

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2025
NAME OF PROVIDER OR SUPPLIER  Midwest Covenant Home		STREET ADDRESS, CITY, STATE, ZIP CODE  615 East 9th Street Stromsburg, NE 68666	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41938</p> <p>Licensure Reference Number 175NAC 12-006.02(H)</p> <p>Based on record review and interview the facility failed to submit a written investigation for alleged abuse to the state agency within 5 working days as required for 2 of 3 residents (Residents 12 and 19). The facility census was 38.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the undated facility policy titled Abuse Neglect and Misappropriation of Property Policy revealed that the facility supports a zero tolerance for resident abuse, neglect, and/or misappropriation of property. The definition of physical abuse includes hitting, slapping, pinching, and kicking. The section titled Resident to Resident Abuse revealed that staff must intervene to protect the residents and separate the individuals immediately. In all cases of alleged abuse, neglect, or misappropriation/exploitation of resident property the role of the facility is to intervene in the situation; report the situation to the proper authorities; investigate the allegation; prevent abuse while the investigation is in process; and have documented evidence that the facility intervened, reported, prevented, and investigated. The facility must ensure that all alleged violations are reported immediately to the administrator of the facility and to other officials in accordance with State Law. A facility investigation report form will be filled out and sent/faxed within 5 working days to: Health Facility Investigations (the State Agency).</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 12 dated 1/29/25 revealed that Resident 12 admitted into the facility on [DATE]. Resident 12 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 3 indicating severely impaired cognition. Resident 12 requires maximal assistance (the staff does more than half the effort) for personal hygiene, toileting and transferring. Resident 12 is frequently incontinent of bladder (urine) and occasionally incontinent of bowel (stool).</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the progress note dated 9/4/24 at 8:31 AM for Resident 12 revealed that Resident 12 was in the dining room. The tablemate of Resident 12 spilled their eggs and Resident 12 attempted to assist the tablemate with cleaning up the eggs. The tablemate balled their fist and hit Resident 12 on the forearm. The Director of Nursing, Facility Administrator, and Social Services Director were informed of the resident to resident incident.</p> <p>Record review of the progress note dated 9/4/24 at 12:41 PM for Resident 12 revealed that the facility contacted Adult Protective Services (APS) (the State of Nebraska agency designated for receiving reports of abuse, neglect, or exploitation) to file the report of the resident to resident incident.</p> <p>Record review of the medical record of Resident 12 revealed no documentation that a written investigation of the 9/4/24 resident to resident incident was completed and submitted to the state agency.</p> <p>Interview on 3/26/25 at 2:27 PM with the Facility Administrator (FA) confirmed that the 9/4/24 resident to resident incident had been reported to APS as alleged resident to resident abuse.</p> <p>Interview on 3/26/25 at 2:39 PM with the facility Director of Nursing (DON) confirmed that the resident to resident incident directed towards Resident 12 occurred on 9/4/24 and was reported to APS. The DON revealed that the resident that hit Resident 12 was moved to a different table. The DON confirmed that the facility did not submit the written investigation to the state agency as required.</p> <p>B.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 19 dated 2/12/25 revealed that Resident 19 admitted into the facility on [DATE]. Resident 19 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 3 indicating severely impaired cognition. Resident 19 is dependent on staff for personal hygiene and bathing. Resident 19 requires maximal assistance (the staff does more than half the effort) for toileting and transferring. Resident 19 is frequently incontinent of bowel (stool) and bladder (urine).</p> <p>Record review of the progress note dated 12/18/24 at 3:26 PM revealed that a nurse aide went to help Resident 19 with cares last evening (12/17/24). Resident 19 became agitated and combative. The nurse aide grabbed the arms of Resident 19 and held them near the resident's chest. The licensed nurse intervened and the Director of Nursing (DON) was called.</p> <p>Record review of the Adult Protective Services Intake Worksheet dated 12/19/24 revealed that APS was notified of the physical abuse on 12/18/24 at 5:14 PM. The worksheet revealed that on 12/17/24 the nurse aide went to provide care for Resident 19. Resident 19 declined and requested to continue watching television in the gathering area. The nurse aide tried to forcibly move Resident 19 from the gathering area by grasping the resident's arms and putting them across the resident's chest while Resident 19 was in the wheelchair. Another staff saw this and immediately intervened.</p> <p>Record review of the medical record of Resident 19 revealed no documentation that a written investigation of the 12/17/24 staff to resident incident was completed and submitted to the state agency.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 3/26/25 at 2:27 PM with the Facility Administrator (FA) confirmed that the 12/17/24 staff to resident incident had been reported to APS.</p> <p>Interview on 3/26/25 at 2:39 PM with the facility Director of Nursing (DON) confirmed that the DON was notified of the staff to resident incident on 12/17/24 and came to the facility. The DON revealed that the staff member involved was agency staff and the DON escorted the staff member out of the building. The DON revealed that that staff member was not allowed to return to work in the facility.</p> <p>Interview on 3/26/25 at 4:22 PM with the DON confirmed that the facility completed an Incident Investigation Report (a written investigation) dated 12/18/24. The DON confirmed that the investigation report was not submitted to the state agency as required.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50105</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on record reviews and interviews the facility failed to follow orders to notify the physician when blood glucose levels were outside of set parameters. This affected two residents, Resident 24, and Resident 38. The facility census was 38.</p> <p>Findings are:</p> <p>A.</p> <p>A review of an Admission Record dated 03/24/2025 showed Resident 24 admitted on [DATE] with primary and admitting diagnoses of:</p> <ul style="list-style-type: none"> <li>-Parkinson's Disease (a brain disorder causing uncontrollable movements)</li> <li>-Calculus of Kidney (formed stones in the kidneys caused by preexisting conditions)</li> <li>-Type 2 Diabetes Mellitus with Diabetic Polyneuropathy (a condition is which the body does not use insulin properly and nerve damage caused by high blood sugars)</li> </ul> <p>A review of Resident 24's Care Plan Report dated 03/18/2025 revealed:</p> <ul style="list-style-type: none"> <li>-Focus: Patient Medical History of Diabetes Mellitus with insulin</li> <li>-Intervention: Diabetic medications as ordered; blood sugars as ordered</li> </ul> <p>A review of Resident 24's Medication Review Report for the month of 03/2025 signed and dated by the physician on 03/12/2025 revealed orders:</p> <ul style="list-style-type: none"> <li>-Notify MD (medical doctor) when blood sugar is &lt; (less than) 60 or &gt;(greater than) 400, order dated 08/28/2024</li> <li>-Insulin Lispro Injection Solution 100 Unit/ML(milliliter) (Insulin Lispro) Inject as per sliding scale: if 0-70 = 0 CALL PCP(Primary Care Provider); 71-149= 0; 150-199= 1; 200-249= 2; 250-299= 3; 300-349= 4; 350-399=5; 400-999= 5 CALL PCP, subcutaneously four times a day related to Type 2 Diabetes Mellitus with Diabetic Polyneuropathy</li> </ul> <p>A review of Resident 24's blood sugars (BS) from 01/01/2025 through 03/21/2025 revealed BS's outside of parameters:</p> <ul style="list-style-type: none"> <li>-03/21/2025 12:02 534.0 mg (milligram)/dL(deciliter)</li> <li>-02/16/2025 16:38 425.0 mg/dL</li> </ul> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-01/17/2025 21:18 425.0 mg/dL</p> <p>A review of Resident 24's Progress Notes dated 12/23/2024 through 01/22/2025 revealed that on 01/17/2025, notification to the physician on the BS reading had not occurred.</p> <p>A review of Resident 24's Progress Notes dated 01/23/2025 through 02/22/2025 revealed that on 02/16/2025, notification to the physician on the BS reading had not occurred.</p> <p>A review of Resident 24's Progress Notes dated 02/23/2024 through 03/25/2025 revealed that on 03/21/2025, notification to the physician on the BS reading had not been documented as occurred.</p> <p>A review of policy titled Midwest Covenant Home Clinical Policy-Routine Medication Monitoring System dated 07/2023 revealed:</p> <p>-Medication-Diabetic Medication oral or insulin-BG checked per accu-check (a blood glucose monitoring device)-scheduled ordered by doctor-Call PCP if BG (blood glucose/blood sugar) is greater than 450 or lower than 50, unless otherwise directed.</p> <p>An interview with the Director of Nursing (DON) on 03/26/2025 at 12:57 PM revealed that the nurse was confused on when to notify the physician on parameters, therefore did not notify when Resident 24's BS reading was between 400 and 450.</p> <p>A review of facility policy/procedure titled Standards of Care with a revision date of 01/01/2024 revealed Professional Nursing Standards:</p> <p>-Staff will notify each resident's physician when needed.</p> <p>-Medications will be administered as ordered by the physician or designee.</p> <p>-Staff will follow all orders given by the physician or designee.</p> <p>41938</p> <p>B.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 1/31/25 for Resident 38 revealed that Resident 38 admitted into the facility on [DATE]. Diagnoses included Diabetes. Medications included insulin injections (a medication that regulates the amount of glucose (sugar) in the blood).</p> <p>Record review of the Order Summary dated 3/25/25 for Resident 38 revealed a physician's order for Insulin injection per sliding scale (An insulin order that varies the dose of insulin based on the blood sugar level. The higher your blood sugar the more insulin you take) dated 1/27/25. The order directed that staff are to call the physician for blood sugar results over 450.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Care Plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 3/24/25 for Resident 38 revealed the potential for adverse drug reactions related to low blood sugar. Interventions included blood glucose monitoring and medications as ordered by the physician and report as warranted.</p> <p>Record review of the Blood Sugar Summary dated 3/26/25 for Resident 38 revealed the blood sugar results for Resident 38 from 1/27/25 through 3/26/25. Blood sugar results over 450 were obtained on 2/21/25 (461); 2/24/25 (461); and 3/2/25 (460).</p> <p>Record review of the progress note dated 2/24/25 at 2:10 PM revealed that Resident 38's blood sugar at 11 AM was 461. The nurse gave the sliding scale insulin and called Resident 38's physician and informed the physician of the blood sugar.</p> <p>Record review of the resident record revealed no documentation that the physician was notified of the blood sugar results over 450 as required for the blood sugar result of 461 on 2/21/25 or the blood sugar result of 460 on 3/2/25.</p> <p>Interview on 3/26/25 at 12:57 PM with the facility Director of Nursing (DON) confirmed that staff are expected to follow physician orders including notification of blood sugars as ordered by the physician.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50253</p> <p>Based on record review, observation, and interviews, the facility failed to discard outdated foods. This had the potential to affect all residents who consumed food from the kitchen. The census was 38.</p> <p>Findings are:</p> <p>Record review of the facility policy and procedure Food Storage dated the year 2021 stated that policy will be that sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing.</p> <p>Record review of the BakerSource company's product data sheet dated [DATE] revealed that the shelf life of Cinnamon Streusel Coffee Cake Mix is 546 days from the date of manufacturer in ambient conditions as was the shelf life of the Carrot Cake Mix.</p> <p>Observation on [DATE] at 9:35 AM in the facility kitchen;</p> <p>One (1) box of Cinnamon Streusel with a manufactured date of 09.28.2023.</p> <p>Three (3) boxes of Cinnamon Streusel with a manufactured date of 11.28.2023.</p> <p>Five (5) boxes of Carrot Cake mix with a manufactured date of 07.08.2023.</p> <p>Four (4) Angel Food Cake mixes from the grocery store had best if used by dates of 4.28.2024.</p> <p>Two (2) Frozen packages of bologna in upright freezer had a use by date of 03.04.2024.</p> <p>One (1) Frozen packages of bologna in upright freezer had a use by date of 01.06.2024.</p> <p>Interview on [DATE] at 9:30 AM with the Food Service Manager (FSM) confirmed to not knowing how long the cake mixes and bologna were good for after the manufacturing date. The angel food cake mixes had best if used by dates on them. The frozen lunch meat (bologna) had a date but was unsure how long it could be in the freezer without need of being discarded or used.</p> <p>Interview on [DATE] at 2:50 PM with the FSM conducted. FSM reported that once manufactured, the cinnamon streusel and carrot cake mixes had a shelf life of 546 days at room temperatures. FSM confirmed that the 5 boxes of the Carrot Cake mixes were outdated (expired) and that the FSM destroyed them.</p> <p>Interview on [DATE] at 1:45 PM with the FSM conducted. FSM stated that the local grocery store was unable to state how long the angel food cake mixes could be used past the used by date, so these were destroyed (thrown away) by the food service manager.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on [DATE] at 9:20 AM with the FSM revealed that the manufacturer would not stand by any foods that had gone past the outdate even if the bologna had been kept in the freezer, so these were destroyed (thrown away).</p> <p>Interview on [DATE] at 11:40 AM with the FSM confirmed that all outdated food identified on [DATE](listed above) were destroyed (thrown away).</p>		