| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285305 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/16/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brookestone Gardens | 2615 West 11th Street<br>Kearney, NE 68845 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 12-006.05(G)Based on record review and interview, the facility failed to ensure that a PRN (as needed) psychotropic medication had a rationale for use for one of one (Resident 3) sampled resident. The facility census was 50.Findings are:Record review of the admission minimum data set (MDS) (a federally required, standardized health assessment tool for residents in Medicare/Medicaid-certified nursing homes, used to create individualized care plans, track resident status (physical, functional, psychological), ensure quality, and determine payment/reimbursement for services like skilled nursing care) dated 11/21/2025 revealed Resident 3 had been admitted to the facility on [DATE]. Resident 3 had a brief interview for mental status (BIMS) score (a standardized cognitive screening tool used primarily in nursing homes) of 14 and indication of being cognitively intact. Resident 3 did not exhibit any behaviors or tendencies to wander and had no previous MDS to compare behavior symptoms. Resident 3 had diagnoses for anxiety, brief psychotic disorder, muscle weakness, cognitive communication deficit, insomnia, and others. Medications Resident 3 was taking at the time of admission included antipsychotic, antianxiety, hypoglycemic, anticoagulant, antibiotic, and diuretic. Resident 3 had an infected surgical wound of the left foot and used a pressure-reducing cushion for a wheelchair and for a bed, and received wound care and dressings to the left foot. Record review of the working care plan (a detailed, personalized strategy developed by healthcare professionals and the individual (or family) to address all health, personal, and social needs) reviewed on 12/10/2025 revealed Resident 3 had the potential for out-of-character responses related to anxiety, demonstrated by agitation, restlessness, difficulty sleeping, and becoming easily worked up. Also exhibits sexually inappropriate behaviors toward team members, and may present as accusatory, threatening and demanding toward staff.Record review of the November 2025 Medication Administration Record (MAR) revealed that Resident 3 had an order for and was administered; Diazepam (a psychoactive medication used to treat anxiety disorders and muscle spasms among other uses) 5 mg every 6 hours as needed for the diagnosis of anxiety. This order was received on 11/17/2025 at 2:45 PM and discontinued on 11/25/2025 at 11:30 AM. Diazepam 5 mg every 6 hours as needed for muscle spasms with a start date of 11/25/2025 at 11:30 AM and was to be discontinued on 12/04/2025 at 8:27 AM.Record review of the December 2025 MAR revealed an order for Resident 3 for: Diazepam 5 mg every 6 hours as needed for muscle spasms for 6 months with a start date of 12/04/2025 at 8:30 AM and no stop date listed.Record review of the Pharmacy Medication Regimen Review (MRR) (a pharmacy review which ensures all medications are safe, effective, appropriate for the patient's condition, and necessary) completed by the pharmacist on 12/01/2025 revealed the following statement: The resident has an order for PRN (as needed) diazepam. Per CMS (Centers for Medicare and Medicaid Services) regulations, for PRN psychotropic use greater than 14 days, the prescriber must document a clinical rationale in the medical record for continuance of the PRN agent and indicate the duration that the medication should be continued.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (F-Tag 605). If continued use is greater than 14 days order is warranted, please provide a clinical rationale as well as duration below. Thank you. Underlined by the pharmacist were the words please provide a clinical rationale. There was no rationale written in the blank space. The duration was indicated by a checkmark for 90 days. The paperwork was signed by the physician and dated 12/3/2025.Record review of a follow-up note to the physician about the MRR completed on 12/01/2025 revealed the following: This resident currently has a PRN (as needed) order for diazepam. Diazepam has a long half-life and an active metabolite which increases the risk of adverse events when used. This medication sis not recommended for use I the geriatric population and is located on the Beers List of potentially inappropriate medications. Please consider a review of the order for diazepam and consider changing to a shorter acting medication. Thank you. Signed by the pharmacist. There was a note from the physician which stated Please continue for now. We will consider this once (Resident 3) moves back to (Resident 3's) assisted living. Signed by the physician on 12/03/2025. The order was reviewed by the nursing staff on 12/03/2025.In an interview with the Director of Nursing (DON) on 12/16/2025 at 12:55 PM it was revealed that the DON did not know why the rationale of the medication had changed from being used for anxiety to now being used for muscle spasms. Confirmed Resident 3 did have the diagnosis of anxiety but there was no diagnosis for muscle spasms. In a confirmation interview with Director of Clinical Services (DCS) who revealed that the Infection Control and Prevention nurse (IP) had received an order from the physician by phone to clarify the orders for the diazepam which indicated as use for Anxiety upon admission and then changed to muscle spasms after text messages exchanged with the physician. DCS confirmed that the pharmacist had asked for documentation of a rationale for the use of the PRN diazepam and that the notices sent to the facility staff in a text message was not the way the facility does this. Secondly the DCS confirmed that the rationale of waiting to review the medication once Resident 3 returned to the assisted living was not a rationale. We have got to work with the doctors to make sure they give us a rationale for these psychotropics. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(i)Based on record review and interview the facility failed to review the required baseline care plan (a written plan required to be developed within 24 hours of admission detailing the instructions needed to provide initial effective and person-centered quality care for a resident) with the resident/resident representative and failed to offer a copy of the summary of the baseline care plan to the resident/resident representative prior to the completion of the comprehensive care plan (a detailed written interdisciplinary comprehensive plan to meet the resident's needs that are identified in the resident's comprehensive assessment covering all of a resident's medical, emotional, and lifestyle health needs) for 6 of 6 residents reviewed (Residents 5, 17, 3, 55, 7, and 40). The facility census was 50.Findings are:Record review of the facility Baseline Care Plan (BCP) Guidelines dated 3.2021 revealed that the baseline guidelines were to be completed per the Nebraska state guidelines which requires them to be completed within 24 hours, rather than the federally mandated 48 hours. An Interdisciplinary team member would review the baseline care plan summary with the resident/representative prior to the completion of the Comprehensive Care Plan (policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a nursing home setting) (7 days from when the minimum data set (MDS) (a standardized, comprehensive health assessment tool for residents in Medicare/Medicaid-certified nursing homes, used to capture their health, functional, cognitive, and psychosocial status for care planning, quality improvement, and determining government reimbursement) data was signed).<br><br>The policy further stated that the signed Care Plan Acknowledgement Form was to be scanned to verify the baseline care plan review was done with the resident/resident representative. The only reason the baseline care plan would not be reviewed and signed would be due to an unplanned discharge. If the resident or the representative prefers not to have a copy of the baseline care plan, this is to be documented in the progress notes and note that the copies were declined.<br><br>Record review of an undated blank admission Agreement given to all new residents revealed under Services subheading C. Baseline Care Plan. Within 24 hours of your admission, the Facility will develop a baseline care plan. The baseline care plan will include instructions needed to provide you effective person-centered care. The baseline care plan will address, at a minimum, your initial goals based upon you admission orders, physician orders, dietary orders, therapy services, social services, and any applicable pre-admission screening and annual resident review recommendations, if applicable. The facility will provide you and/or your representative with a summary of the baseline care plan prior to the completion of the comprehensive care plan.<br><br>In an interview with the Social Services Director (SSD) on 12/11/2025 at 11:55 PM it was revealed that when a resident is admitted to the facility, the baseline care plan is completed within 24 hours by the nursing staff. There are others that will add to it as needed, but the baseline care plan is reviewed by the Director of Nursing (DON) who will then use this with the team to create the comprehensive care plan.<br><br>In a confirmation interview with the DON on 12/11/2025 at 12:15 PM it was revealed that the baseline care plans are completed within 24 hours of arrival of the new resident. The DON then reviews the baseline care plans over a 3 to 7 day period before locking the care plan so no more changes can be made. It is reviewed within that first week of the new resident's entrance. We then complete the<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident assessment, complete a comprehensive care plan, schedule a meeting with the resident and/or resident representatives and give them a copy of the care plan at that meeting. The DON confirmed that the family nor the resident receive a copy of the baseline care plan within 24 hours or prior to the first care plan meeting when the comprehensive care plan is discussed.<br><br>A.<br><br>Record review of the baseline care plan signed and dated on 02/21/2025 by Resident 5 and co-signed by the Social Services Director (SSD) revealed that Resident 5 was admitted to the facility on [DATE]. The DON signed the baseline care plan on 04/30/2025. The baseline care plan revealed that Resident 5 had diagnoses for malignant neoplasm of the endometrium, postmenopausal bleeding, hypertension, major depressive disorder, osteoarthritis of the knee, glaucoma, and others. The current orders from the physician orders, therapy orders, or treatment orders were not attached to the baseline care plan. The baseline care plan indicated that a copy of the current medication list had been given to the resident.<br><br>Review of the Care Plan Acknowledgment Form for Resident 5 was signed and dated on 03/05/2025 and co-signed by the SSD. The agreement stated that the Resident's signature indicated there had been a discussion of the plan of care and that the resident was given the opportunity to ask questions and state preferences about the individual resident's care and goals of care. This agreement had a check-marked space that was marked and stated that the resident had been given a copy of the baseline care plan and a copy of current orders and dietary instructions, which included services and treatments to be provided or arranged by the facility and personnel acting on behalf of the facility, and any updated information based on details of the admission comprehensive assessment.<br><br>Record review of the Progress Notes printed and reviewed on 12/11/2025 for Resident 5 did not reveal any documented entries to show that Resident 5 or the resident representatives were given a copy of the baseline care plan prior to the comprehensive care plan meeting or at the time of the admission.<br><br>In an interview with the DON on 12/11/2025 at 3:20 PM the DON revealed that the check-marked space the Care Plan Acknowledgment Form for Resident 5 should have been checked for the comprehensive care plan and not have been checked as the baseline care plan. Had this been corrected, this would have revealed that the entire comprehensive care plan had been reviewed.<br><br>B.<br><br>Record review of the baseline care plan signed but not dated by Registered Nurse (RN) D and revealed that Resident 17 was admitted to the facility on [DATE]. The DON signed the baseline care plan on 11/16/2025. The baseline care plan revealed that Resident 17 had diagnoses for a fractured upper and lower end of the left fibula and a fractured upper and lower end of the left tibia (both bones of the lower leg). The current orders from the physician orders, therapy orders, or treatment orders were not attached to the baseline care plan. The baseline care plan indicated that a copy of the current medication list had been given to the resident.<br><br>Review of the Care Plan Acknowledgment Form for Resident 17 was signed and dated on 12/03/2025 by Resident 17 and co-signed by the SSD. The agreement stated that the Resident's signature indicated there had been a discussion of the plan of care and that the resident was given the opportunity to ask questions and state preferences about the individual resident's care and goals of care. This<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | agreement had a check-marked space that was marked and stated this was the initial discussion of the entire comprehensive care plan.<br><br>Record review of the Progress Notes printed and dated 12/15/2025 for Resident 17 did not reveal any documented entries to show that Resident 17 or the resident representatives were given a copy of the baseline care plan prior to the comprehensive care plan meeting or at the time of the admission.<br><br>C.<br><br>Record review of the baseline care plan revealed that Resident 3 was admitted to the facility on [DATE]. The DON signed the baseline care plan on 11/17/2025. The baseline care plan revealed that Resident 3 had diagnoses for cellulitis of the left lower leg, diabetes, pulmonary fibrosis (a lung disease where lung tissue becomes scarred and thickened, making it hard for oxygen to get into your bloodstream, leading to shortness of breath), heart failure, chronic kidney disease, coronary artery disease, a history of transient ischemic attacks (often called a mini-stroke because it's a temporary blockage of blood flow to the brain, causing stroke-like symptoms that usually resolve quickly (minutes to hours) but signal a high risk for a major stroke), among others. The current orders from the physician orders, therapy orders, or treatment orders were not attached to the baseline care plan. The baseline care plan indicated that a copy of the current medication list had been given to the resident.<br><br>Review of the Care Plan Acknowledgment Form for Resident 3 was signed and dated on 12/03/2025 by Resident 3 and co-signed by the SSD. The agreement stated that the Resident's signature indicated there had been a discussion of the plan of care and that the resident was given the opportunity to ask questions and state preferences about the individual resident's care and goals of care. This agreement had a check-marked space that was marked and stated this was the initial discussion of the entire comprehensive care plan.<br><br>Record review of the Progress Notes printed and dated 12/15/2025 for Resident 3 did not reveal any documented entries to show that Resident 3 or the resident representatives were given a copy of the baseline care plan prior to the comprehensive care plan meeting or at the time of the admission.<br><br>D.<br><br>Record review of the baseline care plan signed but not dated by Registered Nurse (RN) D and revealed that Resident 55 was admitted to the facility on [DATE]. The baseline care plan revealed that Resident 55 had diagnoses of displaced intertrochanteric fracture of the left femur (broken hip. The current orders from the physician orders, therapy orders, or treatment orders were not attached to the baseline care plan. The baseline care plan did not indicate a current medication list had been given to the resident or to the resident representative. The medication list had not been reconciled with the resident of the resident representative.<br><br>Review of the Care Plan Acknowledgment Form for Resident revealed this to be absent.<br><br>Record review of the Progress Notes printed and dated 12/11/2205 for Resident 55 did not reveal any documented entries to show that Resident 55 or the resident representatives were given a copy of the baseline care plan prior to the comprehensive care plan meeting or at the time of the admission.<br><br>In an interview with the DON on 12/11/2025 at 3:20 PM the DON revealed that the Care Plan<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Acknowledgment Form for Resident 55 had not been completed because there had not been a care plan held to discuss with this resident or with this resident's representative.<br><br>E.<br><br>Record review of the facility Baseline Care Plan (BCP) Guidelines dated 3/2021 revealed that the BCP is to be completed within 24 hours. Each resident will only have one BCP per admission. The baseline care plan is locked by the facility designated process owner when the Comprehensive Care Plan is complete. An Interdisciplinary Team (IDT) member/members will review the baseline care plan summary with the resident/resident representative prior to the completion of the Comprehensive Care Plan (a detailed written interdisciplinary comprehensive plan to meet the resident's needs that is required to be completed 7 days from when the MDS Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) is signed). The signed Care Plan Acknowledgement Form is to be scanned into the Miscellaneous tab under the care plan category in the electronic health record to verify Baseline Care Plan review was done with the resident/resident representative. The only reason the BCP summary would not be reviewed and signed by the resident/representative would be due to an Unplanned Discharge. To address medications, services, and treatments the Physician Order Summary will be printed and reviewed with the resident/representative when completing the BCP summary. If the resident/representative prefers to not have a copy of the BCP and Order Summary, document in the progress notes that a copy of the BCP was offered to the resident/representative and the copies were declined.<br><br>Record review of the undated admission Agreement revealed that the facility will develop a baseline care plan within 24 hours of your admission. The baseline care plan will include instructions needed to provide you effective person centered care. The baseline care plan will address, at a minimum, your initial goals based upon your admission orders, physician orders, dietary orders, therapy services, social services, and any applicable pre-admission screening. The facility will provide you and/or your representative with a summary of the baseline care plan prior to completion of the comprehensive care plan.<br><br>Record review of the MDS assessment dated [DATE] for Resident 7 revealed that Resident 7 admitted into the facility on 7/15/25. Diagnoses included Stroke, Hemiplegia (paralysis affecting one side of the body), and depression.<br><br>Record review of the baseline care plan dated 7/23/25 for Resident 7 revealed no documentation of resident or representative signature or that a copy of the baseline care plan was offered or provided to the resident or resident representative.<br><br>Record review of the progress notes for Resident 7 revealed no documentation that the baseline care plan was reviewed with the resident or resident representative. The progress notes revealed no documentation that a copy of the baseline care plan was offered or provided to the resident or resident representative.<br><br>Record review of the progress note dated 7/30/25 at 2:48 PM revealed that a care conference was conducted and that Resident 7 attended the conference. The note revealed that the resident representative was invited but did not attend. The note contained no documentation that the baseline care plan was reviewed with the resident. The progress note contained no documentation that a copy of the baseline care plan was offered, provided, or refused.<br><br>(continued on next page) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the Care Plan Acknowledgement Form dated 7/30/25 revealed that the type of care plan discussed was the comprehensive care plan. The acknowledgment form contained no documentation that the baseline care plan was discussed and no documentation that a copy of a baseline care plan was offered, provided, or refused.<br><br>Interview on 12/15/25 at 2:40 PM with the facility Director of Nursing (DON) confirmed that the facility did not review and offer a copy of the baseline care plan to Resident 7 or their representative as required. The DON confirmed that the first care plan meeting for Resident 7 was on 7/30/25. (15 days after Resident 7 admitted into the facility).<br><br>F.<br><br>Record review of the MDS assessment dated [DATE] for Resident 40 revealed that Resident 40 admitted into the facility on [DATE]. Diagnoses included Diabetes, High blood pressure, and anxiety.<br><br>Record review of the Baseline Care Plan dated 10/8/25 for Resident 40 revealed no documentation of resident or representative signature or that a copy of the baseline care plan was offered or provided to the resident or resident representative.<br><br>Record review of the progress notes for Resident 40 revealed no documentation that the baseline care plan was reviewed with the resident or resident representative. The progress notes revealed no documentation that a copy of the baseline care plan was offered or provided to the resident or resident representative.<br><br>Record review of the progress note dated 10/15/25 at 3:30 PM revealed that a care conference was conducted. Resident 40 and their representative were invited to the care conference. Resident 40 did not attend. The representative for Resident 40 attended the conference by phone call. The note contained no documentation that the baseline care plan was reviewed with the resident representative. The progress note contained no documentation that a copy of the baseline care plan was offered, provided, or refused.<br><br>Record review of the Care Plan Acknowledgement Form dated 10/15/25 revealed that the type of care plan discussed was the comprehensive care plan. The acknowledgment form contained no documentation that the baseline care plan was discussed and no documentation that a copy of a baseline care plan was offered, provided, or refused.<br><br>Interview on 12/15/25 at 2:40 PM with the facility DON confirmed that the facility did not review and offer a copy of the baseline care plan to Resident 40 or their representative as required. The DON confirmed that the first care plan meeting for Resident 40 was on 10/15/25. (13 days after Resident 40 admitted into the facility). |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2)Based on observation, record review, and interview the facility failed to monitor resident pressure ulcers (A localized wound of the skin and/or underlying tissue, usually over a bony area. A bedsore.) as required for 1 of 1 residents reviewed (Resident 9). This prevented the evaluation of the wound condition progress. The facility census was 50.Findings are:Record review of the facility Skin and Wound Management Standard dated 4/2019 revealed that the routine skin check done by the nurse is added to the electronic treatment record. The Non-Pressure Skin Condition Record (a form for weekly and as needed assessment documentation of the skin condition) is used weekly for all non-pressure skin conditions. The Pressure Ulcer Record (including deep tissue pressure injuries) (a form for weekly and as needed assessment documentation of the pressure ulcer) is used weekly and as needed for all pressure ulcers/injuries. All facility charge nurses will be knowledgeable and involved in preventing, identifying, assessing, treating and documenting all skin and wound conditions. Non-pressure skin conditions will be assessed and measured every 7 days or more frequently if indicated until resolved. Pressure ulcers/injuries will be formally assessed, staged, and measured every 7 days or more frequently if indicated (measure length, width, depth, odor, drainage, pain, wound bed and peri wound appearance). Record review of the admission Record dated 12/11/25 for Resident 9 revealed that Resident 9 admitted into the facility on 7/26/24. Diagnoses included Multiple Sclerosis (A disease where your immune system mistakenly attacks the protective coating on your brain and spinal cord nerves. This damage causes a wide range of unpredictable symptoms like numbness, vision problems, weakness, fatigue, balance issues, and thinking difficulties, affecting how your brain communicates with the rest of your body.) and Functional Quadriplegia (the complete inability to move the arms and legs due to medical conditions). Record review of the Office Visit Wound Clinic note dated 12/4/25 for Resident 9 revealed that Resident 9 sees outpatient wound care for pressure ulcers. The clinic note revealed that the right buttock pressure ulcer is not improving. Apply Critic Aid Clear AF ointment (a medicated ointment containing antifungal medication) four times a day. The clinic note revealed that Resident 9 had dark discoloration to both buttocks with the right buttock wound worse than the left buttock wound. The note revealed Stage 3 pressure ulcer (involves full-thickness skin loss) with deep tissue injury (damage under the skin -purple/red skin) wound. No measurements were documented in the Wound Clinic notes.Observation on 12/11/25 at 8:22 AM outside the room of Resident 9 revealed that Registered Nurse-E (RN-E) set up supplies for the ordered treatment of the pressure ulcers for Resident 9. RN-E and the facility Infection Preventionist (IP) entered the room of Resident 9. Resident 9 was in the bed. IP rolled Resident 9 onto the resident's left side. RN-E removed the brief that Resident 9 wore. Wounds were observed on Resident 9's left and right buttocks. The wound bed on the right buttock was discolored and light to medium dark red in color. Multiple dark reddish purple scab looking areas were scattered within the wound bed. The right buttock wound was approximately 18 centimeters (cm) in length and approximately 11cm in width per visual measurement. The wound had no observed depth. The left buttock wound bed was light to medium dark red in color with multiple reddish purple scab like areas. The left buttock wound was approximately 16 cm in length and approximately 12 cm in width per visual measurement. The wound had no observed depth. The top of the right wound had an irregular shaped area that measured approximately 2 cm in length and approximately 5 cm in width that was a dark reddish purple type scab or eschar (a layer of dead tissue that commonly forms over a wound). RN-E applied Critic Aid Clear AF 2% ointment (a medicated ointment containing antifungal medication) to the wounds on the left and right buttocks of Resident 9 with the gloved hands. Interview on 12/11/25 at 12:33 PM with RN-E revealed that Resident<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 9 had the pressure ulcer wounds on the buttocks on admission to the facility. RN-E revealed that the Treatment Administration Record (TAR) (a legal record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) has the order to do weekly assessment as a reminder for the nurses to complete the wound assessments weekly. RN-E confirmed that the pressure wounds on the buttocks of Resident 9 are to be assessed weekly and the description of the wound condition and measurements are to be documented on the Non-Pressure Skin Condition Record. RN-E was unsure as to why the weekly documentation of Resident 9's pressure wounds were being documented on the Non-Pressure Skin Condition Record instead of the Pressure Ulcer Record. Record review of the TAR for November 2025 dated 12/16/25 revealed to measure and describe the bilateral buttocks weekly. Complete 2 separate assessment forms, #1: Complete a non-pressure skin condition record for red, open spot to right buttock. #2: Complete a non-pressure skin condition record for red, open areas to left buttock. Include measurements of any open areas/fissures (cracks). Complete weekly every Friday until healed. The completion of measuring the buttocks wounds was documented on the TAR on 11/7/25, 11/14/25, 11/21/25, and 11/28/25.Record review of the 11/7/25 Non-Pressure Skin Condition Record for the right buttock pressure ulcer on Resident 9 revealed that the wound was purple/red in color and measured 15.5 cm in length and 9 cm in width. Record review of the 11/7/25 Non-Pressure Skin Condition Record for the left buttock pressure ulcer on Resident 9 revealed that the wound was purple/red in color and measured 12 cm in length and 6.5 cm in width. Record review of the 11/14/25 Non-Pressure Skin Condition Record for the right buttock pressure ulcer on Resident 9 revealed that the wound was dark red in color and measured 16 cm in length and 8 cm in width. Record review of the 11/14/25 Non-Pressure Skin Condition Record for the left buttock pressure ulcer on Resident 9 revealed that the wound was dark red in color and measured 12 cm in length and 7 cm in width. Record review of the 11/28/25 Non-Pressure Skin Condition Record for the right buttock pressure ulcer on Resident 9 revealed that the wound had redness and has a dark area in the center with a light red around it. The wound measured 8 cm in length and 4 cm in width. The summary note revealed that the skin of the right buttock was assessed per the weekly schedule. Record review of the 11/28/25 Non-Pressure Skin Condition Record for the left buttock pressure ulcer on Resident 9 revealed that the wound had redness and has a dark area in the center with a light red around it. The wound measured 8 cm in length and 2 cm in width. The summary note revealed that the skin of the left buttock was assessed per the weekly schedule. Record review of the TAR for December 2025 dated 12/16/25 revealed to measure and describe the bilateral buttocks weekly. Complete 2 separate assessment forms, #1: Complete a non-pressure skin condition record for red, open spot to right buttock. #2: Complete a non-pressure skin condition record for red, open areas to left buttock. Include measurements of any open areas/fissures. Complete weekly every Friday until healed. The completion of measuring the buttocks wounds was documented on the TAR on 12/5/25 and 12/12/25.Record review of the 12/5/25 Non-Pressure Skin Condition Record for the right buttock pressure ulcer on Resident 9 revealed that the wound on the right buttock was dry skin with no open areas. No measurements were documented on the record. Record review of the 12/5/25 Non-Pressure Skin Condition Record for the left buttock pressure ulcer on Resident 9 revealed that the wound on the left buttock was dry skin with no open areas. No measurements were documented on the record. Record review of the 12/12/25 Non-Pressure Skin Condition Record for the right buttock pressure ulcer on Resident 9 revealed that the wound on the right buttock had dry skin with no open areas. Several scabbed areas are intact and also starting to fall off. No measurements were documented on the record. Record review of the 12/12/25 Non-Pressure Skin Condition Record labeled for the left buttock pressure ulcer on Resident 9<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Brookestone Gardens | 2615 West 11th Street Kearney, NE 68845 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | revealed in the Site Description section that right buttock with dry skin no open areas, several scabbed areas are intact and also starting to fall off. (the site description was the description for the right buttock instead of the left buttock). No measurements were documented on the record. Interview on 12/15/25 at 2:40 PM with the facility Director of Nursing (DON) confirmed that a weekly assessment is to be completed by the nurse for both non-pressure skin conditions and for pressure ulcers. The DON confirmed that the weekly assessments are to include documentation of the color, condition, and size of the wound either written or documented per check box on the weekly assessment form. The DON confirmed the assessment form is either the Non-Pressure Skin Condition Record or the Pressure Ulcer Record. The DON confirmed that Resident 9 has a pressure ulcer on the right buttock and on the left buttock that goes through phases of being open and closed. The DON confirmed that the size of the left buttock and right buttock wounds are expected to be documented weekly for Resident 9. Interview on 12/15/25 at 3:26 PM with the DON revealed that the wound care notes for Resident 9 dated 12/4/25 do not contain any measurements of the left buttock or right buttock wound. The DON confirmed that the wound measurements of the right buttock and left buttock wounds for Resident 9 were not documented on 12/5/25 or 12/12/25 as required. The DON revealed that at a weekly meeting the wound documentation is reviewed and education was provided to the nurse that did not document measurements of the wounds on 12/5/25. The DON revealed that the education was not successful and confirmed that no measurements of the wounds were documented on the weekly assessments dated 12/12/25. The DON confirmed that the facility did not have documentation of the left buttock wound assessment for Resident 9 on 12/12/25. |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that the resident and his/her doctor meet face-to-face at all required visits.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure that all residents were seen by a physician on their initial 30 day visit and at least on every alternate visit as required. This affected 3 (Residents 5, 2, and 7) of 3 sampled residents. The facility census was 50. Findings were: Record review of the facility provided policy for physician services was a copy of the CMS (Centers for Medicare and Medicaid Services) policy F712 dated 10/24/2022.<br><br>In an interview on 12/11/2025 at 10:53 AM with the Medical Records Director (MR) it was revealed that some residents are seen only by a nurse practitioner or a physician assistant as that is who the residents have chosen to be their primary care provider. Therefore, those residents are only seen by a nurse practitioner or physician assistant for their 30 day and 60 day physician visits. MR revealed that Physician Assistants and Nurse Practitioners are not Medical Doctors or Physicians. MR stated I think I know where we are going with this conversation but wanted more of an explanation.<br><br>In an interview on 12/11/2025 at 10:55 AM with the Director of Nursing (DON) revealed not knowing that a physician must make the first initial visitation with new residents, and after that, every resident must be seen by a primary physician. There are some residents who do have a nurse practitioner or physician assistant listed as their primary physician. We will make changes to this immediately and list an actual physician in that place.<br><br>In a confirmation interview on 12/11/2025 at 11:00 AM with the MR, it was confirmed that the residents who have listed the preferred primary provider who is an advanced practice provider such as nurse practitioners and physician assistants have only been seeing those individuals and not being seen by an actual physician or medical doctor. Some of these residents have been seen by a specialist, but those physicians were not seen for complete and total care of these residents like a primary care physician would do.<br><br>In an interview on 12/11/2025 at 11:40 AM with the Director of Clinical Services (DCS) it was revealed that the facility is supposed to adhere to the regulations of the facility provided policy of CMS F712.<br><br>A.<br><br>Record review of the quarterly Minimum Data Set (MDS) (a comprehensive, standardized assessment tool for residents in Medicare/Medicaid-certified nursing homes, used to evaluate their health, functional status, mood, and preferences, driving individualized care plans, tracking quality, and determining payment for services like Medicare Part A skilled nursing stays) dated 10/27/2025 revealed that Resident 2 had been admitted to the facility on [DATE]. Resident 2 had diagnoses of debilitating cardio/respiratory conditions, congestive heart failure, major depressive disorder, hypertension, neurogenic bladder, epilepsy, anxiety, depression, paroxysmal atrial fibrillation (intermittent, irregularly-irregular heart rate), was unsteady on feet, and gastroesophageal reflux disease (heart burn). Resident 2 medications for depression, congestive heart failure, a history of blood clots, and finally another for major depressive disorder.<br><br>Record review of the Clinical Resident Profile for Resident 2 revealed that an Advanced Practice Registered Nurse was listed as the resident's physician and primary caregiver.<br><br>(continued on next page) |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of the physician visit from 02/21/2025 60-day visit was completed by an Advanced Practice Registered Nurse (APRN).<br><br>Record review of the physician visit from 04/22/2025 60-day visit was completed by an APRN.<br><br>Record review of the physician visit from 06/20/2025 60-day visit was completed by an APRN.<br><br>Record review of the physician visit from 08/07/2025 visit was completed by an APRN.<br><br>Record review of the physician visit from 08.20.2025/2025 60-day visit was completed by an APRN.<br><br>Record review of the physician visit from 10/24/2025 60-day visit was completed by an APRN.<br><br>B.<br><br>Record review of the quarterly MDS dated [DATE] for Resident 5 revealed an admission date of 02/21/2025. Resident 5 had diagnoses for medically complex conditions which included cancer, high blood pressure, gastroesophageal reflux disease, thyroid disorder, arthritis, anxiety, depression, macular degeneration, overweight, bicipital tendinitis right shoulder, and allergies among others. Resident 5 took medications to treat anxiety, depression, pain, and infections.<br><br>Record review of the Clinical Resident Profile for Resident 5 revealed that a Physician Assistant was listed as the resident's physician and primary caregiver.<br><br>Record review of the initial 30 day physician visit after admission dated 03/20/2025 revealed that Resident 5 was seen by a Physician Assistant (PA).<br><br>Record review of the 60 day physician visit after admission dated 04/24/2025 revealed Resident 5 was seen by a PA.<br><br>Record review of the 90 day physician visit after admission dated 05/20/2025 revealed Resident 5 was seen by a PA.<br><br>Record review of the 60 day physician visit dated 07/22/2025 revealed Resident 5 was seen by a PA.<br><br>Record review of a physician visit on 08/28/2025 revealed Resident 5 was seen by an APRN<br><br>Record review of the 60 day physician visit dated 09/23/2025 revealed Resident 5 was seen by a PA.<br><br>Record review of the 60 day physician visit dated 11/21/2025 revealed Resident 5 was seen by a PA.<br><br>C.<br><br>Record review of the undated facility policy titled Physician Services- Physician Visits, Frequency/Timeliness/Alternate NPPs (Non-Physician Practitioners such as a Physician Assistant or Nurse Practitioner) revealed that after resident admission the first physician visit (this includes the initial comprehensive visit) must be conducted within the first 30 days and then at 30 day intervals up until 90 days after the admission date. The physician may not delegate the responsibility for conducting the initial visit. The authority for Non-Physician Practitioners to Perform Visits revealed that<br><br>(continued on next page) |

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| F 0712<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Nurse Practitioner may not perform the initial comprehensive visit (30 day visit).<br><br>Record review of the admission Record dated 12/11/25 for Resident 7 revealed an admission date of 7/15/25. The admission Record documented the Nurse Practitioner as their primary care provider.<br><br>Record review of the medical clinic office visit note dated 8/20/25 revealed that Resident 7 was at the clinic for their 30 day nursing home visit. The provider completing the 30 day visit was the Nurse Practitioner (NP) and not a physician as required.<br><br>Record review of the medical clinic office visit note dated 9/30/25 revealed that Resident 7 was at the clinic for follow up from the hospital. The provider completing the visit was the NP.<br><br>Record review of the medical clinic office visit note dated 10/22/25 revealed that Resident 7 was at the clinic for their 60 day nursing home follow up. The provider completing the visit was the NP.<br><br>Interview on 12/15/25 at 2:40 PM with the facility Director of Nursing (DON) confirmed that the 30 day initial visit for Resident 7 was completed by the Nurse Practitioner and not by a physician as required. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, record review and interview; the facility failed to ensure the daily posting of nursing hours included the required information. This had the potential to affect all residents. The facility census was 50. Findings are:An observation on 12/10/25 at 2:00 PM revealed, the staff posting titled, Nursing Staff Information form was at the front entrance receptionist desk and was missing the date and the census for the day. An observation on 12/11/25 at 7:25 AM revealed the staff posting titled, Nursing Staff Information form was at the front entrance receptionist desk and was missing the date and the census for the day. An observation on 12/15/25 at 7:20 AM revealed, the staff posting titled, Nursing Staff Information form was at the front entrance receptionist desk and was missing the date and the census for the day. An observation on 12/16/25 at 7:30 AM revealed, the staff posting titled, Nursing Staff Information form was at the front entrance receptionist desk and was missing the date and the census for the day. A record review of the staff posting revealed the facility name, the shift hours, number of team members and staffing hours total. The bottom of the form has a revision date of 9/2025, however missing the date and the census. An interview on 12/16/25 at 10:57 AM with the facility Staff Development Nurse (SDN) confirmed that the requested Nursing Staff Information daily forms did not include the census and were undated. The SDN confirmed that the SDN wrote the dates on the provided copies of Nursing Staff Information forms provided to the surveyors. The SDN revealed that the daily sheets, which include the census are dated and the Nursing Staff Information forms are stapled to them the following day or next business day and filed. The SDN revealed that is how the SDN knew what date to document on each of the forms. Further interviews with the SDN confirmed the staff postings did not have the required documentation. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Licensure Reference Number 175NAC 12-006.18(B) Based on record reviews, observations and interviews, the facility failed to clean and disinfect reusable resident medical equipment between resident use for 4 (Resident 4, Resident 24, Resident 34, and Resident 38) of 14 residents sampled. The facility census was 50. Findings are:A record review of a facility competency for direct care staff titled, Full Body Lift Competency dated 7/2017 revealed that the procedure for using the full body lift #18 states: Wipe all surfaces that come into direct contact with the resident's skin with an approved disinfectant between each resident use whether visibly soiled or not. Heavily soiling may require soap and water scrubbing prior to disinfecting. A record review of a facility competency for direct care staff titled, Sit to Stand Lift Competency dated 7/2017 revealed that the procedure for using the sit to stand lift, #21 states: Wipe all surfaces that come into direct contact with the resident's skin with an approved disinfectant between each resident use whether visibly soiled or not. Heavily soiling may require soap and water scrubbing prior to disinfecting. A record review of a 2025 Skills Competency Fair Checklist for Nurse Aide (NA)-A dated 08/06/25 revealed staff member was checked off for Full Body Lift Competency, Sit to Stand Lift Competency, and Medical Device Disinfection Competency. NA-A and a validator signed the 2025 Skills Competency Fair Checklist on 08/06/25. A record review of a Nurse Aide Competency Checklist for NA-B dated 07/28/25 revealed staff member was checked off for Full Body Lift Competency, Sit to Stand Lift Competency, and Medical Device Disinfection Competency. NA-B, a mentor and an additional staff member, signed the Nurse Aide Competency Checklist on 07/28/25, then validated and initialed on 8/18/25. A record review of a Nurse Aide Competency Checklist for NA-C dated 12/16/25 revealed staff member was checked off on Sit to Stand Lift Competency. NA-C has yet to be checked off on Full Body Lift Competency, or the Medical Device Disinfection Competency. NA-C had not signed the Nurse Aide Competency Checklist, however someone else signed the form on 12/16/25. An interview with the Infection Preventionist (IP) on 12/15/25 at 2:15 PM revealed that all staff are educated and trained during orientation and periodically to clean all reusable resident medical equipment after use. An observation on 12/16/2025 at 7:45 AM NA-A pushed the Sit to Stand into Resident 4's room, additional observations revealed NA-A failed to clean the Sit to Stand. NA-A pushed the lift into the lift enclosure and walked away. An observation on 12/16/2025 at 8:45 AM NA-B pushed the Sit to Stand into Resident 38's room, additional observations revealed NA-B failed to clean the Sit to Stand. NA-B pushed the lift into the lift enclosure and walked away. NA-B went to assist a different resident. The same Sit to Stand was then observed to be taken on 12/16/25 at 9:05 AM by a different Aide NA-A. NA-A pushed the lift into Resident 24's room, additional observations revealed NA-A failed to clean the Sit to Stand. NA-A pushed the lift into the lift enclosure and walked away. An observation on 12/16/25 at 9:00 AM show NA-C pushed the Sit to Stand into the bathhouse to assist with Resident 33 to take a bath. At 9:30 AM, NA-C pushed the Sit to Stand out of the bathhouse and into the lift enclosure. An interview on 12/16/25 at 9:35 AM with NA-C revealed the Sit to Stand did not get cleaned after it was used with Resident 33 in the bathhouse. NA-C stated sometimes we do not get to it or forget. When asked how often it is supposed to be cleaned, NA-C stated after every use. NA-C then cleaned the lift. An interview on 12/16/25 at 10:35 AM with NA-B revealed that sometimes we forget and do not get to clean it, when asked what the process is, NA-B stated the lifts are to be cleaned after every patient. When asked about education or competencies on the process of infection control and cleaning the lifts after resident use, NA-B reveals that management are educating them and others on the process all of the time through group text messaging and on the spot education. |