STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285087	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Square	3119 West Faidley Avenue Grand Island, NE 68803

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5)Based on record review, interview, and observation the facility failed to re-evaluate and revise interventions to treat ongoing constipation for 4 of (Residents 57, 14, 30, and 75) residents sampled. The facility census was 77.Findings were:Record review of the facility Bowel Elimination Protocol dated 06/2024 revealed that each night after midnight the night nurse will review the elimination records for their nurses' station and then prepare a list of residents who are in need of interventions for bowel management and document on the protocol sheet that is used each night.On the 2nd day or 48 hours without a Bowel Movement (BM) the staff would offer 4 ounces of prune juice or natural laxative of resident's choice and then record on the protocol worksheet.On the 3rd day (Day Shift) without a BM, the resident was to receive Milk of Magnesia (MOM) 30 ml orally or Miralax or whatever as needed medication is ordered by their physician in the morning of the 3rd day on the 6:00 AM to 2:00 PM shift. Nursing staff would also assess bowel sounds, then palpate and document assessment of results. The staff would document on the medication administration document (MAR), record the intervention on the protocol sheet, and communicate interventions and results to the oncoming shift for further actions if no BM.On the 3rd day (Evening/Night Shift) without a BM, the evening or night shift nurse would assess bowel sounds, palpate and document results before suppository administration. If no bowel sounds for the day, call the physician immediately. Then give a Dulcolax suppository as ordered a time agreeable to the resident. Document on the MAR. Communicate interventions/results to oncoming shift for further action if no BM. Record on the Protocol sheet.On the 4th day all shifts without a BM, if interventions have not been successful, contact the physician. Advance to the enema as ordered and continue with bowel assessments each shift until resolved. A.Record review of the admission Minimum Data Set (MDS) (a federally mandated, standardized assessment tool for residents in Medicare/Medicaid-certified nursing homes, used to create individual care plans, determine reimbursement (Medicare PDPM, Medicaid case mix), track quality measures, and ensure compliance during surveys, capturing comprehensive data on residents' functional, clinical, and psychosocial health for consistent and high-quality care) dated 09/18/2025 for Resident 57 revealed this resident was admitted on [DATE] with diagnoses of fractured right rib, chronic pain, depression, anxiety, osteoporosis, gastroesophageal reflux disease, and malnutrition. Resident 57 uses a wheelchair and a walker, has pain that interferes with daily activities, and needs minimal assistance with walking.Record review of the working care plan (a personalized, formal, comprehensive document that guides staff in meeting a resident's unique medical, personal, and social needs, outlining goals, treatments, preferences (like food/activities), and required support for their overall well-being, ensuring consistent, person-centered care) dated 12/04/2025 revealed there is nothing stated or care planned about Resident 57 having issues with constipation. The care plan only states: *Toilet Use: Modified independent with front wheeled walker (FWW) and intermittent supervision in room.Record review of the Bowel Assessment Form dated 09/22/2025 revealed that Resident 57 was at risk of constipation related to the use of antipsychotic medication, antidepressant medication, and opioid medications. Currently Resident 57 was continent of bowel and able to feel bodily urges to have a (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BM.Record review of the physician medication orders as of 12/03/2025 revealed Resident 57 was taking the following medications:Miralax 17 grams(gm) orally twice daily for constipationColace 100 milligrams (mg) one capsule orally every 12 hours as needed for constipationDulcolax Rectal suppository 10 mg one every 24 hours rectally as needed for constipationMilk of Magnesia (MOM) 30 milliliters (ml) orally every 24 hours for constipationOxycodone 10 mg orally every 6 hours as needed for pain (PRN) for a maximum of 40 mg oxycodone daily.Oxycodone 10 mg twice daily scheduled for chronic pain.Omeprazole 20 mg orally daily for gastroesophageal reflux diseaseTums 500 mg orally as needed for indigestion related to osteoporosisMagnesium Citrate (magnesium supplement and laxative) oral tablet give 1 tablet by mouth one time a day for leg cramps. There was no dosage on the medication.Acetaminophen 325 mg 2 tablets every 4 hours as needed for mild pain and fever not to exceed 3.25 grams daily.Melatonin 3 mg every 24 hours as needed for difficulty sleeping related to insomniaLexapro (escitalopram) 20 mg once daily related to depressionOndansetron disintegrating tablet 4 mg every 6 hours as needed for nausea and vomiting.Aldactone 100 mg 1 tablet daily for localized edemaLasix 20 mg one tablet daily for localized edemaAmbien 5 mg one tablet as needed for difficulty sleeping related to insomniaXanax 0.25 mg one tablet every 6 hours as needed for anxietySeroquel 50 mg one tablet orally at bedtime for depression.Mag citrate one tablet daily for leg cramps. Record review of the Medication Administration Record (MAR) for the month of 09/2025 revealed that Resident 57 received the following medications on the following dates with the indications.Miralax (an osmotic laxative primarily used to treat occasional constipation or irregular bowel movements) 17 grams orally for constipation every evening at mealtime - Received daily 09/16/2025 to 09/30/2025.Colace (a stool softener used to treat and prevent occasional constipation. It helps to soften the stool, making it easier and more comfortable to pass without straining) 100 mg orally every 12 hours as needed for constipation - Received 09/30/2025.Dulcolax Rectal suppository (a stimulant laxative used to provide fast, short-term relief of occasional constipation) 10 mg one every 24 hours rectally as needed for constipation- Received 09/20/2025.Milk of Magnesia (MOM) (a saline laxative to treat occasional constipation and as an antacid to relieve heartburn and indigestion) 30 ml orally every 24 hours for constipation - Received 09/19/2025.Omeprazole (a medication used to reduce the amount of acid produced in the stomach to treat and prevent various acid-related digestive conditions. It belongs to a class of drugs called proton pump inhibitors) 20 mg orally daily for gastroesophageal reflux disease- Received daily 09/16/2025 to 09/30/2025.Tums (calcium carbonate to neutralize stomach acid) 500 mg orally as needed for indigestion related to osteoporosis - Received 09/17/2025.Oxycodone (an opioid medication primarily used to manage moderate to severe pain which commonly causes constipation) 10 mg orally every 6 hours as needed for pain - Received 09/16/2025 through 09/30/2025 up to 3 times daily.Record review if the (MAR) for the month of 10/2025 revealed that Resident 57 received the following medications on the following dates with the indications.Miralax 17 grams orally for constipation every evening at mealtime - Received daily 10/01/2025 to 10/28/2025. Began taking this twice a day on 10/29/2025.Colace 100 mg orally every 12 hours as needed for constipation - Received 10/1, 2, 8, 12, 14, 15, 17, 21, 22, 23, 27, 28, 29, 20.Dulcolax Rectal suppository 10 mg one every 24 hours rectally as needed for constipation- Received 10/1.Milk of Magnesia (MOM) 30 ml orally every 24 hours for constipation - Received 10/1, 5, 13, 18, 20, 22, 25, 30, and 31.Oxycodone 10 mg orally every 6 hours as needed for pain - Received 10/01/2025 to 10/31/2025 up to 3 times daily.Omeprazole 20 mg orally daily for gastroesophageal reflux disease- Received daily 10/01/2025 to 10/31/2025.Tums 500 mg orally as needed for indigestion related to osteoporosis - Received 10/12, 14, 15, 17, 18, and 19.Record review if the (MAR) for the month of 11/2025 revealed that Resident 57 received the following medications on the following dates with the indications.Miralax 17 grams orally for constipation twice daily for constipation - Received daily.Colace 100 mg orally every 12 hours as needed for constipation - Received 11/4, 8, 11, 12, 16, 17, 19, and 21.Dulcolax Rectal suppository 10 mg one every 24 hours rectally as needed for constipation- Received none.Milk of Magnesia (MOM) 30 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ml orally every 24 hours for constipation - Received 11/3, 13, 20, 29.Oxycodone 10 mg orally every 6 hours as needed for pain - Received every day except November 10th.Oxycodone 10 mg twice daily for chronic pain. Received twice a day starting 11/25.Omeprazole 20 mg orally daily for gastroesophageal reflux disease- Received daily.Tums 500 mg orally as needed for indigestion related to osteoporosis - Received 11/2, 5, 6, 21, 24, 25, 26, 27, 28.Magnesium Citrate (magnesium supplement and laxative) oral tablet give 1 tablet by mouth one time a day for leg cramps - Started this medication daily on 11/25/2025. There was no dosage on the medication.Record review of the Progress Notes for Resident 57 dated 09/15/2025 to 12/04/2025 revealed that there was no documentation related to assessments for bowel sounds and abdominal palpation assessments as per the facility policy requirements. Colace and MOM were frequently requested by Resident 57 and then given by the staff members. In a note dated 10/25/2025 at 3:51 PM, there was an entry that stated the physician had been sent a fax to ask about increasing the Miralax dose. In a note dated 10/30/2025, the entry stated Resident 57 refused offered acetaminophen, wants two pain pills because [gender] is cramping so bad, and you took too long to give me milk of mag. So now I want two pain pills too. Resident is holding stomach, and had just come out of bathroom after unsuccessfully trying to have a bm. Further review of the progress notes revealed that many times the resident is asking for medication for constipation. There are notes as to if the resident medication was effective or ineffective. There are no notes describing the bowel sounds or the results of the abdominal palpation and if stomach was soft to touch, firm to touch, and if doctor was notified in instances in which the medications were ineffective for more than 3-4 days at a time. In an interview on 12/01/2025 at 4:12 PM, Resident 57 stated I have a lot of issues with constipation.In an interview on 12/02/2025 at 9:35 AM, Medication Aide (MA) L revealed MA L was very familiar with the bowel and constipation protocol and was able to explain how this system works as well as how the information is passed from one shift to the next about the current resident needs.ˆ1. The nurses make the bowel list every night .at least it is usually at night. ˆ2. On day 2, any residents who have not had a bowel movement (BM), the residents are given prune juice or something else to get their body adjusted, regulated, and hopefully they will have a BM. Sometimes it is prune juice, sometimes it is apple juice or bananas. We also use butter and prune juice mix that the residents seem to like. ˆ3. We also will encourage the residents to walk, exercise, take a bath or have a spa, and even simply eating something will make their body feel the urge to have a BM. ˆ4. On the day shift of day 3, the residents will receive a prescribed, as needed medication, usually. It depends on what is ordered and as a Medication Aide, we all have to ask the nurses what we should give the residents. Usually, it is Milk of Magnesia (MOM) or Miralax (both medications are used to help relieve constipation).ˆ5. On the night shift of Day 3, we offer them (the residents) a suppository. Some residents will take that or ask to wait until later.ˆ6. On Day 4, the order is to give the resident an enema. Usually the nurses call the doctor, I think. Sometimes they just get that drink stuff, mag citrate.ˆ7. After day 3, the nurses must get involved in the care of the residents.ˆ8. We (medication aides) always let the nurses know what it going on so that they can do their investigative or assessment too. But Medication Aides always have to ask the nurses what they want us to do. We do not assess the residents. That is something that the nurses do. In a second interview with MA L on 12/02/2025 at 9:42 AM, MA L revealed Resident 57 does have an order for Mag citrate for leg pain. It just states to give one tablet. I guess there is no milligrams, so I don't know why it says just to give one tablet. (At this time, MA L looks in the medication cart, removes the medication and confirmed there is a dosage for the medication on the medication card of 125 milligrams (mg).) The tablets we are giving are for 125 mg but that is not listed on the order because that just says to give one tablet. The dose should be a part of the order. In an interview on 12/2/2025 at 9:45 AM with MA K (DOH 12/28/2025) revealed knowing the bowel policy and protocol. I don't have the entire process here to read but this is more or less what we do for the residents;ˆ1. According to the Bowel Regimen, we start on the second day and give prune juice. I do not really know what else we would give that is a natural supplement except maybe Senna, but since (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that is a medication then it probably isn't going to be that. ˆ2. Then it will depend on the physician orders and what the nurses tell us (medication aides) to do. We would give the resident that is constipated MOM, a suppository, and then finally an ENEMA. But the nurses have to let us know what they want us to do. ˆ3. We just follow the bowel protocol that the nurses make each day and then that is given to us each morning to follow. In an interview on 12/2/2025 at 10;10 AM with the director of Nurses (DON) there was a discussion about the medication Mag Citrate ordered for Resident 57. Well as I look at the order for the Mag Citrate, it is a laxative, but it states it is being used for Leg cramps. There is no listed dosage. The five rights of medication administration include the right dose and so I do not know how the Medication Aides are giving the right dose, nor do I know how the pharmacy decided how much to send to the facility. I will need to reach out to the physician. There are no milligrams listed for the medication. No nothing for the mag citrate. In regards to the Bowel regimen, the staff and medication aides are to follow the protocol. As I look at the different residents, there is no documentation that the residents were assessed, nothing is charted about their concerns. This is supposed to be a part of the protocol so that we can assure that the residents are not getting constipated and that they stay regular. But this is not being done. Per the protocol, the prune juice and other natural things are done on day 2 of the protocol, this information should be charted. It is not even charted in the progress notes. It is not charted in the TAR. I don't think it is being charted so I don't know how anyone can prove that the protocol is being followed. To see an order for Stool softener to be given as needed (PRN) every 12 hours and then to skip that and go straight to the MOM or Suppositories or other medications really doesn't make any sense. The DON confirmed that a stool softener should be used more often than it is being used at this time.Confirmation from the DON that the protocol for constipation was not being followed by nursing staff. The DON confirmed assessments were not being charted as required so how could one prove that they were being completed. The DON confirmed that one medication, mag citrate, a laxative, that has a dual purpose, had no milligrams designated in the order for the medication and that resident taking this medication does have issues with constipation regularly. The DON confirmed that the stool softener for Resident 57 was not being used to assist with Resident 57's constipation should be used more frequently on a PRN basis. The DON confirmed that the DON was unable to find documentation where the physician had been notified that residents who had not had a BM by day 4 per the bowel elimination protocol.B.Record review of the quarterly MDS for dated 11/10/2025 revealed that Resident 14 had diagnoses for neurocognitive disorder with Lewy bodies, gastroesophageal reflux disease, type 2 diabetes, muscle weakness, major depressive disorder, dementia, anxiety, and others. Resident 14 was taking an antidepressant and a hypoglycemic medication and had no swallowing or weight issues. Record review of the working care plan printed 12/02/2025 revealed that Resident 14 does reveal Resident 14 has issues with bladder incontinence and must be checked frequently and toileted before and after meals but does not reveal that Resident 14 has issues with constipation. Record review of the Physician Orders for Resident 14 revealed the resident was prescribed the following:-Fleets Enema (laxative) rectally 1 application every 24 hours as needed for constipation.-Bisacodyl rectal suppository (Laxative) 10 mg every 24 hours as needed for constipation.-Bupropion HCl ER 150 mg one tablet daily for depression.-Polyethylene glycol 17 grams every 24 hours as needed (PRN) for constipation.-Senna S oral tablet 8.6-50 mg 2 tablets twice daily for bowel management.-Furosemide (diuretic) 20 mg daily for edema.-Duloxetine HCl 30 mg capsule daily for major depressive disorder.-Other medications and vitamin and mineral supplements.Record review of the past 3 months of bowel movement charting revealed that the resident had issues with constipation. The following are dates that needed to be monitored due to no BM are as follows: -9/4/2025- day 2 no BM, -9/5/2025 - day 3 no BM, -9/6/2025 - day 4 no BM, -10/18/2025 - day 2 no BM, -10/19/2025 - day 3 no BM, -10/20/2025 - day 4 no BM, -10/21/2025 - day 5 no BM, -11/05/2025 - day 2 no BM, -11/06/2025 - day 3 no BM, -11/23/2025 - day 2 no BM, -11/24/2025 - day 3 no BM, -11/25/2025 - day 4 no BM.Record review of the Progress Notes for Resident 14 revealed that on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/06/2025 Resident 14 as given as needed polyethylene powder for constipation but there was no documentation of the abdominal assessment and bowel sounds in the progress notes of on the MAR. On 10/18/2025 through 10/21/2025 there are no entries related to Resident 14's constipation, conversations with the physician, or documentation notes about bowel sounds and abdominal assessments. On 11/05/2025 and 11/06/2025 there is no documentation about the resident abdominal assessments or bowel sounds or documentation that the resident is on days two and three with no BM. On 11/24/2025 at 10:39 AM Resident 14 was given Polyethylene Glycol Powder 17 gram by mouth every 24 hours as needed for Constipation for day 3 with no bm. There was no documentation of bowel sounds or about the palpation assessment of Resident 14's abdomen. On 11/24/2025 at 1:21 there is documentation that the medication was ineffective, and the resident did not have a BM. On 11/25/2025 there is no documentation about bowel sounds or of the abdominal assessment. There is also no documentation for any medication given on this date for constipation and no documentation that the physician was notified. On 11/26/2025 at 5:08 AM there is documentation that the resident received a bisacodyl suppository but there is no documentation that the physician was called. On 11/26/2025 at 6:22 AM it is documented that the medication had been effective, and the resident had a large BM. In an interview on 12/01/2025 at 12:34 PM with a family member, it was revealed that Resident 14 has issues with constipation.In an interview on 12/2/2025 at 10:10 AM with the Director of Nurses (DON) confirmed that there is no documentation of the use of the prune juice or other natural supplements record in the progress notes and confirmed there are no notes that document the abdominal assessments and bowel sounds or of the physician being called.C.Record review of the admission MDS data dated 10/23/2025 for Resident 30 revealed this resident had been admitted on [DATE] for a short-term stay following a hospitalization. The resident had a Brief Interview for Mental Status (BIMS) (a 15-point assessment of an individual's cognitive function, typically used in long-term care and skilled nursing facilities) score of 15 meaning the resident was cognitively intact. The resident was continent of bowel and bladder and had diagnoses of a fractured sacrum (tail bone), gastroesophageal reflux disease, muscle weakness, abnormalities of gait and mobility, and cellulitis (skin infection and inflammation) of the lower left limb.Record review of the working care plan printed on 12/02/2025 did not reveal any issues with constipation.Record review of Resident 30's entire short-term stay of bowel movement charting revealed that the resident had issues with constipation. The following are dates that needed monitored due to no BM are as follows:-11/11/2025 - day 2 with no BM,-11/12/2025 - day 3 with no BM,-11/13/2025 - day 4 with no BM,-11/14/2025 - day 5 with no BM,-11/19/2025 - day 2 with no BM,-11/20/2025 - day 3 with no BM,-11/21/2025 - day 4 with no BM.Review of the Progress notes for the dates with no BM for Resident 30 revealed showed daily skilled care notes about the resident. Under the notes for Bowel/GI functions it stated resident bowel function unchanged for each entry. Under the notes of Bowel/GI changes; each entry stated No notable changes in bowel or GU function. On 11/16/2025 at 9:19 there is an order note that stated the order is outside of the recommended dose or frequency. Senna-docusate sodium tablet 8.6/50 mg give 1 tab by mouth in the morning for constipation. The dosing regimen of 1 tablet daily is below the usual dosing regimen or 2 tablets daily to 4 tablets 2 times daily. There was no documentation related to the resident's constipation or any calls to the doctor. There was no documentation of bowel sound or abdominal assessments after palpation recorded.Record review of the November 2025 MAR revealed that there had been no prn medications given to Resident 30 to aid with constipation. There is no indication that the facility bowel protocol had been followed for this resident.Interview on 12/02/2025 at 2:53 PM revealed that resident 30 had a difficult time with constipation.In an interview on 12/2/2025 at 10:10 AM with the director of Nurses (DON) confirmed that there is no documentation of the use of the prune juice or other natural supplements record in the progress notes and confirmed there are no notes that document the abdominal assessments and bowel sounds or of the physician being called.D.Record review of the quarterly MDS dated [DATE] for Resident 75 revealed that the resident had a BIMS (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	score of 8 which indicated moderate cognitive impairment, was frequently incontinent of urine and occasionally incontinent of bowel, had diagnoses for non-Alzheimer's dementia, anxiety, generalize muscle weakness, abnormality of gait and mobility, insomnia, lumbar region disk displacement, osteoporosis and adult failure to thrive.Record review of the working care plan printed on 12/01/2025 did reveal that the resident had a potential for the alteration in bowel elimination related to constipation. Interventions included administering medications per the physician order, administering PRN medications as indicated, documenting and reporting PRN complications related to bowel elimination and monitoring medications for adverse side effects and update the physician PRN. Record review of the Physician Medical Diagnoses printed and reviewed on 12/03/2025 did indicate that Resident 75 had a diagnosis of constipation.Record review of the bowel documentation from 11/01/2025 to 11/30/2025 revealed the Resident 75had a BM on 11/21/2025, and 11/23/2025 no BM -day 2.Resident 75 was not available for part of the day on 11/24 and thus not assessed, and no 11/25.11/26,11/27.Record review of the progress notes for the month of October 2025 revealed there were no PRN medications given to Resident 75 for constipation. There was no indication that prune juice had been given on day 2 without a BM as these were all left blank. The resident had been in the hospital for a short stay and returned to the facility on [DATE] at 4:48 PM. During the assessment of the resident it did state that the toilet use was not assessed at this time. However, the progress notes did state that the bowel sounds were present in the upper right quadrant, the lower right quadrant, the upper left quadrant and the lower left quadrant. There was documentation that with palpation the abdomen was soft, non-tender. Resident was incontinent of bowel and bladder. This was the only documentation of the resident as it pertained to the bowel assessment for the month of November 2025.Record review of the November MAR for Resident 75 did not indicate that the resident had been given prune juice on day 2. Nor did the resident receive any PRN medications on day 3 where there had been no bowel movement.In an interview on 12/2/2025 at 10:10 AM with the director of Nurses (DON) confirmed that there is no documentation of the use of the prune juice or other natural supplements record in the progress notes or on the MAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 1-005.06(D)Licensure Reference Number 175 NAC 12-006.18(B)Based on observation, record review, and interview the facility failed to perform hand hygiene (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) prior to applying gloves for patient contact, and failed to maintain infection control for catheter use for Resident 42. The facility census was 77. Findings are: A. Record review of the facility policy titled Hand Hygiene dated 9/12/17 revealed that hand hygiene is to occur before and after patient contact. Record review of the current care plan for Resident 7 dated 12/1/25 revealed that Resident 7 was at risk for infection related to indwelling Foley Catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine). Interventions included proper hand hygiene. Observation on 12/3/25 at 2:15 PM outside the room of Resident 7 revealed that Nurse Aide-I (NA-I) put on a gown and gloves. (NA-I did not perform hand hygiene prior to putting on the gown or gloves). NA-I knocked on the room door and entered the resident room. NA-I went into the bathroom and obtained a paper towel, graduate container (a container with markings on the side that is used to measure the amount of liquids), and alcohol prep pads. Resident 7 was seated in the motorized wheelchair in the middle of the room. NA-I went to the resident. NA-I removed the catheter urine collection bag from the privacy cover. NA-I removed the drain from the holder and wiped the tip with an alcohol prep pad. NA-I opened the drain and emptied the moderate dark yellow urine into the graduate. NA-I closed the drain and wiped the tip with a new alcohol prep pad. NA-I placed the drain back into the holder. NA carried the graduate into the bathroom and observed 525cc of urine were drained. NA-I emptied the urine into the toilet and rinsed and dried the graduate. Interview on 12/3/25 at 2:19 PM with NA-I confirmed that hand hygiene is to be completed prior to putting on gown and gloves. B. Observation on 12/4/25 7:31 AM in the room of Resident 19 revealed that Registered Nurse-J (RN-J) administered oral medications to Resident 19. RN-J put on gloves and used the lancet (a small surgical blade with a sharp point) to poke the right middle finger of Resident 19. (RN-J did not perform hand hygiene prior to putting on gloves). RN-J wiped the first drop of blood with a cotton ball and then applied the second drop of blood to the test strip. A blood sugar reading of 98 was obtained. RN-J removed the gloves and repositioned a pillow that fell on the floor underneath Resident 19's legs. RN-J exited the room and performed hand hygiene. Interview with RN-J confirmed that staff were trained on performing hand hygiene and glove use to perform hand hygiene prior to putting on gloves. C. A record review of a Face Sheet dated 12/02/24 for Resident 42 revealed an admission date of 03/20/25. Additional reviews revealed a diagnosis of Neuromuscular Dysfunction of Bladder (a disorder or problem with the nerve control of urinary continence or the ability to completely void). (continued on next page)

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	285087	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Square	3119 West Faidley Avenue Grand Island, NE 68803

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a Care Plan (a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) dated 3/20/25 for Resident 42 revealed a potential risk for infection related to indwelling Foley Catheter (an invasive/aseptic device to collect urine). On 12/01/25 at 3:32 PM, Resident 42 was observed in their room, sitting in a recliner adjacent to their bed. Resident 42 was observed to have a tube running down the inside pant leg extended out to a urine collection bag (catheter) hanging onto the trash can between the recliner and the bed. The can was observed to have various items of trash inside of the can. On 12/02/25 at 10:13 AM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be hanging onto the trash can. The trash can had various items in the trash can. On 12/02/25 at 4:04 PM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be sitting on the floor next to the trash can. On 12/03/25 at 10:11 AM, Resident 42 was observed in their room, sitting in the recliner while medications were dispensed to Resident 42 by the Medication Aide. The catheter was observed to be hanging onto the trash can. On 12/04/25 at 10:25 AM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be hanging onto the trash can. The trash can had various items in the trash can. An interview with the Infection Control and Prevention Nurse (IP) on 12/04/25 at 10:35 AM revealed knowledge that staff were hanging the catheter bags on trash cans. The IP Nurse further revealed and agreed that this is an infection control risk for residents with indwelling foley catheters.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)Based on Record review and interviews, the facility failed to ensure approved diagnosis and monitoring for medications and side effects of antipsychotic medications for 2 of 5 residents reviewed (Resident 57 and Resident 10) as required. This had the potential for adverse side effects of antipsychotic medication to go unaddressed. The facility census was 77.Findings were:A. Record review of the admission MDS dated [DATE] for Resident 57 revealed the resident was admitted on [DATE]. Resident 57 had no moods or behaviors, did not wander, did have frequent pain which at times interfered with daily activities, and took the following types of medications: antipsychotic, antianxiety, antidepressant, hypnotic, diuretic, and opioids. Record review of the Medical Diagnoses listed in the electronic medical record on 12/2/2025 revealed Resident 57 had diagnoses for depression, insomnia (difficulty sleeping), anxiety disorder, chronic pain, hypertension (high blood pressure), fractured right rib, and others. A record review of the working care plan (a document that describes different areas of care needed for this resident) revealed that Resident 57 was receiving medications for anxiety and depression and that staff members were to monitor for adverse effects by monitoring, documenting, and reporting specific signs and symptoms which included changes in behaviors, lack of energy, slurred speech, disorientation, depression, dizziness, light-headedness, impaired thinking or judgment, memory loss, forgetfulness, suicidal thoughts, decline in activities of daily living, constipation, tremors, insomnia, among many others. Record review of the Physician orders revealed Resident 57 had orders for the following psychoactive medications; Melatonin 3 mg every 24 hours as needed for insomnia. Lexapro 20 mg daily for depression Ambien 5 mg as needed for insomnia Xanax 0.25 mg every 6 hours as needed for anxiety Seroquel 50 mg daily at bedtime for depression Record review of the policy dated 5/2025 Psychoactive Medication and Medication Regimen Review Management Standard revealed on page one that 1.) each Psychoactive Medication must have an appropriate diagnosis to support the use of the medication. 2.) a gradual dose reduction was required for all Psychoactive Medications. 3.) the interdisciplinary team acts as a resident advocate to ensure that psychoactive medications are necessary to ensure quality of life for each resident. 4.) there were various forms of tools for each resident which included behavior/intervention monthly flow records, AIMS (Abnormal Involuntary Movement Scale) and other tracking on the electronic medical charting system, 5.) if a resident was on an antipsychotic, it is best practice to monitor for possible seizure side effects due to the medications potentially lowering the threshold of seizures. 6.) if a resident is (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on a psychoactive medication, there should be a separate care plan in place (separate problem/need, goal, and interventions), 7.) The Care Plan is reflective of the Out of Character Response/Behavior and management. The policy defined a psychoactive drug as any drug that affects brain activities associate with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Antipsychotics Antidepressants Antianxiety Sedative/Hypnotic The definition for the Indications for Use revealed this is the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical stands of proactive, medication references clinical studies or evidence-based review articles that are published in medical and or pharmacy journals. The policy further defined an Unnecessary Drug as those used In excessive dose (including duplicate drug therapy) or, For excessive duration or, Without adequate monitoring or, Without adequate indications for its use or, In the presence of adverse consequences which indicate the dose should be reduced or discontinued, or Any combination of the reasons above. The policy revealed the documentation requirements of Psychoactive Medications which included: Consent for use of the psychoactive medication Behavior and Intervention monthly flow record for out of character response tracking Care Planning Finally, the policy revealed the Guidelines for Psychoactive Medications Antipsychotic Medications Approved diagnosis for Antipsychotic medications in Schizophrenia, Schizo-affective disorder, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Schizophreniform disorder delusional disorder, mood disorders, psychosis in the absence of dementia, medical illnesses with psychotic symptoms, Tourette's disorder, Huntington's disease, hiccups, nausea and vomiting associated with cancer or chemotherapy. An AIMS (Abnormal Involuntary Movement Scale - an assessment used to assess and monitor for abnormal irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips caused by antipsychotic medications) must be completed initially when medication order is revived and also if resident admitted on antipsychotic, then quarterly and as needed. Record review of the admission Medication Regimen Review dated 09/15/2025 for Resident 57 revealed the consulting pharmacist had identified the following; Resident 57 was receiving psychoactive mediations and wanted the facility to ensure that there was an appropriate diagnosis, ongoing monitoring for efficacy, target behaviors identified, and side effect monitoring ordered per the facility policy for the Alprazolam (XANAX) used for anxiety, escitalopram (Lexapro) used for depression, quetiapine (Seroquel) an antipsychotic being used to treat depression, and zolpidiem (Ambien) being used for insomnia. Resident 57 was receiving PRN (as needed only) psychoactive medications and needed an appropriate stop date and to be certain there was a documented rationale and specified duration of use if to be used greater than 14 days for the alprazolam and the zolpidiem. Resident 57 was receiving an antipsychotic and needed to have an AIMS score completed per the facility policy and to monitor for tardive dyskinesia (a neurological condition causing involuntary, repetitive body movements, often in the face (grimacing, tongue thrusting, lip-smacking), neck, limbs, or trunk, resulting from long-term use of certain medications, particularly antipsychotics), and other extrapyramidal symptoms (movement disorders, often severe side effects of antipsychotic drugs). Record review of the AIMS score for Resident 57 revealed there was no AIMS score conducted upon admission [DATE]) or through the current time period (12/04/2025). Record review of the Informed Consent for psychoactive medications was signed by Resident 57 on 09/15/2025 for the Seroquel, Lexapro, and Xanax, although under the heading Statement of Consent where an X indicated consent of the medication, no medication was listed and the forms were incomplete. Seroquel was listed as an antipsychotic to be used for the treatment of depression, Lexapro was an antidepressant to be used for the treatment of depression, and Xanax was an antianxiety medication to be used for the treatment of anxiety. A record review of the order dated 10/28/2025 for the Ambien (a medication for the treatment of insomnia) which was used on an as needed basis, did not have a rationale as to why it was being continued for the next 6 months from the physician. This order further revealed that the consultant pharmacist who had requested rationale for the medication had also listed the Centers for Medicare and Medicaid Systems (CMS) regulations for PRN (as needed) psychotropic use greater that 14 days, and stated that the provider must document a clinical rationale in the medical record for the continuance of the PRN agent, and indicate the duration that the medication should be continued. If continued use is greater that 14 days of this PRN order is warranted, please provide a clinical rationale as well as the duration below. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the order dated 10/28/2025 for the Xanax given as needed for anxiety did not have a rationale indicated by the physician. This order further revealed that the consultant pharmacist who had requested rationale for the medication had also listed the Centers for Medicare and Medicaid Systems (CMS) regulations for PRN (as needed) psychotropic use greater that 14 days, and stated that the provider must document a clinical rationale in the medical record for the continuance of the PRN agent, and indicate the duration that the medication should be continued. If continued use is greater that 14 days of this PRN order is warranted, please provide a clinical rationale as well as the duration below. Record review of the medication administration record (MAR) for the month of 09/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications. Record review of the (MAR) for the month of 10/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications. Record review of (MAR) for the month of 11/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications. Record review of (MAR) for the month of 12/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications. Record review of the Progress Notes from the date of admission [DATE]) until the current date of 12/03/2025 revealed there were no entries related to the monitoring of behaviors or side effects of the psychotropic medications. In an interview with the Director of Nurses (DON) on 12/04/2025 at 9:05 AM it was revealed that there should be behavior charting being completed for all residents on psychotropic medications. The DON confirmed that these medications should be closely monitored for behaviors and side effects. The DON revealed there are issues with a few of the physicians' writing rationales for the medications that they have prescribed for the residents. The DON confirmed that not all medications have a rationale even after the pharmacists have requested on. The nurses also try to reach out to these same physicians to receive a rationale for the medications, but it isn't easy to get this information at times. The DON did confirm that depression is not an acceptable diagnosis for the use of the medication Seroquel for Resident 57. In an interview with the Administrator on 12/04/2025 at 9:10 AM it was confirmed that the current Medical Director did not always reach out to the other physicians who have residents in the facility and ensure that the regulations for certain medications and the documentation for certain medications were being followed. In an interview on 12/04/2025 at 10:35 AM Confirmation from the DON that there is no behavioral charting related to the medication Seroquel for Resident 57. In an interview on 12/04/2025 at 11:05 AM with the Minimum Data Set Coordinator (MDS) (The MDS is used to evaluate a resident's clinical, functional, and psychosocial status, and the data collected is (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	crucial for developing individualized care plans, monitoring resident progress, and determining facility reimbursement) confirmed that there is no AIMS Assessment in the chart for Resident 57. B. Record review of the facility policy titled Psychoactive Medication and Medication Regimen Review Management Standard dated 5/2025 revealed that an Abnormal Involuntary Movement Assessment (AIMS) (an assessment used to assess and monitor for abnormal irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips caused by antipsychotic medications) (antipsychotics are a class of medications used to treat symptoms of psychosis, such as hallucinations and delusions, which are often associated with conditions like schizophrenia, bipolar disorder, and severe depression) must be completed initially when an antipsychotic medication order is received, when a resident is admitted on an antipsychotic, and then quarterly and as needed. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 9/30/25 revealed that Resident 10 admitted into the facility on 2/12/24. The MDS revealed that Resident 10 takes an antipsychotic medication. Record review of the Order Recap Report dated 12/3/25 for Resident 10 revealed an order for Rexulti 0.5 milligrams (mg) (an antipsychotic medication) 1 tablet at bedtime dated 6/28/24. The order for Rexulti was renewed on 7/23/25. Record review of the current medication administration record (MAR) (a legal record of the medications administered to a resident at a facility by a health care professional) for Resident 10 for December 2025 dated 12/3/25 revealed that Rexulti 0.5 mg was administered daily to Resident 10. Record review of the care plan dated 12/1/25 for Resident 10 revealed that Resident 10's medications included medications with a Black Box Warning (a medication with the Food and Drug Administration's strictest warnings for medications with serious risks like death or permanent injury and severe adverse effects, requiring careful resident monitoring). The care plan revealed that the consulting pharmacist will conduct monthly medication review and advise the facility related to Black Box Warning Medications. Observe the resident for any complications related to Black Box Warnings. Record review of the medical record for Resident 10 revealed documentation of the completion of only one AIMS assessment for Resident 10 dated 12/4/21(during a prior stay in the facility). The medical record revealed that no AIMS assessments for Resident 10 were completed during the current stay in the facility that began on 2/12/24, and no AIMS assessments were completed quarterly as required. Interview on 12/4/25 at 10:29 AM with the facility Director of Nursing (DON) confirmed that the DON had only found 1 AIMS assessment for Resident 10 that was from some time ago. Record review of the Consultant Pharmacist's Medication Review dated 10/8/25 revealed the recommendation to the facility to update the chart for Resident 10 with a more recent AIMS assessment due to Rexulti use (last AIMS in December 2021). Interview on 12/4/25 at 10:47 AM with the DON confirmed that Resident 10 takes the antipsychotic medication Rexulti and that AIMS assessments should be completed quarterly. The DON confirmed that the facility had not completed AIMS assessments on Resident 10 as required. The DON confirmed that the facility had not followed up on the Consultant Pharmacist recommendation.