

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2025
NAME OF PROVIDER OR SUPPLIER The Maples at Centennial		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Centennial Circle North Platte, NE 69101	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>51560</p> <p>Licensure Reference Number 175 NAC 12.006.09(H)(i)(3)</p> <p>Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living for one (Resident 4) of five sampled residents. The facility identified a census of 67.</p> <p>Findings are:</p> <p>A record review of a Day Shift Routine/Checklist revealed at 6:15 AM Nurse Aides (NA) were to begin AM cares, including brushing teeth, and getting residents up and ready for breakfast. They were to obtain daily weight and vital signs as ordered. All residents should get dressed. If they refuse to get up or dressed, inform the Charge Nurse.</p> <p>A record review of an admission face sheet revealed Resident 4 was admitted to facility 11/26/24. Resident 4's pertinent diagnoses are as follows: Acute Kidney Failure (a significant decline in kidney function that leads to an accumulation of waste products in the blood), Chronic Obstructive Pulmonary Disease (a disease that causes inflammation and damage to the airways and air sacs in the lungs, leading to breathing difficulties), Muscle Weakness, Repeated Falls, and Anxiety.</p> <p>A record review of a quarterly Minimum Data Set (MDS- a federally mandated assessment tool used in nursing homes to evaluate level of function) revealed in Section C that Resident 4 has a Brief Interview for Mental Status (BIMS- a standardized assessment tool used to screen for cognitive impairment and track cognitive function in long-term care facilities) score of 9/15 indicating mild cognitive impairment.</p> <p>A record review of an Interdisciplinary Team Meeting Note dated 2/24/25 revealed Resident 4 required set up assistance with eating. Resident 4 was noted to dependent with all other cares including dressing/undressing, bathing, toileting, and transferring.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 3/17/24 at 11:00 AM revealed Resident 4 in their room, laying on their back in bed. Resident 4 had on a yellow hospital gown with small green dots and a small pink food/liquid stain on the upper left collar. Resident 4's hair had a disheveled and uncombed appearance. An oxygen concentrator was turned on with the tubing draped over Resident 4's stomach and was not attached to their nose. Resident 4 did not show any signs of shortness of breath at that time. The bedside table was noted to be over the bed and had a clear, dried sticky substance on the surface. A nutritional supplement was observed on the bedside table with a straw inserted. When asked if Resident 4 had gotten up for breakfast or planned on getting up for lunch, [gender] responded they don't get me up, there's no need to.</p> <p>An observation on 3/17/25 at 12:30 PM of Resident 4 in their room revealed Resident 4 laying in bed, on their back, with oxygen tubing draped over abdomen and not placed in nose in the same fashion as previous observation. Resident 4 was noted to be awake and alert. No changes were noted from the previous observation.</p> <p>An observation on 3/17/25 at 3:00 PM of Resident 4 in bed, laying on their back with oxygen tubing draped over abdomen and not placed in nose. The bedside table was free from debris and trash.</p> <p>An observation on 3/18/25 at 7:50 AM revealed Resident 4 in bed, laying on their back. The oxygen tubing was noted to be placed in the nose and the concentrator was turned on. Resident 4 discussed their family photos at that time.</p> <p>An observation on 3/17/25 at 11:00 AM of Resident 4 in their room revealed Resident 4 laying in bed, on their back. Resident 4 was awake and talking with this surveyor. Resident 4's oxygen concentrator was turned on and the tubing was placed in their nose. Resident 4 had on a yellow hospital gown with green dots with a small pink food/fluid stain on the upper left collar. It appeared to be gown observed on 3/17/25. Resident 4 was observed to have their eyes closed and had a neck pillow placed behind her head.</p> <p>An interview on 3-17-25 at 3:15 PM with Nurse Aid (NA) G revealed Resident 4 is totally dependent on staff for cares. NA-G revealed that they, personally, have never assisted Resident 4 out of bed, but states they have asked Resident 4 if they'd like to and that [gender] has refused. NA-G stated that Resident 4 is supposed to be repositioned every few hours and have their brief changed.</p> <p>An interview on 3/17/25 at 3:30PM with Registered Nurse (RN) A revealed that Resident 4 is on comfort cares and is bed bound and stated that they were using the lift on [gender] but not anymore. RN-A revealed that Resident 4 wore a gown to make it easier to change [gender] brief. RN-A stated I told the same thing to the family when [gender] asked me about why Resident 4 had to wear the gown all the time. RN-A confirms it is the shift expectation for all residents to be assisted with cares including: washing face, brushing teeth, combing hair, and getting dressed for the day. RN-A confirmed that Resident 4 is not actively dying and was often awake and alert enough to get out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3-18-25 at 9:15 AM Interview with the Director of Nursing (DON) revealed staff are educated regarding the implementation and expectation of assistance with cares including dressing for the day, combing hair, and getting out of bed. The DON confirmed that Resident 4 should not be left in a gown for staff convenience and if Resident 4 chooses to wear a gown that it should be changed daily. The DON confirms that Resident 4 should be assisted with AM cares every morning and PM cares every evening. The DON confirms that if Resident 4 wants to stay in bed then it should be documented and that a more rigorous repositioning schedule should be implemented.</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(i)(3)</p> <p>Licensure Reference Number 175 NAC 12-006.09(J)(i)(1)</p> <p>Based on observations, record reviews, and interviews; the facility failed to implement interventions to prevent weight loss for 2 (Residents 6 & 7) of 4 sampled residents. The facility census was 68.</p> <p>Findings Are:</p> <p>A record review of the facility policy Nutritional Management with review/revise date of 4/9/24 revealed the facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of (gender) overall condition. In the Care plan implementation section, the policy stated an example of an intervention was to provide physical assist or provision of assistive devices and stated that real food would be offered first before adding supplements.</p> <p>A record review of a facility provided document Staff Education dated 2/11/2025 revealed that a nurse must be present in the dining room during every meal.</p> <p>A.</p> <p>A record review of Resident 6's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of dementia.</p> <p>A record review of Resident 6's most recent Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/26/24 revealed the resident had not had any weight changes, was on a therapeutic diet, and required supervision or touch assistance with eating.</p> <p>A record review of Resident 6's undated Care Plan revealed a Focus area stating the resident was at nutritional risk, which had a goal dated 12/16/24 of I will maintain a stable weight with no significant changes. The care plan also revealed in the Activities of Daily Living section that for eating/dining the resident required prompting, cueing, and set up.</p> <p>A record review of Resident 6's weights documented in their electronic health records revealed the following:</p> <p>-On 2/7/25 the resident weighed 82.5 pounds (lbs) and on 3/14/25 the resident weighed 76 lbs. This was a 7.8% weight loss in one month.</p> <p>-On 12/13/24 the resident weighed 86.5 lbs and on 3/14/25 the resident weighed 76 lbs. This was a 12.1% weight loss in 3 months.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-On 9/13/24 the resident weighed 84.5 lbs and on 3/14/25 the resident weighed 76 lbs. This was a 10% weight loss in 6 months.</p> <p>A record review of Resident 6's Medication Administration Record (MAR) for February and March of 2025 revealed the resident had an order for Ensure or Glucerna three times a day, with a start date of 8/15/2024. Further review revealed the resident drank 100% of most doses.</p> <p>A record review of Resident 6's Task Monitor Amount Eaten documentation from 2/16/25 through 3/17/25 revealed Resident 6 consumed less than 50% of 40 out of the 90 meals, and there were 16 out of the 90 meals that had no documentation.</p> <p>A record review conducted on 3/18/25 of Resident 6's Progress Notes revealed a progress note dated 2/2/25 which stated the resident had been seen by their provider with no changes to medications and a statement to encourage protein drink/supplement daily. There were no additional progress notes after that date.</p> <p>A record review conducted on 3/18/25 of Resident 6's electronic medical records revealed no evidence that the facility had reached out to a provider or the dietitian in the prior 30 days related to the resident's weight loss.</p> <p>An observation on 3/17/25 beginning at 11:57 AM in the dining room revealed staff were bringing residents into the room at that time. At 12:10 PM the dietary aides began passing meal trays out to the residents who were in the room. At 12:16 PM nurse aides began entering the room and assisting residents with eating at two of the tables. Resident 6 was sitting in a chair approximately 1.5 feet away from the table where their food and drinks were. At 12:29 PM Resident 6 dropped their fork on the floor and a nurse took a new one to the resident. At 12:41 PM, Resident 6 left the dining room after consuming less than 25% of their food, 50% of their water, and 25% of their tea. No staff approached the resident during the meal to assist them to scoot their chair closer to the table, ask if they needed any assistance, or ask if they would like something different to eat.</p> <p>An observation on 3/18/25 from 7:37 AM through 8:23 AM of breakfast meal service in the dining room revealed Resident 6 was not in the dining room.</p> <p>An observation on 3/18/25 at 8:25 AM revealed the door to Resident 6's room was closed. In the dining room, Resident 6's meal ticket was sitting on the table next to the serving window, which is where the facility kept them until the resident was served their meal.</p> <p>A continuous observation on 3/18/25 beginning at 8:44 AM revealed Resident 6's call light was turned on and their room door was closed. At 8:57 AM, staff entered Resident 6's room, turned off the call light, and left the room. At 9:00 AM, the bath aide entered Resident 6's room and 3 minutes later both the bath aide and Resident 6 exited the room and walked down the hallway. Resident 6 attempted to walk into the dining room and the bath aide redirected the resident into the bathing room, stating lets go take a bath first. At 9:24 AM, Resident 6 exited the bathing room, and the bath aide guided the resident to a table in the dining room where the resident sat down. At 9:27 AM, the bath aide returned to the dining room and placed a plate of food, cup of orange juice, and cup of hot tea in front of Resident 6. The aide then left the dining room, the resident and a dietary aide remained in the dining room. Resident 6 spent from 9:27 AM until 9:34 AM opening their sugar packets and pouring them into the hot tea cup. Resident 6 began eating their breakfast at 9:36 AM.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 3/18/25 at 9:36 AM with Dietary Aide (DA)- E revealed that there were typically 3-4 days per week at breakfast time where 2-3 residents were not taken to the dining room for their meal until after most of the other residents were done eating.</p> <p>An interview on 3/18/25 at 10:10 AM with NA-C revealed the staff did not provide assistance to Resident 6 during meals because this resident did not need assistance. When asked what staff were to do if a resident did not eat very well during a meal, NA-C stated the facility did not have any set guidelines, but that NA-C would offer the resident something different if the resident did not want to eat what had been served.</p> <p>An interview on 3/18/25 at 10:20 AM with Licensed Practical Nurse (LPN)-B revealed the nurse's responsibility when a resident had weight loss identified was to ask staff to re-weigh the resident to verify the weight, and to fax the resident's doctor and ask for Ensure. LPN-B stated that the nurse working the medication cart was responsible for administering any Ensure that was ordered for residents. LPN-B stated Resident 6's morning dose of Ensure was usually given around 8:00 AM with their breakfast and medications, and that Resident 6 usually drank all of their Ensure.</p> <p>An interview on 3/18/25 at 10:25 AM with the Director of Nursing (DON) revealed that the facility addresses resident's not eating well on a case-by-case basis. DON stated the facility discusses residents with weight loss during their daily stand up meetings, during weekly risk meetings, and during monthly Quality Assurance (QAPI) meetings. DON stated Resident 6 has had weight loss and receives a supplement three times a day, which the resident did drink routinely. DON stated that Resident 6 was an independent person and did not often want assistance from staff, but that the DON would still expect staff to offer to assist the resident if they were not eating during meals.</p> <p>B.</p> <p>A record review of Resident 7's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of an unspecified fracture of shaft of left femur (the bone in the upper portion of the leg).</p> <p>A record review of Resident 7's Admission MDS dated [DATE] revealed the resident required set up or clean up assist with eating.</p> <p>A record review of Resident 7's undated Care Plan revealed a nutritional status goal of Resident will maintain adequate nutritional and hydration status as evidenced by weight being stable with no signs or symptoms of malnutrition or dehydration being present. An intervention in this section stated, Registered dietitian to evaluate and make diet/supplement change recommendations as needed. In the Activities of Daily Living section, it revealed the resident was independent with eating.</p> <p>A record review of Resident 7's weights documented in their electronic health record revealed the following:</p> <p>-The resident was admitted to the facility on [DATE] with a weight of 117.5 and on 3/1/25 their weight was 110.5. This was a 5.9% weight loss in one month.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 7's MAR for February and March 2025 revealed an order with a start date of 2/2/25 for Ensure or house supplement twice a day; to be administered between 7 AM-11 AM and between 4 PM-7 PM. The order did not allow for documentation of how much the resident consumed.</p> <p>A record review of Resident 7's Task Monitor Amount Eaten documentation from 2/16/25 through 3/17/25 revealed the resident refused their meal for 11 out of the 90 meals and consumed 0-25% of 47 out of the 90 meals. There was also no documentation present for 16 out of the 90 meals.</p> <p>A record review of a scanned document Appointment Order Form dated 3/7/25 for Resident 7 revealed the resident was seen by their provider that day and had an order to start taking a multivitamin. There was no evidence that the provider had been made aware of Resident 7's weight loss.</p> <p>An observation on 3/17/25 from 11:57 AM through 12:39 PM in the dining room revealed residents entering the dining room in preparation for the lunch meal. At 12:10 PM, staff began distributing meal trays to the residents that were present in the room, at this time Resident 7 was sitting in their wheelchair at a table. At 12:19 PM an aide sat down between Resident 7 and another resident but neither resident had their meals yet. Resident 7 received their meal shortly after this. At 12:31 PM, Resident 7 had taken a couple of bites of food and a drink of their tea. The aide sitting next to Resident 7 had been assisting another resident at the table. At 12:39 PM, Resident 7 independently exited the dining room after consuming less than 25% of their meal. Staff had not provided any assistance to the resident during the meal.</p> <p>An observation on 3/18/25 from 7:37 AM through 10:17 AM revealed staff began taking residents into the dining room at 7:37 AM, Resident 7 was sitting in a recliner outside the dining room at that time. The first meal trays began to be delivered at 8:02 AM in the dining room. At 9:00 AM, an aide set up a meal tray on an overbed table in front of Resident 7, who remained sitting in the recliner outside the dining room with their feet elevated, in a slouched position and leaning to the left. Resident 7 could be heard stating to their spouse that they could not get their feet down. The overbed tray was level with Resident 7's chin, and their silverware was sitting on the tray on the far side of their juice cup. The plate contained scrambled eggs, sausage links, and a slice of raisin toast. At 9:02 AM, Resident 7 picked up their juice cup and took a drink. Resident 7 did not take any further drinks from their cup or attempt to eat any of the food on their plate from 9:02 AM through 10:17 AM, and no staff approached the resident. At 10:18 AM, an aide approached Resident 7, cut a piece of egg, held the egg up to the resident and asked if the resident wanted a bite. Resident 7 said no, and then the aide took the plate and silverware into the dining room without any further conversation with the resident.</p> <p>An interview on 3/18/25 at 10:17 AM with Registered Nurse (RN)-A revealed the facility staff removed food trays from residents once they had been sitting out for 2 hours. RN-A then instructed a nearby aide to go see if they could assist Resident 7 after the surveyor pointed out that resident had had their meal tray for over an hour with no food consumption.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 3/18/25 at 10:10 AM with NA-C revealed the staff knows which residents need assistance with meals by looking at the resident care plans which are in a book at the nurse's station. NA-C stated each resident's meal slip, which is placed on their tables with their meals, also states what type of assistance the residents need. When asked what staff were to do if a resident did not eat very well during a meal, NA-C stated the facility did not have any set guidelines, but that NA-C would offer the resident something different if the resident did not want to eat what had been served. NA-C stated that Resident 7 did need assistance with meals but that the resident would not eat. NA-C stated staff sit Resident 7 with their spouse for meals and offers the resident something different that they might enjoy more. NA-C also stated that sometimes Resident 7 ate in the dining room and sometimes in a recliner outside the dining room depending on the day and how the resident was feeling.</p> <p>An interview on 3/18/25 at 10:25 AM with the Director of Nursing (DON) revealed that the facility addresses resident's not eating well on a case-by-case basis. DON stated the facility discusses residents with weight loss during their daily stand up meetings, during weekly risk meetings, and during monthly Quality Assurance (QAPI) meetings. When asked about Resident 7, the DON stated that this resident doesn't ever want to eat. Facility recently changed resident's primary provider at the request of the resident's family due to the previous provider not meeting the resident's needs. DON stated the facility has tried supplements and milkshakes for this resident. DON also stated they would expect staff to cue Resident 7 at mealtimes and as needed. DON stated the facility's Dietitian works remotely and did provide consulting for some residents on 3/14/25, but not for Resident 7. The DON was unsure why Resident 7 was not reviewed/consulted on that date.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51560</p> <p>Licensure Reference Number 175 NAC 1-005.06(D)</p> <p>Based on observation, interview, and record review, the facility failed to don (put on) Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP- infection control measures that involve targeted use of gowns, gloves, and mask during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms) for one (Resident 5) of three sampled residents. The facility identified a census of 67.</p> <p>Findings are:</p> <p>A record review of an Enhanced Barrier Precautions Policy dated 4/1/24 revealed that EBP was required while performing high-contact care including: dressing, bathing, transferring, hygiene, changing linens, changing briefs or assisting with toileting, device care (central lines, urinary catheters, feeding tubes) and wound care.</p> <p>An observation on 3/17/24 at 1:00 PM revealed Nurse Aid (NA)-C and NA-F use a hooyer lift (a mechanical device designed to assist caregivers in safely transferring individuals with limited mobility from one place to another) to transfer Resident 5 from their wheelchair to their bed for the purpose of perineal (the area of skin and underlying tissues located between the anus and the genitals) care and catheter care. Resident 5 was noted to have an EBP sign on the outside of door related to their urinary catheter. NA-C and NA-F were observed entering Resident 5's room without donning PPE, with the exception of gloves, which were applied while performing perineal care and catheter care.</p> <p>An interview with NA-F on 3/17/25 at 1:50 PM revealed that NA-F was knowledgeable of the EBP policy and situations in which that policy was enacted. NA-F confirmed that Resident 5 was on EBP due to their urinary catheter. NA-F confirmed that perineal care and catheter care are considered high-contact care and confirmed that they were not wearing the PPE that was required per facility policy.</p> <p>An interview with NA-C on 3/17/25 at 1:45 PM revealed that NA-C was knowledgeable of the EBP policy and the situations that required EBP to be implemented. NA-C confirmed that Resident 5 had an EBP sign on their door which indicated the use of PPE for high-contact care. NA-C confirmed that they should have applied the required PPE prior to perineal care and catheter care.</p> <p>An interview with the Director of Nursing (DON) on 3/17/25 at 3:00 PM revealed staff are expected to apply PPE when performing any high-contact cares. The DON confirmed that both nurse aides should have applied PPE prior to providing care for Resident 5.</p>		