

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Falls City Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 Burton Drive Falls City, NE 68355	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47312</p> <p>Licensure Reference Number 175 NAC 12-006.09B</p> <p>Based on record review and interview; the facility failed to code the Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) assessment to reflect the resident's status for 4 (Residents 9, 11, 19 and 34) of 12 sampled residents. The facility census was 39.</p> <p>Findings are:</p> <p>A. Review of Resident 9's May 2024 Medication Administration Record (MAR) revealed Resident 9 received Seroquel (an antipsychotic medication used to treat certain mental/mood disorders) 50 milligrams (mg) at bedtime.</p> <p>Review of Resident 9's Note to Attending Physician/Provider, dated 5/8/24, revealed Resident 9's physician marked no, that a Gradual Dose Reduction (GDR) is contraindicated because previous GDRs had failed.</p> <p>Review of Resident 9's MDS, dated [DATE], revealed the following:</p> <p>-Yes coded to the question: Did the resident receive antipsychotic medications since admission/entry?</p> <p>-Yes coded to the question: Has a GDR been attempted with 5/18/24 entered as the date of the last attempted GDR</p> <p>-No coded to the question: Physician documented GDR as clinically contraindicated</p> <p>Review of the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual v1.18.11, dated October 2023 revealed the following:</p> <p>-Code no if a GDR has not been attempted</p> <p>-Code yes if a GDR has been documented by a physician as clinically contraindicated and enter the date the physician documented GDR attempts as clinically contraindicated.</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 7/10/24 at 10:49 AM, the MDS nurse confirmed that a GDR had not been attempted and should have been coded No and that a GDR had been documented as contraindicated by Resident 9's physician should have been coded Yes with a date of 5/8/24 entered.</p> <p>B. Review of Resident 11's April MAR revealed Resident 11 received Seroquel 12.5mg at bedtime.</p> <p>Review of Resident 11's Note to Attending Physician/Provider, dated 11/17/23, revealed Resident 11's physician marked ok when asked if [gender] would consider decreasing Resident 11's Seroquel from 25mg to 12.5mg at bedtime due to staff reporting Resident 11 had not displayed any behaviors and felt as though [gender] could trial a reduction at this time.</p> <p>Review of Resident 11's MDS, dated [DATE], revealed the following:</p> <p>-Yes coded to the question: Did the resident receive antipsychotic medications since admission/entry?</p> <p>-Yes coded to the question: Has a GDR been attempted with 7/24/23 entered as the date of the last attempted GDR</p> <p>-Yes coded to the question: Physician documented GDR as clinically contraindicated with 7/24/23 entered as the date of the last attempted GDR</p> <p>Review of the MDS 3.0 RAI User's Manual v1.18.11, dated October 2023 revealed the following:</p> <p>-Code yes if a GDR had been attempted and enter the date of the last attempted GDR</p> <p>-Code no if a GDR had not been documented by a physician as clinically contraindicated</p> <p>In an interview on 7/10/24 at 11:00 AM, the MDS nurse confirmed the date of the last attempted GDR for Resident 11 was 11/17/24, not 7/24/23 and that 11/17/24 should have been entered instead of 7/24/23. The MDS nurse further confirmed a GDR had not been documented as clinically contraindicated for Resident 11 and that question should have been coded no.</p> <p>C. Review of Resident 19's May MAR revealed Resident 19 did not have an order for an anticoagulant (blood thinner) or a diuretic (medication that increases the production of urine). The MAR did reveal that Resident 19 had taken Aspirin (antiplatelet used to prevent blood from forming a clot) DR (delayed release) 81mg twice a day.</p> <p>Review of Resident 19's MDS, dated [DATE], revealed that Resident 19 had taken an anticoagulant and diuretic. The MDS further revealed that Resident 19 had not taken an antiplatelet medication.</p> <p>Review of the MDS 3.0 RAI User's Manual v1.18.11, dated October 2023, revealed the following:</p> <p>-Anticoagulant: check if an anticoagulant medication was taken by the resident at anytime during the 7-day look-back period</p> <p>-Diuretic: check if a diuretic medication was taken by the resident at any time during the 7-day look-back period</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Antiplatelet: check if an antiplatelet medication (e.g. aspirin/extended release) was taken by the resident at any time during the 7-day observation period</p> <p>-Do not code antiplatelet medications such as aspirin/extended release as an anticoagulant.</p> <p>In an interview on 7/10/24 at 10:54 AM, the MDS nurse confirmed that Resident 19 did not have an order for an anticoagulant or diuretic and did have an order for an antiplatelet medication. The MDS nurse further confirmed that anticoagulant and diuretic should not have been marked as taken and that antiplatelet should have been marked as taken on the MDS.</p> <p>D. Review of Resident 34's April and May 2024 MARs revealed Resident 34 did not have an order for an anticoagulant. The MARs did reveal that Resident 34 had taken Clopidogrel (antiplatelet used to prevent blood from forming a clot) 75mg once every three days.</p> <p>Review of Resident 34's MDS, dated [DATE], revealed that Resident 34 had taken an anticoagulant and had not taken an antiplatelet.</p> <p>Review of the MDS 3.0 RAI User's Manual v1.18.11, dated October 2023, revealed the following:</p> <p>-Anticoagulant: check if an anticoagulant medication was taken by the resident at anytime during the 7-day look-back period</p> <p>-Antiplatelet: check if an antiplatelet medication (e.g. clopidogrel) was taken by the resident at any time during the 7-day observation period</p> <p>-Do not code antiplatelet medications such as clopidogrel release as an anticoagulant.</p> <p>In an interview on 7/10/24 at 10:47 AM, the MDS nurse confirmed that Resident 34 did not have an order for an anticoagulant and did have an order for an antiplatelet during the 7-day look-back period in April and May. The MDS nurse further confirmed that anticoagulant should not have been marked as taken and that antiplatelet should have been marked as taken on the MDS.</p> <p>E. Review of Resident 34's hospice plan of care, dated 5/2/24, revealed the following:</p> <p>-admitted to hospice on 5/2/24 with a diagnosis of vascular dementia (caused by decreased blood flow to brain tissue causing memory problems, problems with movement, urinary problems, and tremors</p> <p>-A verbal certification was given on 5/2/24 from Resident 34s physician that [gender] certified that Resident 34s prognosis is 6 months or less if the disease runs its normal course</p> <p>Review of Resident 34's MDS, dated [DATE], revealed the following:</p> <p>-No coded on the question: Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?</p> <p>Review of the MDS 3.0 RAI User's Manual v1.18.11, dated October 2023, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Code yes if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services</p> <p>In an interview on 7/10/24 at 10:47 AM, the MDS nurse confirmed that Resident 34 had physician documentation that [gender] is terminally ill and was receiving hospice services. The MDS nurse further confirmed that yes should have been coded for the question: Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>47312</p> <p>Licensure Reference Number 175 NAC 12-006.09C</p> <p>Based on interview and record review, the facility failed to develop and implement a resident-centered comprehensive care plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) that accurately reflected the needs for 1 (Resident 34) of 12 sampled residents. The facility census was 39.</p> <p>Findings are:</p> <p>Review of Resident 34's Significant Change Minimum Data Set (MDS- a comprehensive assessment completed when a resident has a major decline or improvement in their status), dated 5/3/24, revealed that Resident 34 was receiving hospice services while a resident.</p> <p>Review of Resident 34's comprehensive care plan, dated 7/9/24, revealed no resident-centered care plan related to hospice.</p> <p>Review of the facility's Care Plan policy, undated, revealed the following:</p> <p>-1. Care plans are modified between care plan conference when appropriate to meet the resident's current needs, problems, and goals.</p> <p>-3. The care plan will be updated and/or revised for the following reasons: a significant change in the resident's condition.</p> <p>In an interview on 7/10/24 at 10:47 AM, the MDS nurse confirmed that there was no hospice care plan for Resident 34 and that one should have been developed and implemented after Resident 34 had been admitted to hospice and a significant change MDS had been completed.</p>		