morning, but their insulin had still been administered. NP revealed the facility could not provide justification for why no one had notified the NP about the blood glucose monitoring strips not arriving the evening prior. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available, that the facility did not attempt any other method of obtaining strips, and the facility did not reach back out to the NP after being unable to obtain the strips the evening of 10/21/2025. F. A record review of Resident 17's admission Record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus. A record review of Resident 17's October 2025 MAR revealed an order to obtain blood glucose checks before meals and at bedtime and to notify the provider if the resident's blood sugar was less than 60 or greater than 400 or if resident is symptomatic. The order had a start date of 9/10/2025. The (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order revealed documentation that a blood glucose check had not been completed for any of the scheduled times on 10/21/2025 or for the 7:00 AM and 11:00 AM times on 10/22/2025. A record review of Resident 17's Progress Notes for the month of October 2025 revealed no evidence of the facility notifying the provider of the inability to obtain blood glucose checks per the provider's orders on 10/21/2025 and 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, and the facility could not provide justification for why no one had notified the NP about the blood glucose monitoring strips not arriving the evening prior. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available, that the facility did not attempt any other method of obtaining strips, and the facility did not reach back out to the NP after being unable to obtain the strips the evening of 10/21/2025.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference 175 NAC 12-006.09(H) Based on interviews and record reviews, the facility failed to ensure residents were free from neglect by ensuring adequate supplies to meet residents' needs for 2 (Resident 2 and Resident 14) of 2 sampled residents. The facility identified a census of 25.Findings are:A record review of the SCARAB (Skyview Care and Rehab at Bridgeport) Facility Assessment - 2025 (dated 11/10/2025) revealed the following:- Services offered include pressure injury prevention and wound care.- The nurse management team assesses medical supplies weekly to ensure availability.A.A record review of the facility's policy, Wound Care (dated December 2011) in preparation for wound care, assembled all equipment and supplies needed. A record review of an admission Record revealed the facility admitted Resident 2 on 1/20/2017. Resident 2 had diagnoses of dementia (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), Chronic Inflammatory Demyelinating Polyneuritis (CIPD, a rare autoimmune disorder where the body's immune system attacks the myelin sheath, the protective covering of the nerves, primarily in the peripheral nervous system which can lead to progressive weakness and sensory changes in the arms and legs) and a Stage 4 Pressure Ulcer (a severe, open wound with full-thickness tissue loss that extends through the skin and into underlying muscle, tendon, or bone.) A record review of Resident 2's Care Plan Report revealed a focus area for skin integrity and pressure ulcer/injury with a last revised date of 9/3/2025. The area revealed Resident 2 was at risk for skin integrity impairment and pressure ulcer development due to impaired mobility, suprapubic catheter, bowel incontinence, and occasional moist skin folds due to obesity. Resident 2 had a stage Pressure Ulcer to her coccyx/sacrum. An intervention of Cleanse wound with Anasept cleanser, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound and cover with border dressing twice a day and as needed with a last revised date of 10/16/2025 had been added. A record review of Resident 2's TAR for October 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. Additional review of the TAR order revealed on 10/31/2025, the order was documented as held with reason of Other/See Progress Note. A record review of Resident 2's TAR for November 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. The order had been documented as held with reason of Other/See Progress Note on 11/1/2025 night shift. A record review of Resident 2's Progress Notes revealed on 10/31/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Treatment not done, unable to find the anasept cleanser. A record review of Resident 2's visit notes with the NP revealed the following:- Resident 2 was seen on 10/28/2025 to follow up on wound progress. The note revealed the wound appeared to be consistent with a possible yeast infection. Resident 2 started on an antifungal medication. The note also revealed concerns with the wound healing have slowed, questioning the potential benefit of restarting wound vacuum therapy.- Resident 2 was seen again on 11/3/2025 per the staff request for wound concerns. The note revealed the wound was significantly worse with an increase in length, width, and depth since the last evaluation on 10/30/2025. The note also revealed the current order to cleanse the wound with Anasept spray, but at the time of the assessment (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was unavailable. An interview on 11/13/2025 at 12:12 with the NP revealed the night shift nurse had admitted to the NP to not have changed the dressing after 10/31/2025, citing the lack of Anasept being available and confirmed that Anasept was still not available on 11/3/2025. Additionally, the NP revealed Resident 2 had passed away on 11/6/2025 from osteomyelitis (bone infection) and sepsis (infection in the blood stream), citing the failure of providing the dressing changes as ordered and a lack of bathing as the main contributors to the osteomyelitis/sepsis. An interview on 11/13/2025 at 2:25 with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) revealed the following:- The DON confirmed the facility was out of Anasept as of 10/31/2025 and had been aware of being out. On 11/3/2025, they urgently placed an order for additional Anasept spray due to the worsening of Resident 2"s wound. - The last time Anasept had been ordered was on 9/27/2025. The DON additionally confirmed Resident 2's wound treatment order had been in place since 10/14/2025 and Anasept spray should have been ordered and available. B.A record review of Resident 14's admission Record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of Type I Diabetes Mellitus with Diabetic Polyneuropathy (diabetes of a form that usually develops during childhood or adolescence and is characterized by a severe deficiency of insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency toward ketoacidosis). A record review of Resident 14's October 2025 MAR revealed the following orders:-Insulin (medication used to treat diabetes) Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (milliliter), inject as per sliding scale: if blood glucose is 201 - 225 = 2; 226 - 250 = 3; 251 - 299 = 4; 300 - 350 = 5; 351 - 375 = 6; 376 - 400 = 7; 401 - 402 = 8 and call provider. Give one time a day before supper. This order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the dose on 10/21/2025.-Tresiba (medication used to treat diabetes) FlexTouch Subcutaneous Solution Pen injector 100 UNIT/ML, inject 25 unit subcutaneously one time a day. The order had a start date of 9/20/2025. The blood glucose and insulin were documented as NA on 10/22/2025.-Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML, inject as per sliding scale: if blood glucose is 176 - 200 = 3; 201 - 225 = 4; 226 - 250 = 5; 251 - 299 = 7; 300 - 350 = 8; 351 - 375 = 9; 376 - 400 = 10; 401 - 402 = 12 call provider. Give two times a day. The order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the midday dose on 10/21/2025 and for the AM dose on 10/22/2025.-Monitor blood glucose levels four times a day and PRN. Notify provider if blood sugar is less than 80 or greater than 400 or if the resident is symptomatic. This order had a start date of 9/02/2025. The blood glucose was documented with an X on the 10/21/2025 midday, PM, and HS (hour of sleep) administration times and for the AM administration time on 10/22/2025. The midday time on 10/22/2025 revealed a blood glucose of 528. A record review of Resident 14's Progress Notes for October 2025 revealed no progress notes documented by the facility staff related to notifying the provider about the resident not receiving blood glucose checks or insulin the evening of 10/21/2025 and morning of 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, therefore Resident 14's blood glucose level had not been obtained since the previous morning, and the resident had not received any of their scheduled insulin doses. NP stated the strips arrived prior to lunchtime on 10/22/2025 and at that time Resident 14's (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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F 0600 Level of Harm - Actual harm Residents Affected - Few	blood glucose was 528 and the NP had to order an extra dose of insulin to help lower the level. NP stated Resident 14 was a very fragile diabetic and that missing blood glucose checks, and insulin doses could have easily caused Resident 14 significant harm. An interview on 11/13/25 at 12:20 PM with the DON confirmed the code NA on the MAR indicated not applicable. The DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available and that the facility did not attempt any other method of obtaining strips, which resulted in Resident 14 not having their blood glucose level checked for four consecutive scheduled times. The DON also confirmed that Resident 14 did not receive their scheduled insulin doses during that timeframe.

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F 0675 Level of Harm - Actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Licensure Reference 175 NAC 12-006.09(H)Based on observations, interviews, and record review, the facility failed to identify and address uncontrolled pain and withdrawal symptoms when the resident could no longer reliably swallow their oral medications for 1 (Resident 6) of 1 sampled resident. The facility identified a census of 25.Findings are: A record review of the facility's policy, Pain - Clinical Protocol (dated October 2022) revealed the following:- Nursing staff will identify any situation or interventions where an increase in the residents' pain may be anticipated.- Nursing staff will reassess the resident's pain at regular intervals, at least every shift for acute pain or significant changes in levels of chronic pain.- Nursing staff will evaluate and report on the residents' use of standing and as needed pain medications.- There was no evidence of how pain should be evaluated for residents who are non-verbal. A record review of Resident 6's admission Record revealed the facility admitted Resident 6 on 12/11/2018. Resident 6 had diagnoses of dementia and generalized muscle weakness. A record review of Resident 6's quarterly MDS with a date of 8/12/2025 revealed Resident 6 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 0/15, which indicated severe cognitive impairment. Additionally, it revealed Resident 6 is sometimes understood and sometimes understands others. A record review of Resident 6's Care Plan Report revealed a focus area of pain was initiated on 1/15/2024. The area revealed Resident 6 had chronic pain due to osteopenia (low bone density) and had generalized aches and pain. Interventions were as follows:- Administer analgesia (pain medication) per the orders.- Anticipate the resident's need for pain relief and respond immediately to any complaints of pain.- Evaluate the effectiveness of pain interventions. A record review of Resident 6's Order Summary as of 11/12/2025 revealed the following orders:- buspirone 5 milligrams (mg) to be given three times a day for anxiety/depression.- celecoxib 100 mg to be given once a day for arthritis in the hip.- fluvoxamine 100 mg to be given once a day for depression.- hydrocodone 5-325 mg with a half a table to be given three times a day for pain.- hydrocodone 5-325 mg once a day for pain.- methocarbamol 500 to be given three time a day for muscle weakness. A record review of Resident 6's Progress Notes revealed the following:- On 10/28/2025 at 12:31PM, Resident 6's order for Hydrocodone was documented as not given with note that resident had refused the medication.- On 10/28/2025 at16:33, it was documented that the resident's hydrocodone was held. There was no reason provided.- On 10/30/2025 at 10:07 AM, Resident's buspirone was documented as not given with note that resident kept pushing hand away and would not open mouth.- On 10/30/2025 at 10:08 AM, Resident's fluvoxamine, hydrocodone, methocarbamol, and celecoxib were documented as not given with note that resident kept pushing hand away and would not open mouth.- On 10/302025 at 11:49 AM, Resident's buspirone, hydrocodone, and methocarbamol was documented as not given with note stating resident would not open mouth and kept pushing their hand away.- On 11/1/2025 at 2:20 PM, Residents buspirone and methocarbamol were documented as not given with note stating resident refused.- On 11/2/2025 at 12:27-12:29 AM, Resident's hydrocodone and buspirone were documented as not given and note stating resident sleeping soundly.- On 11/3/2025 at 4:28 PM, Resident's hydrocodone was documented as not given without a reason provided.- On 11/3/2025 at 8:04 PM, Resident's buspirone and methocarbamol were documented as not given with a reason of resident refused.- On 11/7/2025 at 10:14 AM, a note was charted that Resident 6's medication were crushed and put into yogurt. Resident took four small bites then refused.- On 11/7/2025 at 8:45 PM, a note was charted that resident only took one small bite of medication and was unable to complete the rest.- On 11/8/2025 at 11:41 PM, resident's buspirone, methocarbamol, and hydrocodone were documented as not given with a reason of resident refused.- On 11/9/2025 at 9:37 AM, resident's methocarbamol was documented as not given with a reason of (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	resident only taking a few bites than refusing.- On 11/11/2025 at 1:45 AM, it was noted the writer had asked the Director of Nursing (DON) if it would be possible to obtain comfort medication for day as the resident is not taking any medication, so the resident could remain comfortable.- On 11/11/2025 at 9:15 PM, resident's buspirone was documented as not given with a reason of resident refused.- On 11/12/2025 at 12:37 AM, resident's hydrocodone was documented as not given with a reason of resident refused. An observation on 11/12/2025 at 9:45 AM revealed Resident 6 had been laying in bed. Resident 6 had been displaying non-verbal indications of pain, including facial grimacing and groaning. Posturing appeared to be rigid. An observation on 11/12/25025 at 11:10 AM revealed Resident 6 could be heard groaning from down the hallway. Resident 6 continued to be displaying non-verbal indication of pain including facial grimacing, furrowed brows, tense/rigid body posturing, restless legs, and loud/constant groaning. An interview on 11/12/2025 at 11:20 AM with the DON and Registered Nurse (RN) - A confirmed resident's assessment of non-verbal pain indications would rate at 6/10. RN-A stated they had difficulty administering Resident 6's medications, including their pain medications as the resident would only accept a few bites of the crushed medication. The DON revealed unaware if the resident not swallowing their medications had been reported to the Nurse Practitioner (NP) but stated comfort cares had been discussed, but no changes to the resident's regimen had been made due to an issue with the Power of Attorney (POA). Further record review of Resident 6's Progress Notes revealed the following:- On 11/12/2025 at 10:03 AM, RN-A had documented the resident would only take a few bites of their medication that had been crushed and put in pudding.- On 11/12/2025 at 11:34 AM, the DON documented they had spoken to the POA about change in medication, the DON followed up with the NP about comfort care medication being approved by the family. An interview on 11/13/2025 at 12:22 with the NP revealed the NP had been unaware until informed by this surveyor now that Resident 6 had not been taking their oral medications. The NP revealed Resident 6 did have a baseline behavior of mumbling, but being able to hear the resident from down the hallway would be outside their normal and would identify this as a non-verbal indication of pain. The NP also identified Resident 6's restless legs as being uncomfortable from withdrawals from the fluvoxamine and methocarbamol, as the resident needs these medications due to their tight spasticity in their legs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference 175 NAC 12-006.09(H)(i)(3) Based on record review and interview, the facility failed to assist residents with bathing for 3 (Resident 2, 6, and 18) of 3 sample residents. The facility identified a census of 24.Findings are: A. A record review of Resident 6's admission Record revealed the facility admitted Resident 6 on 12/11/2018. Resident 6 had diagnoses of dementia (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) and generalized muscle weakness.A record review of Resident 6's quarterly MDS with a date of 8/12/2025 revealed Resident 6 was fully dependent on staff for bathing and required total assistance for transferring in and out of the tub/shower. A record review of Resident 6's Documentation Survey Report v2 for September 2025 revealed Resident 6 received a bath on 9/26/2025. A record review of Resident 6's Documentation Survey Report v2 for October 2025 revealed Resident 6 received a bath on 10/6/2025, 10/17/2025, and 10/22/2025, 10/24/2025 and 10/31/2025. A record review of Resident 6's Documentation Survey Report v2 for November 2025 revealed Resident 6 received a bath on 11/10/2025 and 11/14/2025. A record review of Skin Assessment & Bathing Documentation forms for Resident 6 revealed the following:- Documentation Resident 6 received a bath on 10/12/2025.- Documentation Resident 6 received a bath on 10/14/2025.- Documentation Resident 6 received a bath on 10/23/2025. An interview on 11/17/2025 at 9:00 AM with the DON confirmed the following:- Resident 6 had not received a bath between 9/26/2025 and 10/6/2025 (10 days).- Resident 6 had not received a bath between 10/31/2025 and 11/10/2025 (10 days). B.A record review of Resident 18's admission Record revealed Resident 18 was re-admitted to the facility on [DATE]. Resident 18 had diagnoses of a Stage 2 Pressure Ulcer (an open wound involving the loss of the outermost layer of skin) and generalized muscle weakness. A record review of Resident 18's significant change MDS with a date of 9/13/2025 revealed Resident 18 had one-side impairment of their upper extremities. Resident 18 was also fully dependent on staff for bathing and required total assistance with transfer in and out of the tub/shower. A record review of Resident 18's Documentation Survey Report v2 from October 2025 revealed Resident 18 had a bath on 10/8/2025, 10/18/2025, and 10/29/2025. Not applicable had been documented on 10/25/2025. An interview on 11/17/2025 at 9:30 AM with the DON confirmed Resident 18 had not received a bath between 10/8/2025 and 10/18/2025 (10 days) nor 10/18/2025 and 10/29/2025 (11 days). C.A record review of an admission Record revealed the facility admitted Resident 2 on 1/20/2017. Resident 2 had diagnoses of dementia , Chronic Inflammatory Demyelinating Polyneuritis (CIPD, a rare autoimmune disorder where the body's immune system attacks the myelin sheath, the protective covering of the nerves, primarily in the peripheral nervous system which can lead to progressive weakness and sensory changes in the arms and legs) and a Stage 4 Pressure Ulcer (a severe, open wound with full-thickness tissue loss that extends through the skin and into underlying muscle, tendon, or bone.) A record review of Resident 2's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with a date of 8/25/2025 revealed Resident 2 had one-sided extremity impairment of their upper and lower extremities. Additionally, Resident 2 was dependent on staff for bathing and required substantial assistance for transferring in and out of the tub/shower. A record review of Resident 2's Documentation Survey Report v2 (a report that includes all bathing documentation for the month) from October 2025 revealed Resident 2 had received a bath on the following dates: 10/2/2025, 10/7/2025, 10/9/2025, 10/14/2025, 10/23/2025, 10/28/2025, and 10/30/2025. It was documented Resident 2 refused on 10/19/2025. A record review of Skin Assessment & Bathing Documentation (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	forms for Resident 2 revealed the following:- Documentation Resident 2 had received a bath on 10/18/2025.- Documentation Resident 2 had refused a bath on 10/23/2025.- Documentation Resident 2 had received a bath on 10/28/2025, 10 days since their previous bath. A record review of a Resident Refusal of Shower/Bed Bath revealed a date of 10/23/2025. An interview on 11/13/2025 at 2:25 with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) confirmed Resident 2 had gone from 10/18/2025 to 10/28/2025 without a bath.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)&(iv)Licensure Reference Number 175 NAC 12-006.10 Based on observations, interviews, and record reviews; the facility failed to follow their bowel protocol to prevent constipation for 1 (Resident 6) of 4 sampled residents, and failed to implement orders as written by the provider for 4 (Residents 1, 3, 11, and 17) of 5 sampled residents. The facility census was 25. A. A record review of a facility policy titled Bowel and Bladder program and Toileting Program dated October 2010 stated every night shift, the charge nurse is responsible for reviewing the Clinical Dashboard Alerts and completing the Bowel Movement (BM) Monitoring Form: -Interventions for no BM x 3 days: Milk of Magnesia 30 ml (Milliliter), by mouth (po) -monitor for effectiveness. -Interventions for no BM x 4 days: Bisacodyl suppository 10 mg (Milligrams) per rectum PRN (as needed) -monitor for effectiveness. -Interventions for no BM x 5 days: Fleets Enema 1 unit per rectum PRN-Monitor for effectiveness. -Evaluating Effectiveness-SMALL BMs do not count as effective A record review of the Nurse Practitioners (NP) report dated 10/23/2025 on Resident 6, revealed the chief complaint documented had been abdominal pain. Further review revealed NP documented Resident 7 had not had a bowel movement for 11 days. The NP ordered Polyethylene 17 GM (Grams) per scoop, orally daily for 30 days on 10/23/2025. A Medication Record (MAR) for October 2025 revealed Polyethylene 17 GM was not administered until 10/28/2025 in the AM. A record review of Resident 6s Task: Bowel Elimination document revealed from 10/28/2025 through 11/3/2025 (total of 7 days), revealed no documentation that the resident had a bowel movement for the dates shown. A record review of the (MAR) dated 10/1/2025 through 10/31/2025 revealed Resident 6 had a PRN (as needed) order for a bowel protocol with a start date of 08/12/2019. An interview on 11/17/2025 at 11.50 AM with Registered Nurse (RN)-A who gave a confirming statement no bowel movements were charted in the medication administration record for 10/28/2025 through 11/3/2025. An interview on 11/17/2025 at 11.50 AM with RN-A confirmed no PRN Milk of Magnesia (MOM) was administered as per the Bowel and Bladder program and Toileting Program policy for no BM after 3 days. Further confirming a Bisacodyl suppository was not administered after day 4 with no BM, and a Fleets enema was not administered after day 5 with no BM. B. A record review of Resident 1's admission Record revealed the resident was admitted to the facility (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on [DATE]. A record review of Resident 1's Progress Notes revealed an admission Summary note dated 10/30/25 at 4:11 PM stating the resident had arrived at the facility via the facility van. A record review of Resident 1's October 2025 Medication Administration Record revealed: -levofloxacin (an antibiotic) oral tablet 750 milligrams (mg), give 1 tablet by mouth one time a day for UTI (urinary tract infection) for 6 days. The order had a start date of 10/31/25 at 4:00 PM. -Ipratropium Bromide nasal solution 0.06 %, 2 spray in both nostrils two times a day for rhinorrhea (runny nose). The order had a start date of 10/31/2025 at 4:00 PM. -Saccharomyces boulardii (a probiotic) Oral Capsule 250 MG, give 1 capsule by mouth two times a day for Prophylaxis (prevention). The order had a start date of 10/31/2025 at 4:00 PM. -Acetaminophen (an over-the-counter pain medication) oral tablet 500 MG, give 1 tablet by mouth every 6 hours as needed for pain. The order had a start date of 10/31/2025 at 1:15 PM. -Bisacodyl (a laxative) oral tablet delayed release 5 MG, give 1 tablet by mouth as needed for constipation, may have daily. The order had a start date of 10/31/2025 at 1:15 PM. -Triamcinolone Acetonide external cream 0.1 %, apply to affected area topically every 12 hours as needed for pruritus (itching) of skin. The order had a start date of 10/31/2025 at 2:15 PM. A record review of Resident 1's Discharge Orders from the hospital dated 10/30/25 revealed no evidence the facility was to wait to start any medications, besides the levofloxacin, until 10/31/25. A record review of Resident 1's admission Medication Regimen Review from the pharmacy dated 10/30/25 revealed no evidence of a directive to wait to start the resident's medications until 10/31/25. An interview on 11/13/25 at 12:20 PM with the DON confirmed Resident 1 was admitted to the facility at 4:00 PM on 10/30/2025. The DON confirmed there was no evidence of a reason for the resident's medication orders not being put in on the date of admission. C. A record review of Resident 11's admission Record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Major Depressive Disorder. A record review of Resident 11's Provider Visit note dated 10/23/2025 revealed the resident the resident was seen to follow up on their mood and behavioral changes. The resident described feeling persistently down, depressed, and hopeless. In the treatment section of the note, it stated the provider was going to start the resident on escitalopram oxalate (an antidepressant medication) 5 mg daily. A record review of Resident 11's Provider Order Form dated 10/23/2025 revealed an order to start escitalopram 5 milligrams (MG) by mouth daily. The order was noted by RN-B, there was no date indicating when the RN noted the order. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 11's Order Summary revealed an order for escitalopram oxalate 5 mg daily with a start date of 10/27/2025. A record review of Resident 11's Provider Visit note dated 10/30/2025 revealed the resident was seen for a follow up on depression, anxiety, and wandering. The note stated the provider had ordered escitalopram oxalate 5 mg daily on 10/23/2025 and that the resident had not received this medication on 10/24, 10/25, 10/26, or 10/27; and that the medication was reordered. An interview on 11/13/2025 beginning at 11:10 AM with the NP confirmed that the NP had given the facility an order to change Resident 10's tizanidine order from routine to as needed on 10/23/2025 and the facility did not change the order until 10/27/2025. D. A record review of Resident 17's admission Record revealed the resident was admitted to the facility on [DATE] and had a new diagnosis added on 10/20/2025 of otitis media (ear infection) to the right ear. A record review of Resident 17's Provider Visit note dated 10/20/2025 revealed the resident had persistent ear discomfort and wax buildup in their right ear. The note stated that attempted right ear irrigation was unsuccessful, and the wax would need to be softened prior to removal. In the treatment section of the note, it stated the resident was to start carbamide peroxide solution, 6.5%, 5 drops into the affected ear twice a day for four days, then on day 5 irrigate the right ear. A record review of Resident 17's Physician's Order Form dated 10/20/2025 revealed an order for carbamide peroxide solution, 6.5%, 5 drops into the affected ear twice a day for four days. There was also an order stating the day following the completion of the carbamide ear solution, irrigate right ear. This order was noted by the DON on 10/20/2025. A record review of Resident 17's October 2025 MAR revealed the following orders: -Carbamide Peroxide-Saline otic kit 6.5 %, instill 5 drop in right ear two times a day every 4 days related to otitis media to the right ear until 10/25/2025. The order had a start date of 10/21/2025 and was documented as administered on 10/21/2025 and 10/25/2025. -day following the completion of the carbamide ear solution, irrigate right ear one time only related to otitis media to the right ear for 1 day. This order had a start date of 10/26/2025 and there was no documentation of it being completed. A record review of Resident 17's Provider Visit note dated 10/27/25 revealed the resident reported decreased hearing in their right ear. The provider identified this as likely due to impacted cerumen and noted that ear drops and irrigation had been ordered but not completed. In the treatment section of the note, it stated the Carbamide peroxide 6.5% otic solution, 5 drops in the right ear twice daily for 4 days and on day 5 irrigating the right ear was not completed so the provider reordered it. A record review of Resident 17's Physician's Order Form dated 10/27/25 revealed an order for carbamide peroxide solution, 6.5%, 5 drops into the affected ear twice a day for four days. There was also an order stating the day following the completion of the carbamide ear solution, irrigate right ear. (continued on next page)

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Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review of Resident 17's October 2025 MAR revealed an order for carbamide peroxide otic solution 6.5 %, instill 5 drops in the right ear two times a day for wax build up for 8 administrations. This order had a start date of 10/27/2025. An interview on 11/13/25 at 12:20 PM with the DON confirmed that the order entered on 10/21/2025 was entered incorrectly. The DON stated that once the facility realized this, they discussed it with the NP, and they received a new order to start the carbamide peroxide treatment again. E. A record review of Resident 3's Order Summary Report dated 11/12/2025 revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Major Depressive Disorder. A record review of Resident 3's Provider Order Form dated 10/7/2025 revealed an order to start fluoxetine 10 mg by mouth daily for Major Depressive Disorder. A record review of Resident 3's October 2025 MAR revealed the following: - fluoxetine HCl oral tablet 10 mg, give 1 tablet by mouth one time a day related to Major Depressive Disorder. This order had a start date of 10/09/2025 and a discontinued date of 10/14/2025. - fluoxetine HCl oral tablet 10 mg, give 1 tablet by mouth one time only for depression for 1 Day. This order had a start date of 10/16/2025 at 1:45 PM and was documented as administered the same day. - fluoxetine HCl oral tablet 10 mg, give 1 tablet by mouth one time a day for depression. This order had a start date of 10/17/2025. A record review of Resident 3's Progress Notes for the month of October 2025 revealed no evidence of a reason for their fluoxetine to have been discontinued on 10/14/2025. An interview on 11/13/25 at 12:20 PM with the Regional Nurse Consultant (RNC) confirmed the fluoxetine was discontinued on 10/14/2025, a one-time dose was given on 10/16/2025, and the medication was re-entered on 10/17/2025. The RNC also confirmed the order should not have been discontinued on 10/14/2025.

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1)Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on observations, record reviews, and interviews; the facility failed to develop and implement interventions to prevent the development of a pressure ulcer for 1 (Resident 6) of 1 sample resident and the failed to implement interventions and complete wound care treatments as ordered for 4 (Resident 2, 3, 6, and 18) of 4 sampled residents. The facility identified a census of 25.Findings are: A record review of a facility policy, Prevention of Pressure Ulcers, (dated March 2005) revealed the following: - Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. - The most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the head around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes. - Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e., perspiration, feces, urine, wound discharge, soap residue, etc.), decline in nutrition and hydration status, acute illness and/or decline in the resident's physical and/or mental condition. - Under General Preventative Measures: - Identify risk factors for pressure ulcer development. Factors that indicate residents at risk include decreased or impaired mobility; co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; drugs that may affect wound healing such as steroids; impaired blood flow; resident refusal or treatments; cognitive impairment; exposure of skin to urinary and fecal incontinence; undernutrition, malnutrition, and hydration deficits; and past history of pressure ulcers. - Change position at least every two hours or more frequently if needed. - Routinely assess and document the condition of the resident's skin for any signs and symptoms of irritation or breakdown. A record review of facility policy, Pressure Ulcer Treatment, (dated December 2007) revealed the following: - Pressure ulcer treatment requires a comprehensive approach, including: 1. Debridement. 2. Managing infections. 3. Managing systemic issues (edema, venous insufficiency, etc.). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	4. Maximizing the potential for healing. 5. Pain control. - Stage 1 Pressure Ulcer was defined as intact skin with non-blanchable (an area of skin that remains red when pressure is applied). - Stage 1 Pressure Ulcer interventions and care strategies included to determine cause of pressure and relieve; redistribute pressure; implement pressure-relieving devices; evaluate until redness is no longer persistent; notify physician, family, and appropriate facility personnel; and initiate a skin grid and care plan. For incontinence, cleanse, consider a toileting program or schedule and use protective barrier cream. For immobility, implement a turn schedule. - Stage 2 Pressure Ulcer was defined as partial thickness loss of the middle layer of skin presenting as a shallow open ulcer. - Stage 3 Pressure Ulcer was defined as a full thickness loss of the middle layer of skin with the potential for fat to be visible. - Stage 4 Pressure Ulcer was defined as a full thickness loss of the middle layer of skin where the bone, tendon, or muscle is exposed. - An unstageable pressure ulcer was defined as a full thickness loss of the skin where the base of the ulcer is covered by slough (a type of dead, devitalized tissue that appears in a wound as a soft, yellow, stringy, or thick, adherent material. It impedes wound healing by preventing new tissue growth, harboring bacteria, and blocking oxygen and nutrients. Removing slough is necessary for the wound to heal properly and is often done through a process called debridement.) or eschar (a layer of dead, leathery tissue, often black, brown, or tan, that forms over a wound or burn. It can be a sign of tissue death). - The first steps in the procedure of wound care were to first check the Treatment Administration Record (TAR) and obtain necessary supplies. A. A record review of an admission Record revealed the facility admitted Resident 2 on 1/20/2017. Resident 2 had diagnoses of dementia (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), Chronic Inflammatory Demyelinating Polyneuritis (CIPD, a rare autoimmune disorder where the body's immune system attacks the myelin sheath, the protective covering of the nerves, primarily in the peripheral nervous system which can lead to progressive weakness and sensory changes in the arms and legs) and a Stage 4 Pressure Ulcer (a severe, open wound with full-thickness tissue loss that extends through the skin and into underlying muscle, tendon, or bone.) A record review of Resident 2's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) with a date of 8/25/2025 revealed Resident 2 had one-sided extremity impairment of their upper and lower extremities. Additionally, Resident 2 was dependent on staff for bathing and required substantial assistance for transferring in and out of the tub/shower. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 2's Care Plan Report revealed a focus area for skin integrity and pressure ulcer/injury with a last revised date of 9/3/2025. The area revealed Resident 2 was at risk for skin integrity impairment and pressure ulcer development due to impaired mobility, suprapubic catheter, bowel incontinence, and occasional moist skin folds due to obesity. Resident 2 had a stage Pressure Ulcer to her coccyx/sacrum. Interventions were as follows: - Assist me in staying clean, dry, and comfortable with a start date of 4/21/2024. - Cleanse wound with Anasept cleanser, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound wound and cover with border dressing twice a day and as needed with a last revised date of 10/16/2025. A record review of Resident 2's TAR for October 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. Additional review of the TAR order found the following: - On 10/17/2025, there was no evidence the order had been completed for the morning shift and was documented as held with reason of Other/See Progress Note on the night shift. - On 10/23/2025, the order was documented as held with reason of Other/See Progress Note. - On 10/31/2025, the order was documented as held with reason of Other/See Progress Note. A record review of Resident 2's TAR for November 2025 revealed an order with a start date of 10/15/2025 to cleanse the resident's sacral would with Anasept spray, apply skin preparation, moisten a 2x2 gauze with Anasept, gently pack into the wound, fold another 2x2 gauze into quarter placing over the top of the wound, and cover with a border dressing twice a day and as needed. The order had been documented as held with reason of Other/See Progress Note on 11/1/2025 night shift. A record review of Resident 2's Progress Notes revealed the following: - On 10/18/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Day nurse did treatment before [gender] left. - On 10/20/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Resident is sleeping most of the night. - On 10/24/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Dressing intact. - On 10/28/2025, Resident 2 was started on fluconazole (an antifungal medication) for a skin yeast infection. - On 10/31/2025, Resident 2's wound treatment was documented as not completed with a free text entry reason of Treatment not done, unable to find the Anasept cleanser. - On 11/2/2025, Resident 2's wound treatment was documented as not completed with a free text entry (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	reason of Reposition resident, dressing intact day shift did treatment late. - On 11/4/2025 at 8:37 AM, the nurse received orders for the Nurse Practitioner (NP) to send Resident 2 via ambulance to the hospital for wound evaluation and treatment. - On 11/4/2025 at 10:15 AM, the nurse placed a call to set transportation for Resident 2 to be transferred to the hospital, noting the wound dressing was intact. A record review of Resident 2's visit notes with the NP revealed the following: - Resident 2 was seen on 10/21/2025 to follow up on their wound progression. In this note, the NP noted the wound to have shown improvement, with drainage decreasing and less areas of slough and eschar. - Resident 2 was seen again on 10/28/2025 to follow up on wound progress. The note revealed the wound appeared to be consistent with a possible yeast infection. Resident 2 started on an antifungal medication. The note also revealed concerns with the wound healing have slowed, questioning the potential benefit of restarting wound vacuum therapy. - Resident 2 was seen again on 11/3/2025 per the staff request for wound concerns. The note revealed the wound was significantly worse with an increase in length, width, and depth since the last evaluation on 10/30/2025. The note also revealed the current order to cleanse the wound with Anasept spray, but at the time of the assessment was unavailable. An interview on 11/13/2025 at 12:12 with the NP revealed the following: - On 10/28/2025, the NP had notified the Director of Nursing (DON) of wound worsening and brought forth the idea of ordering a wound vacuum. - Verified the night shift nurse had not brought forth the concern of Resident 2's further worsening and stated the night shift nurse had admitted to not have changed the dressing, citing the lack of Anasept being available. - Revealed Resident 2 had passed away on 11/6/2025 from osteomyelitis (bone infection) and sepsis (infection in the blood stream), citing the failure of providing the dressing changes as ordered and a lack of bathing as the main contributors to the osteomyelitis/sepsis. A record review of Resident 2's Documentation Survey Report v2 (a report that includes all bathing documentation for the month) from October 2025 revealed Resident 2 had received a bath on the following dates: 10/2/2025, 10/7/2025, 10/9/2025, 10/14/2025, 10/23/2025, 10/28/2025, and 10/30/2025. It was documented Resident 2 refused on 10/19/2025. A record review of Skin Assessment & Bathing Documentation forms for Resident 2 revealed the following: - Documentation Resident 2 had received a bath on 10/18/2025. - Documentation Resident 2 had refused a bath on 10/23/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	- Documentation Resident 2 had received a bath on 10/28/2025, 10 days since their previous bath. A record review of a Resident Refusal of Shower/Bed Bath revealed a date of 10/23/2025. An interview on 11/13/2025 at 2:25 with the Director of Nursing (DON) and Regional Nurse Consultant (RNC) revealed the following: - The DON confirmed the facility was out of Anasept as of 10/31/2025 but had been unaware and acknowledge the order was not new and should have been in supply. - The RNC urgently order additional Anasept spray on 11/3/2025 due to the worsening of Resident 2's wound. - Confirmed Resident 2 had gone from 10/18/2025 to 10/28/2025 (10 days) without a bath. B. A record review of Resident 6's admission Record revealed the facility admitted Resident 6 on 12/11/2018. Resident 6 had diagnoses of dementia and generalized muscle weakness. A record review of Resident 6's quarterly MDS with a date of 8/12/2025 revealed Resident 6 required moderate assistance with rolling left and right, substantial assistance with sitting to lying, and was fully dependent on staff for all other transfers and movements. Additionally, the MDS identified Resident 6 at risk for the development of pressure ulcers. Under skin and ulcer/injury treatments, a pressure reducing device for the chair and application of ointments/medication other than to the feet was identified. A record review of Resident 6's Care Plan Report revealed no evidence Resident 6 had been identified as at-risk for pressure ulcers prior to 11/5/2025. An interview on 11/17/2025 at 9:00 AM with the Director of Nursing (DON) confirmed Resident 6 was at risk for the development of a pressure ulcer due to their incontinence and immobility. An additional risk factor of impaired nutrition occurred within the last two weeks. The DON confirmed Resident 6 did not have a care plan developed for their risk of pressure ulcers prior to 11/5/2025 and should have, including interventions of repositioning and incontinence care to prevent the breakdown. A record review of Resident 6's Treatment Administration Record (TAR) from October 2025 revealed an order to complete a skin assessment and document finding in a weekly skin assessment under the assessment tab every Thursday for skin integrity with a start date of 8/14/2025. The order had been documented as completed on 10/2/2025, 10/9/2025, and 10/16/2025. There was no evidence that this had been completed on 10/23/2025 or 10/30/2025 as ordered. A record review of Resident 6's assessments under the assessment tab for Weekly Skin Assessment revealed assessments had been completed on 10/2/2025, 10/9/2025, 11/6/2025, and 11/13/2025. There was no evidence that a skin assessment had been completed on 10/16/2025. A record review of Resident 6's Weekly Skin Assessment with a date of 10/9/2025 revealed the resident's skin was intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	A record review of Resident 6's Weekly Skin Assessment with a date of 11/6/2025 revealed resident skin was intact, except for their sacral area where a dressing was intact. A record review of Skin Assessment and Bathing Documentation forms for Resident 6 revealed the following: - On 10/6/2025, Nurse Aide (NA)-G had written pick marks on chest. - On 10/12/2025, Medication Aide (MA) – F had circled wound on the form, circling areas of the resident's left chest and sacral area. Registered Nurse (RN) – A had additionally signed the form. A record review of Resident 6's note from their visit with the NP on 10/21/2025 revealed Resident 6 presented with an unstageable sacral pressure injury. The wound was non-blanchable with a black/dark purple center. An order for wound care was provided to the facility. An interview on 11/17/2025 at 9:50 AM with MA-F confirmed they had found an open wound on Resident 6's sacral area on 10/12/2025. MA-F was unable to recall if she had notified the charge nurse but had provided the Skin Assessment and Bathing Documentation form for RN-A to sign. An interview on 11/17/2025 at 9:52 AM with RN-A confirmed they had signed the Skin Assessment and Bathing Documentation form on 10/12/2025 but was unable to recall if they had completed a skin assessment. RN-A confirmed documentation of the skin assessment should have been documented in the resident's medical record if it had been completed. An interview on 11/17/2025 at 9:55 AM with the DON confirmed there had been no documented skin assessment completed between 10/9/2025 and 10/21/2025, when the wound had been documented as being found in the resident's medical record. Additionally, the wound had gone without treatment from 10/12/2025 to 10/21/2025. Additional record review of Resident 6's Care Plan Report revealed on 11/5/2025 a focus area for pressure ulcers had been added. This area revealed Resident 6 had an unstageable pressure ulcer to their sacrum due to impaired mobility, incontinence and decrease food and fluid intake. An intervention to follow facility policies for the prevention/treatment have also been added. An observation on 11/12/2025 at 8:10 AM revealed Resident 6 laying on their back in bed. Resident 6's air mattress was set to 180 pounds (lbs.) An observation on 11/12/2025 at 9:45 AM revealed Resident 6 laying on their right side in bed. Resident 6's air mattress continued to be set at 180 lbs. An observation on 11/12/2025 at 11:10 AM revealed Resident 6 laying on their right side in bed. Resident 6's air mattress continued to be set at 180 lbs. An interview on 11/12/2025 at 11:11 AM with RN-A revealed Resident 6's current weight was 88 lbs. as of Sunday (2 days prior.) An interview on 11/12/2025 at 11:15 AM with the DON confirmed Resident 6's bed was set for 180 lbs., which exceeded the correct setting of near 88 lbs. The DON was unsure why it was set so high as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	there should be an order on the TAR for the nurses to check that the air mattress was set to the correct level. An observation on 11/12/2025 from 1:00 PM to 3:50 PM revealed Resident 6 to be positioned on their right side facing the wall. An interview on 11/12/2025 at 3:55 PM with NA-E confirmed Resident 6 had not been repositioned on evening shift (since 2:00 PM) and had been laying on their right side since prior to shift change when dayshift repositioned the resident that way after lunch. C. A record review of Resident 18's admission Record revealed Resident 18 was re-admitted to the facility on [DATE]. Resident 18 had diagnoses of a Stage 2 Pressure Ulcer (an open wound involving the loss of the outermost layer of skin) and generalized muscle weakness. A record review of Resident 18's significant change MDS with a date of 9/13/2025 revealed Resident 18 had one-side impairment of their upper extremities. Resident 18 required substantial assistance for rolling left and right and was fully dependent on staff for position changes and transfers. A record review of Resident 18's Care Plan Report (last revised 10/1/2025) revealed Resident 18 had 3 stage 2 pressure injures to their sacrum and buttocks. Interventions of the following had been added: - Follow facility policies for the prevention/treatment of skin breakdown. - Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. - The resident requires supplemental protein, amino acids, vitamins and minerals as ordered to promote wound healing. A record review of Resident 18's visit notes with the NP from 10/28/2025 revealed Resident 18 had ongoing challenges with their pressure ulcers, including a stage 2 ulcer on their right buttock, 2 unstageable areas, and two resolving stage 1 pressure ulcers on both buttocks. The NP expressed concerns that the wound was not progressing as expected despite the now controlled urinary incontinence. Additionally, the note revealed Resident 18 was dependent on staff for turning and reposition, which was essential for [gender] wound management. Resident 18's weight was documented as 133.8 pounds (lbs.) An observation on 11/12/2025 at 8:10 AM revealed Resident 18 had been lying in bed. Their air mattress had been set for a weight of 170-230 lbs. An observation on 11/12/2025 at 1:15 PM revealed Resident 18 to be lying on their left side. The air mattress continued to be set for a weight of 170-230 lbs. An observation on 11/12/2025 at 3:45 PM revealed Resident 18 continued to be laying on their left side. Resident 18 was stating their rear hurt. The air mattress continued to be set for a weight of 170-230 lbs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	An interview on 11/12/2025 at 3:50 PM with Registered Nurse (RN) – A revealed they were unsure of what setting Resident 18's air mattress should be set on and referred the question to the nearby DON. An interview on 1/12/2025 at 3:51 PM with the DON revealed the resident's air mattress should be set according to their weight. A follow up interview on 11/12/2025 at 3:52 PM with RN-A confirmed Resident 18's bed was set to 170-230 pounds, which exceeded Resident 18's current weight status of 136 lbs. Additionally, RN-A confirmed Resident 18 had been in this position since after returning from lunch, sometime around 1:00 PM, and should be repositioned every two hours. Further observation on 11/12/2025 at 3:52 PM revealed Resident 18 continue to complain of pain. RN-A asked Resident 18 if they would like Tylenol for their pain. RN-A did not offer to reposition Resident 18 until after being prompted by this surveyor, which Resident 18 accepted assistance with repositioning. RN-A was assisted by the DON to reposition. A follow up interview on 11/12/2025 at 4:01 PM with Resident 18 revealed repositioning helped some with their rear pain. D. A record review of Resident 3's Order Summary Report dated 11/12/2025 revealed the resident was admitted to the facility on [DATE]. The report also revealed the resident had an order to cleanse the right superior aspect of ear, both areas with wound cleanser, and apply bacitracin-zinc with a cotton tipped applicator twice a day. The order had a start date of 11/6/2025. An observation on 11/12/25 at 1:02 PM revealed the Director of Nursing (DON) was at the nurse's station preparing to perform wound care for Resident 3. The DON checked their orders in a binder, then placed the supplies needed into a plastic container and carried them to the resident's room. After the DON performed wound cares to the resident's Moisture Associated Skin Damage (MASD) on their thigh and buttocks, two aides assisted the resident out of their bed and into their wheelchair. While this took place, the DON performed HH via ABHR, opened a package of sterile gauze, put on new gloves, and squirted Skintegrity wound cleanser onto the gauze. The DON used the gauze to cleanse Resident 3's right upper ear, then threw the gauze and their gloves into the trash and performed HH via ABHR. After putting on new gloves, the DON put Hydrogel onto a Q-Tip and rubbed it onto the area in the crease of the resident's upper right ear. The DON then removed their gown and gloves, put their supplies back into the plastic container, and carried their supplies back to the nurse's station. An interview on 11/12/25 at 1:58 PM with the DON confirmed they used Hydrogel for the treatment to Resident 3's right ear. The DON stated they did not realize Resident 3's order had been changed from Hydrogel to bacitracin-zinc six days prior. An interview on 11/12/25 at 1:59 PM with the Registered Nurse Consultant confirmed Resident 3's right ear treatment order had been changed from Hydrogel to bacitracin-zinc in the electronic medical records six day prior.

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	285224	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D) Based on record review and interviews, the facility failed to ensure significant medication errors did not occur for 2 (Residents 10 and 14) of 14 sampled residents. The facility census was 25.A.A record review of Resident 10's admission Record revealed the resident was admitted to the facility on [DATE] and had diagnoses of postlaminectomy syndrome (a complication after spinal surgery involving persistent pain), chronic pain syndrome and muscle spasms of the back. A record review of Resident 10's Provider Visit note dated 10/23/2025 revealed the resident was seen due to recent drowsiness and dizziness. The resident had described these symptoms as emerging after their Baclofen (a muscle relaxer) dose was increased from 10 milligrams (mg) to 15 mg, in addition to their ongoing use of tizanidine (a muscle relaxer). In the treatment section of this note, it stated the provider was going to change the resident's Tizanidine 2 mg to PRN (as needed) every 6 hours. A record review of Resident 10's Provider Order Form dated 10/23/25 revealed a new order to change the resident's routine tizanidine to PRN for muscle spasms. The order was noted by Registered Nurse (RN)-B on 10/27/25. A record review of Resident 10's Progress Note dated 10/24/2025 at 12:38 PM revealed that the Director of Nursing (DON) had contacted the Nurse Practitioner (NP) as the resident had been alert but not oriented after taking their medications for muscle spasms. The NP recommended the facility continue to monitor Resident 10 and hold their medication for muscle spasms. A record review of Resident 10's October 2025 Medication Administration Record (MAR) revealed the following orders:-Tizanidine HCl oral tablet 2 mg, give 1 tablet by mouth every 6 hours (midnight, 6 AM, noon, and 6 PM) for spondylolisthesis, thoracolumbar region (a forward slippage of a vertebra where the thoracic and lumbar spine join). This order had a start date of 10/21/2025 and a discontinue date of 10/27/2025.-Tizanidine HCl oral tablet 2 mg, give 1 tablet by mouth every 6 hours as needed for muscle spasms of the back. This order had a start date of 10/27/2025.-Baclofen oral tablet 10 mg, give 1.5 tablets by mouth three times a day for postlaminectomy syndrome. This order had a start date of 10/22/2025, was placed on hold on 10/26/2025 at 1:24 PM, then was discontinued on 10/27/2025. A record review of Resident 10's Provider Visit note dated 10/27/2025 revealed the resident was being seen to follow up on their pain and muscle spasms. The note stated the resident had begun taking new medications for muscle spasms and rigidity, however their interaction lead to increased sleepiness. An order was given to change the resident's routine tizanidine to PRN on 10/23/2025, the following day it was reported that the resident was experiencing excessive lethargy, and the resident's Baclofen was placed on hold. The resident continued to receive the tizanidine routinely on 10/23, 10/24, 10/25, 10/26, and 10/27, although the order was changed to PRN on 10/23. In the treatment section of the note, it stated to continue the tizanidine 2 mg by mouth every 6 hours as needed. An interview on 11/13/2025 at 11:10 AM with the NP confirmed that the NP had given the facility an order to change Resident 10's tizanidine order from routine to as needed on 10/23/2025 and the facility did not change the order until 10/27/2025. B.A record review of Resident 14's admission Record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of Type I Diabetes Mellitus with Diabetic Polyneuropathy (diabetes of a form that usually develops during childhood or adolescence and is characterized by a severe deficiency of insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency toward ketoacidosis). A record review of Resident 14's October 2025 MAR revealed the following orders:-Insulin (medication used to treat diabetes) Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (milliliter), inject as per sliding scale: if blood glucose is 201 - 225 = 2; 226 - 250 = 3; 251 - 299 = 4; 300 - 350 = 5; 351 - 375 = 6; 376 - 400 = 7; 401 - 402 = (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8 and call provider. Give one time a day before supper. This order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the dose on 10/21/2025.-Tresiba (medication used to treat diabetes) FlexTouch Subcutaneous Solution Pen injector 100 UNIT/ML, inject 25 unit subcutaneously one time a day. The order had a start date of 9/20/2025. The blood glucose and insulin were documented as NA on 10/22/2025.-Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML, inject as per sliding scale: if blood glucose is 176 - 200 = 3; 201 - 225 = 4; 226 - 250 = 5; 251 - 299 = 7; 300 - 350 = 8; 351 - 375 = 9; 376 - 400 = 10; 401 - 402 = 12 call provider. Give two times a day. The order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the midday dose on 10/21/2025 and for the AM dose on 10/22/2025. -Monitor blood glucose levels four times a day and PRN. Notify provider if blood sugar is less than 80 or greater than 400 or if the resident is symptomatic. This order had a start date of 9/02/2025. The blood glucose was documented with an X on the 10/21/2025 midday, PM, and HS (hour of sleep) administration times and for the AM administration time on 10/22/2025. The midday time on 10/22/2025 revealed a blood glucose of 528. A record review of Resident 14's Progress Notes for October 2025 revealed no progress notes documented by the facility staff related to notifying the provider about the resident not receiving blood glucose checks or insulin the evening of 10/21/2025 and morning of 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, therefore Resident 14's blood glucose level had not been obtained since the previous morning, and the resident had not received any of their scheduled insulin doses. NP stated the strips arrived prior to lunchtime on 10/22/2025 and at that time Resident 14's blood glucose was 528 and the NP had to order an extra dose of insulin to help lower the level. NP stated Resident 14 was a very fragile diabetic and that missing blood glucose checks, and insulin doses could have easily caused Resident 14 significant harm. An interview on 11/13/25 at 12:20 PM with the DON confirmed the code NA on the MAR indicated not applicable. The DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available and that the facility did not attempt any other method of obtaining strips, which resulted in Resident 14 not having their blood glucose level checked for four consecutive scheduled times. The DON also confirmed that Resident 14 did not receive their scheduled insulin doses during that timeframe.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 Based on record review and interviews, the facility failed to provide and report timely laboratory services for 4 (Residents 7, 8, 14, and 17) of 7 sampled residents and failed to perform blood glucose monitoring per the provider's orders for 3 (Residents 7, 14, and 17) of 3 sampled residents. The facility census was 25.A. A record review of Resident 7's face sheet revealed Resident 7 was admitted on [DATE] with diagnoses of congestive heart failure, Type 2 diabetes mellitus (a disease in which the body cannot regulate blood sugar effectively), obesity, hypertension, and atrial fibrillation (an abnormal heart rhythm that is irregular in the chambers of the heart are out of sync). A record review of a facility document scanned into Resident 7's electronic medical record dated 10/3/25 revealed a new provider order from the Nurse Practitioner (NP) to obtain a BMP (Basic Metabolic Panel, a blood test that measures 8 substances in the blood that relate to chemical balance and metabolism) on 10/17/25. A record review of Resident 7's nurses notes in PCC revealed an entry on 10/3/25 which stated that the provider visited Resident 7 in the facility and ordered a BMP to be drawn on 10/17/25. A record review of Resident 7's provider orders in the electronic medical record (Point Click Care, PCC) revealed an order entered 10/3/25 to obtain a BMP with a start date of 10/17/25 and an end date of 10/19/25. A record review of resident 7's progress notes in PCC for the month of October 2025 did not reveal any mention of lab work to be collected (or an attempt to collect any). A record review of a facility document titled Clinical Laboratory Report, dated 10/23/25 revealed a blood sample from Resident 7 was collected on 10/23/25 at 2:56 PM and received at the laboratory on the same day at 3:35 PM. The document also revealed results of a comprehensive blood panel (CMP, a blood test that measures 14 substances in the blood that relate to chemical balance, kidney, and liver function) for Resident 7. A record review of Resident 7's electronic medical record did not reveal any other lab results for the month of October 2025. An interview with the Director of nursing (DON) on 11/13/25 at 9:43 AM confirmed that Resident 7's BMP order was supposed to be drawn on 10/17/25 but was not drawn until 10/23/25 and should have been collected on 10/17/25. The interview also confirmed there was no documentation of efforts to collect or obtain a sample or report results to the provider. B. A record review of Resident 8's face sheet revealed Resident 8 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus, a history of urinary tract infections (UTIs), coronary heart disease (a type heart disease that affects the main vessels that supply blood to the heart), and blindness category 5 in both eyes (profound vision loss). (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a facility document scanned into Resident 8's electronic medical record, dated 10/15/25 revealed a new provider order from the NP to obtain several blood tests, and urine microalbumin and creatinine. A record review of the nursing progress notes in PCC between10/15/25 and 10/24/25 revealed no documentation of efforts to collect or submit a urine sample for lab testing for Resident 8. An interview on 11/14/25 at 9:43 AM with the Regional Nurse Consultant (RNC) revealed that Resident 8 was usually continent of urine, needed assistance to get to the bathroom, and was blind. The interview revealed the resident preferred to catch the urine in a hat, a container that is placed in the toilet to collect urine before it reaches the water. An interview on 11/17/25 at 12:30 PM with the NP revealed that the NP asked nursing staff several times between 10/15/25 and 10/24/25 to obtain a urine sample from Resident 8. The interview also revealed that the NP reported taking the resident to the bathroom during that period, the resident had been continent in the toilet, but no hat had been present in order to collect a urine sample. A record review of a facility document titled Clinical Laboratory Report, dated 10/24/25 revealed results of a lab testing including urine microalbumin and urine creatinine from a sample that had been collected from Resident 8 on 10/24/25. An interview on 11/14/25 at 9:43 AM with the DON confirmed that the urine tests were ordered on 10/15/25 to be collected promptly but were not collected until 10/24/25, 9 days later. The interview also confirmed that the blood tests ordered on 10/15/25 were collected on 10/18/25. The interview confirmed that there was no documentation in Resident 8's medical record that the provider was notified of a delay in sample collection or that the facility received a change in the provider's order. C. A record review of Resident 14's face sheet revealed Resident 14 was admitted on [DATE] with diagnoses of type 1 diabetes mellitus (a chronic condition in which the body does not produce insulin, which is essential in regulating blood sugar), dementia (a decline in cognitive function affecting memory, thinking, and behavior), and epilepsy (a complex neurological disorder which leads to seizures). A record review of a note written by Resident 14's provider NP on 10/22/25 revealed that Resident 14 had a Vitamin D level on 9/17/25 that was considered low, and that the next level would be obtained on 10/28/25. A record review of Resident 14's electronic medical record revealed a provider order entered on 9/19/25 for a Vitamin D level to be drawn on 10/28/25. An interview with RNC 11/14/25 at 9:43 AM revealed the order for collecting Resident 14's blood for a Vitamin D level was electronically signed off on 10/29/25 at 12:38 PM. A record review of Resident 14's electronic medical record revealed a nurses note for 11/6/25 at 7:00 AM which stated blood was drawn for a Vitamin D level at that time. A record review of Resident 14's medical record revealed no Vitamin D level results for the resident between 10/1/25 and 11/14/25. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The interview with RNC 11/14/25 at 9:43 AM confirmed there was no documentation in Resident 14's medical record of Vitamin D level results, or notifying the provider of a delay in collecting a sample. D. A record review of Resident 17's face sheet revealed Resident 17 was admitted on [DATE] with diagnoses of rheumatoid arthritis, Type 2 diabetes mellitus, obesity, recurrent UTIs, and chronic kidney disease. A record review of Resident 17's census records in the electronic medical record revealed that the resident was in the hospital from [DATE] to 10/11/25. A record review of Resident 17's electronic medical record revealed a scanned provider note dated 10/13/25 stating Resident 17 was seen by the NP for readmission to the facility following hospitalization due to rheumatoid arthritis flare and a urinary tract infection. A record review of Resident 17's electronic medical record revealed a progress note dated 10/17/25 which stated Resident 17 was seen by the facility NP at 7:11 AM for a follow-up which included a complaint of urinary retention. A record review of Resident 17's electronic medical record revealed a scanned copy of a provider order from an office visit on 10/17/25 outside the facility to obtain a urine sample on 10/20/25 for urinalysis (UA) and to call the provider with results. A record review of Resident 17's electronic medical record revealed a scanned copy of a provider order from the NP dated 10/27/25 for urinalysis (UA), culture and sensitivity (C/S) if needed, and signed by a nurse. A record review of Resident 17's electronic medical record revealed results from a urinalysis from the hospital lab for a specimen collected on 10/28/25. The results revealed the presence of bacteria, and a urine culture was set up. A record review of Resident 17's electronic medical record revealed a provider order starting on 10/31/25 for Ciprofloxacin (an antibiotic) to treat a urinary tract infection. A record review of Resident 17's electronic medical record revealed no documentation of efforts to collect or submit a urine sample, or mention of UA results prior to the urinalysis being reordered on 10/27/25. An interview with the DON 11/14/25 at 9:43 AM confirmed Resident 17's urine was not collected for the 10/20/25 urinalysis. A record review of an undated facility policy titled, Lab management system, revealed the steps and responsibilities in the process of laboratory orders and results for the facility beginning with receiving the order and including how to communicate results to the provider. The policy revealed that new lab orders were recorded on a Lab Tracking Log, lab requisitions were completed accurately, and that all labs were drawn on the day ordered. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with NP 11/13/25 at 12:30 PM revealed their expectation was that orders for lab testing would be collected within 48–72-hours if the test was routine (such as chronic disease monitoring), and on the same day or within 24 hours if it was ordered on a more urgent basis. An interview with DON on 11/13/25 at 4:10 PM confirmed the facility was not following the process outlined in the facility policy titled, Lab management system. E. A record review of the facility policy Diabetes- Clinical Protocol with revision date of December 2020 revealed in the Monitoring and Follow Up section that the staff will identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia. A record review of Resident 14's admission Record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of Type I Diabetes Mellitus with Diabetic Polyneuropathy (diabetes of a form that usually develops during childhood or adolescence and is characterized by a severe deficiency of insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency toward ketoacidosis). A record review of Resident 14's October 2025 MAR revealed the following orders: -Insulin (medication used to treat diabetes) Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML (milliliter), inject as per sliding scale: if blood glucose is 201 - 225 = 2; 226 - 250 = 3; 251 - 299 = 4; 300 - 350 = 5; 351 - 375 = 6; 376 - 400 = 7; 401 - 402 = 8 and call provider. Give one time a day before supper. This order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the dose on 10/21/2025. -Tresiba (medication used to treat diabetes) FlexTouch Subcutaneous Solution Pen injector 100 UNIT/ML, inject 25 unit subcutaneously one time a day. The order had a start date of 9/20/2025. The blood glucose and insulin were documented as NA on 10/22/2025. -Insulin Aspart FlexPen Subcutaneous Solution Pen injector 100 UNIT/ML, inject as per sliding scale: if blood glucose is 176 - 200 = 3; 201 - 225 = 4; 226 - 250 = 5; 251 - 299 = 7; 300 - 350 = 8; 351 - 375 = 9; 376 - 400 = 10; 401 - 402 = 12 call provider. Give two times a day. The order had a start date of 9/10/2025. The blood glucose and insulin were documented as NA for the midday dose on 10/21/2025 and for the AM dose on 10/22/2025. -Monitor blood glucose levels four times a day and PRN. Notify provider if blood sugar is less than 80 or greater than 400 or if the resident is symptomatic. This order had a start date of 9/02/2025. The blood glucose was documented with an X on the 10/21/2025 midday, PM, and HS (hour of sleep) administration times and for the AM administration time on 10/22/2025. The midday time on 10/22/2025 revealed a blood glucose of 528. A record review of Resident 14's Progress Notes for October 2025 revealed no progress notes documented by the facility staff related to notifying the provider about the resident not receiving blood glucose checks or insulin the evening of 10/21/2025 and morning of 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, therefore Resident 14's blood glucose level had not been obtained since the previous morning, and the resident had not received any of their scheduled insulin doses. NP revealed the facility could not provide justification for why no one had notified the NP about the blood glucose monitoring strips not arriving the evening prior. NP stated the strips arrived prior to lunchtime on 10/22/2025 and at that time Resident 14's blood glucose was 528 and the NP had to order an extra dose of insulin to help lower the level. NP stated Resident 14 was a very fragile diabetic and needs their blood glucose checked frequently due to unpredictable and erratic levels. NP also stated that missing blood glucose checks, and insulin doses could have easily caused Resident 14 significant harm. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available and that the facility did not attempt any other method of obtaining strips, which resulted in Resident 14 not having their blood glucose level checked for four consecutive scheduled times. The DON also confirmed that Resident 14 did not receive their scheduled insulin doses during that timeframe. The DON confirmed the facility did not reach back out to the NP after being unable to obtain the strips the evening of 10/21/2025. F. A record review of Resident 7's admission Record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus without complications (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). A record review of Resident 7's October 2025 MAR revealed the following orders: - Insulin Glargine Subcutaneous Solution Pen injector 100 UNIT/ML, inject 20 unit subcutaneously one time a day, to be given at HS. The order had a start date of 10/21/2025. There was documentation of the medication being administered on 10/21/2025 but the associated blood glucose was documented as NA. - Insulin Glargine Subcutaneous Solution Pen injector 100 UNIT/ML, inject 50 unit subcutaneously one time a day, in the AM. The order had a start date of 10/22/2025. There was documentation of the medication being administered on 10/22/2025 but the associated blood glucose was documented as NA. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, did not obtain additional strips until mid-morning on 10/22/2025, and Resident 7's blood glucose was not obtained per the provider orders on 10/21/2025 and 10/22/2025. G. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 17's admission Record revealed the resident was admitted to the facility on [DATE] and had a diagnosis of Type 2 Diabetes Mellitus. A record review of Resident 17's October 2025 MAR revealed an order to obtain blood glucose checks before meals and at bedtime and to notify the provider if the resident's blood sugar was less than 60 or greater than 400 or if resident is symptomatic. The order had a start date of 9/10/2025. The order revealed documentation that a blood glucose check had not been completed for any of the scheduled times on 10/21/2025 or for the 7:00 AM and 11:00 AM times on 10/22/2025. An interview on 11/13/25 at 11:10 AM with the NP revealed the NP was in the facility on 10/21/2025 at around 11:30 AM and overheard the staff discussing that they had run out of blood glucose monitoring strips. NP stated they were told by facility staff that they had ordered the strips, and the strips were to arrive in the facility later that day, and that if the strips did not arrive by suppertime, the facility was going to go to the pharmacy to purchase some. NP revealed that when they arrived back at the facility on 10/22/2025, the NP was made aware that the facility had not obtained any of the strips, and the facility could not provide justification for why no one had notified the NP about the blood glucose monitoring strips not arriving the evening prior. An interview on 11/13/25 at 12:20 PM with the DON confirmed the facility ran out of blood glucose monitoring strips the morning of 10/21/2025, the order for new strips did not arrive that day as expected, and the facility did not have a backup supply in the facility. The DON also confirmed that the pharmacy did not have any strips available, that the facility did not attempt any other method of obtaining strips, and the facility did not reach back out to the NP after being unable to obtain the strips the evening of 10/21/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285224	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Care and Rehab at Bridgeport	505 O Street Bridgeport, NE 69336

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18 Based on observations, interviews, and record review; the facility failed to prevent the potential for cross contamination during wound care for 2 (Residents 3 and 6) of 3 sampled residents. The facility census was 25.Findings Are: A record review of the facility policy Wound Care with revision date of December 2011 revealed in the Steps in the Procedure section that Step 1 was to use a disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. A.A record review of Resident 3's Order Summary Report dated 11/12/2025 revealed the resident was admitted to the facility on [DATE]. The report also revealed the resident had the following wound care orders:-Cleanse right posterior thigh proximal and distal sites with wound cleanser, apply skin prep, apply hydrogel, cover with border dressing. This order had a start date of 10/28/2025. -Cleanse left buttock/sacral crease with wound cleanser, apply skin prep, apply calcium alginate, then apply the sacral dressing. This order had a start date of 10/29/2025. An observation on 11/12/25 at 1:02 PM revealed the Director of Nursing (DON) was at the nurse's station preparing to perform wound care for Resident 3. The DON checked their orders in a binder, then placed the supplies needed into a plastic container and carried them to the resident's room. Upon entering the resident's room, there were two nurse aides with gowns and gloves on who assisted the resident to lay in a flat position on their bed. The DON applied a gown and gloves, obtained a bottle of Skintegrity wound cleanser and sterile gauze from the plastic bin, and had the nurse aides roll Resident 3 to [gender] side. The DON then squeezed the Skintengrity wound cleanser from the bottle onto the resident's wound on their right thigh and wiped the area with the sterile gauze. The DON put the wound cleanser bottle on the table at the foot of the resident's bed, used their gloved hand to grab a measuring paper from the plastic bin, and measured the area to the resident's thigh with the paper and a permanent marker. The DON then capped the marker and laid it on the resident's bed, removed their gloves, and put on a new pair of gloves. DON obtained bordered gauze, hydrogel, and skin prep from the plastic container and placed these items, as well as the binder with the wound care orders on the resident's bed. The DON removed their gloves, performed hand hygiene (HH) via alcohol-based hand rub (ABHR), put on new gloves, and finished performing the wound care to the resident's thigh using the supplies that were laying on the resident's bed. The DON removed their gloves, performed HH via ABHR, and obtained a package of sterile gauze from the plastic container, placing it on the resident's bed. DON opened a new bottle of wound cleanser and placed the lid facing down on the bed, then applied new gloves, opened the gauze, squirted the wound cleanser onto the resident's buttocks, and wiped the area with the gauze. The DON then removed their gloves, performed HH via ABHR, put on new gloves, and obtained a measuring paper, a package of Sorbalgon, skin prep, and a package of bordered gauze, placing all items on the resident's bed. Next, the DON measured the wound, used a pair of scissors to cut a portion of the Sorbalgon out of the packaging, laid the scissors on the bed, then moved the scissors into the open package of Sorbalgon, applied the dressings that had been laid on the bed to the wound, removed their gloves and performed HH via ABHR. The DON then put the remaining Sorbalgon in the package, the scissors, and the bottle of wound cleanser back into the plastic bin with the remaining clean wound care supplies for Resident 3. An interview on 11/12/25 at 1:58 PM with the Director of Nursing (DON) confirmed they laid the clean wound care supplies on Resident 3's bed without first placing a clean barrier. An interview on 11/12/25 at 1:59 PM with the Regional Nurse Consultant (RNC) confirmed the DON should have placed a clean barrier prior to putting Resident 3's wound care supplies on the bed. B.A (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review of Resident 6's Order Summary Report revealed the resident was admitted to the facility on [DATE]. The report also revealed the resident had an order for staff to cleanse sacrum with wound cleanser, apply skin prep, cut calcium alginate to fit, and cover with border dressing. The order had a start date of 10/28/2025. An observation on 11/13/25 at 3:23 PM revealed the DON performing HH via soap and water at the nurse's station. DON then took a plastic container from the wound treatment cart, gloves, ABHR, and an electronic tablet and carried the items to Resident 6's room. The DON placed the container on the resident's bedside table, obtained a gown and paper towel from the bathroom, and put on the gown. After the nurse aides that were in the room performed peri-cares on the resident and positioned the resident onto their right side, the DON placed Skintegrity wound cleanser bottle and a package of sterile gauze from the plastic container onto the paper towel, which had been laid on the resident's bed. The DON then put on gloves, removed the resident's soiled dressing from their sacrum using an alcohol wipe to release the adhesive, removed their gloves, and performed HH via ABHR. DON put on new gloves, cleansed the area with Skintegrity wound cleanser and sterile gauze, laid the wound cleanser bottle back on the paper towel, removed their gloves and performed HH via ABHR. After the DON checked Resident 6's order on the tablet, they opened new dressings from the plastic container, placed them on the paper towel, and put on new gloves. During this time, the Skintegrity wound cleanser bottle had rolled off the paper towel and was laying on the resident's bedding next to their pillow, the DON picked the bottle up and placed it directly onto the bedside table. Next, the DON performed the remainder of the wound care, which included opening a package of Sorbalgon and cutting a portion of the dressing off to use on the resident's wound and leaving the remainder of the dressing in the open packaging inside the plastic container, removed their PPE, and performed HH via ABHR. The DON then picked up the Skintegrity wound cleanser bottle, put it back in the plastic container with the rest of Resident 6's clean wound care supplies and carried the container out of the room. The plastic container had sealed wound care supplies, the open package of Sorbalgon, as well as wound measuring papers laying exposed inside of it. An interview on 11/13/25 at 3:38 PM with the DON confirmed the Skintegrity wound cleanser bottle was laying directly on Resident 6's bedding and then was placed back into the plastic container with the remainder of Resident 6's clean wound dressing supplies, contaminating the supplies.