STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285071	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Estates	2325 Lodge Drive Gering, NE 69341

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 22445 Licensure Reference Number 172 NAC 12-006.05(21) Based on observations, interviews, record reviews, and facility policy review, the facility failed to maintain the dignity of 3 (Residents #43, #87, and #60) of 3 residents who were observed during dining. The facility failed to serve all residents who were sitting at the same table their meal at the same time before proceeding to the next table, leaving the residents to watch their tablemate's eat. The facility census was 99. Findings are: An undated excerpt from the employee handbook titled [Name of facility ownership] Values revealed, We will create a living environment that radiates love, peace, spiritual contentment, dignity and safety, while encouraging personal independence. A. A review of an Admission Record revealed the facility admitted Resident #43 on 04/02/2017. According to the Admission Record, the resident had a medical history that included diagnoses of hypertension and dementia. A review of Resident #43's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/10/2024 revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS revealed the resident required supervision or touching assistance from staff with eating. A review of Resident #43's care plan revealed a Focus area revised on 04/04/2024 that indicated the resident required assistance with activities of daily living (ADLs). Interventions indicated the resident could eat independently after the meal was set up. B. A review of an Admission Record revealed the facility admitted Resident #87 on 10/02/2023 with diagnoses of unspecified dementia with behavioral disturbances and unspecified anxiety disorder. A review of Resident #87's quarterly MDS, with an ARD of 03/27/2024, revealed Resident #87 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS revealed the resident required setup or clean-up assistance from staff with eating. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #87's care plan revealed a Focus area initiated on 10/15/2023 that indicated the resident required assistance with ADLs. Interventions indicated the resident could eat independently after the meal was set up. An observation was made of the breakfast service in the 300 unit dining room on 04/17/2024 beginning at 8:15 AM. There were six tables in the dining room, with two to three residents seated at each table, for a total of 13 residents having breakfast in the dining room. Resident #43 was seated at a table with two other residents. At 8:30 AM, a tablemate of Resident #43 was served their breakfast. This was the first resident to receive their breakfast, and immediately, staff started to assist the resident with eating. Resident #43 and the other tablemate were sitting and looking at the resident who was eating. Resident #43's other tablemate was served at 8:40 AM. Resident #43 was the last resident in the dining room to receive their breakfast tray at 8:50 AM. During this same observation, Resident #87 was observed seated at a table with one other resident. Resident #87's tablemate was served breakfast at 8:35 AM. Resident #87 stated loudly, Where is my breakfast? Everyone is eating but me. Staff tried to assure the resident that their meal would be served shortly. Two other residents received their breakfast tray, at which time Resident #87 again stated, Where is my food? Resident #87 received their tray at 8:40 AM. During an interview on 04/17/2024 at 8:52 AM, Medication Aide (MA) A stated they had been trained to serve all residents at one table before starting meal service at other tables. MA A stated they would feel bad if they had to sit and wait 20 minutes to receive their meal tray and watch their tablemate's eat, as had happened between Resident #43 and their tablemate's. MA A stated they had no reason why they had not followed the meal service process as they had been trained. During an interview on 04/17/2024 at 9:00 AM, Registered Nurse (RN) B, who had been in the dining area assisting residents during the meal service, stated staff had been trained to serve all residents at one table before beginning meal service at another table. RN B stated it was important to serve all residents at one table at the same time so no resident would feel left out. RN B stated the expectation was for one table to be completely serviced before proceeding to the next table. RN B acknowledged that Resident #43 should not have waited to receive the breakfast tray for 20 minutes after the first resident at their table had been served. RN B acknowledged they had heard Resident #87 yelling out for their breakfast tray and stated everyone else was eating but Resident #87. During an interview on 04/18/2024 at 8:59 AM, RN C stated staff were taught to serve all residents at one table before moving to another table. RN C stated that when a resident was not served at the same time as their tablemate's, it was considered a dignity issue. During an interview on 04/18/2024 at 9:47 AM, the Social Services Director (SSD) stated staff were encouraged to serve everyone at a table before proceeding to the next table and added this was important so all residents could eat their meals together. The SSD stated that dining in the facility was like dining in a restaurant and that it was a dignity issue to make tablemate's wait for their meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/2024 at 12:18 PM, the Social Services Assistant (SSA) stated that during the past few months, residents had mentioned an issue regarding not all residents at one table being served at the same time. The SSA stated they understood how not being served at the same time as tablemate's would bother some residents, but added the facility had open-concept dining, which meant residents came to the dining room as they wished. The SSA stated that when Resident #87 asked where their food was during the observation, the staff should have served Resident #87 next and not passed other trays. During an interview on 04/18/2024 at 1:10 PM, the Director of Nursing (DON) stated the facility was trying to get away from a strict dining schedule and give the residents more choices. The DON stated if all residents were sitting at a table ready to be served, they expected all residents at the table to be served before moving to another table. During an interview 04/18/2024 at 12:38 PM, the Administrator stated they did not see residents at one table not being served at the same time as a dignity issue since the facility had an open concept dining plan. The Administrator stated they did not want anyone to feel bad about not having their meal served and the facility tried to serve everyone as quickly as possible. 29673 C. A review of an Admission Record revealed the facility admitted Resident #60 on 08/22/2020. The Admission Record revealed the resident had a diagnosis of need for assistance with personal care. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/07/2024, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. According to the MDS, the resident required setup or clean-up assistance with eating. During an interview on 04/15/2024 at 11:52 AM, Resident #60 stated their only complaint was that the facility did not serve meals to those seated at the table in the dining room at the same time. The resident said they sat at a table with three other residents and that it could take up to 20 minutes for everyone at the table to receive their meal. Resident #60 stated they did not like watching others eat while he/she was hungry and did not like to eat while others did not have their food. An observation was made of the noon meal being served in the 500 Unit dining room on 04/18/2024 at 12:03 PM. Resident #60 was seated at a table with three other residents with the first resident at the table was served at 12:04 PM, and the second resident was served at 12:05 PM. After serving the second resident seated at Resident #60's table, staff served residents at two separate tables before returning to Resident #60's table. Resident #60 received their tray at 12:10 PM. During an interview on 04/18/2024 at 8:59 AM, Registered Nurse (RN) C stated staff were taught to serve all residents at one table before moving to another table. RN C stated that when a resident was not served at the same time as their tablemate's it was considered a dignity issue. During an interview on 04/18/2024 at 9:47 AM, the Social Services Director (SSD) stated staff were encouraged to serve everyone at a table before proceeding to the next table and added that it was important so all residents could eat their meal together. The SSD stated it was considered a dignity issue to make tablemate's wait for their meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/18/2024 at 1:10 PM, DON stated if all residents seated at the same table were ready to be served, staff were expected to serve all residents at the table before serving another table.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Licensure Reference Number 175 NAC 12-006.14 Based on observation, interviews, record review, and facility policy review, the facility failed to provide routine dental services for 1 (Resident #71) of 1 sampled resident reviewed for dental services. The facility census was 99. Findings are: A review of the facility policy titled Dental Policy dated August 2017, revealed the Facility must arrange for transportation to and from the dental services locations; and must assist residents who are eligible to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan such as Medicaid. A review of an Admission Record indicated the facility admitted Resident #71 on 04/13/2021 with diagnoses of unspecified dementia and convulsions. The Admission Record identified Dental Provider D as Resident #71 dental provider and indicated the resident was a Medicaid recipient. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2024, revealed Resident #71 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #71 required supervision or touching assistance from staff for the completion of oral hygiene. The MDS further indicated Resident #71 had no dental/oral issues and no significant weight loss. A review of Resident #71's care plan revealed a Focus area revised on 03/22/2024 that indicated the resident had an activities of daily living (ADL) self-care performance deficit and identified the resident's teeth as being in poor condition and the resident was missing a majority of their teeth. The care plan further indicated the resident had upper partials. Further review of the care plan revealed a Focus area revised on 03/22/2024 that indicated dental exams would be tracked to meet the overall resident's dental needs. Interventions directed staff to set up appointments and allow the provider to be chosen as indicated. The care plan revealed that Resident #71 had last seen the dentist on 06/29/2021. A review of Resident #71's quarterly Nutritional Risk assessment dated [DATE] indicated Resident #71 had no significant weight changes. The assessment failed to address the resident's dental status. A review of Resident #71's Order Summary Report, with active orders as of 04/18/2024, revealed an order to remove the resident's partial dentures at bedtime and clean and soak the dentures in a denture cup. The Order Summary Report for Resident #71 did not contain orders for dental appointments. An observation was made on 04/15/2024 at 10:01 AM. Resident #71 was missing teeth. The resident was unable to relay if the missing teeth were causing a problem. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) C was interviewed on 04/17/2024 at 3:53 PM. RN C stated dental appointments for residents were arranged by the Social Services Director (SSD) and the Administrator. RN C added the facility utilized a contract dental company that visited the facility every six months, while other residents had their own established dental providers. RN C stated a resident's payer source determined which provider they were seen by. RN C stated local dental providers rarely accepted Medicaid as a payment source. RN C stated that upon admission, the resident and/or the family signed a contract for dental service. RN C stated all residents were offered the option of seeing a dentist at least yearly but had the right to refuse dental services. The Social Services Director (SSD) was interviewed on 04/18/2024 at 9:12 AM. The SSD stated residents were seen by the dentist quarterly. The SSD stated dental services were provided by two companies, which included Dental Provider D and Dental Provider E. The SSD stated Dental Provider E started last fall, and all residents were asked to enroll. The SSD reviewed the list of residents who had signed up for Dental Provider E and stated Resident #71 was not on the list because the family chose not to accept the offer. The SSD stated there was no documentation that a conversation about dental services had been held with Resident #71's family or that the family had declined dental services. The SSD confirmed Resident #71 had not been seen by a dentist for routine dental care, cleaning, or assessment of their remaining teeth since 2021. A telephone interview was held with Resident #71's Power of Attorney (POA) on 04/18/2024 at 10:50 AM. Resident #71's POA acknowledged the facility had asked if they would like for Resident #71 to be seen by Dental Provider E, and stated they told the facility the preference was for Resident #71 to be seen by Dental Provider D, where the resident was already comfortable. Resident #71's POA stated that a co-pay for Dental Provider E was not discussed, but the preference was still for Resident #71 not to change dentists, and they wanted Resident #71 to be seen by a dentist as needed. The Director of Nursing (DON) was interviewed on 04/18/2024 at 1:10 PM. The DON defined routine dental services as being as the public would see a dentist, such as yearly or every six months. The DON stated they were unaware Resident #71 had not seen a dentist in three years. The DON added they were sure contact had been made with the family regarding dental services, but it probably had not been documented. The DON stated they would have expected arrangements to be made for Resident #71 to be seen by dental services within the past three years. The Administrator was interviewed on 04/18/2024 at 12:38 PM. The Administrator stated if any resident chose not to sign up with Dental Provider E, that resident would continue to be seen by Dental Provider D. The Administrator stated the problem with Dental Provider D was the company did not accept appointments, and residents had to show up and wait in line. The Administrator stated they were surprised Resident #71 had not been seen by a dentist in three years and stated they would have expected staff to present the option of a dental visit to the resident and family within the past three years.