STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285126	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Nebraska City	1800 14th Avenue Nebraska City, NE 68410

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.09(I) Based on interview and record review, the facility failed to ensure evaluations were completed for 5 (Residents 7, 12, 15, 47, and 205) of 8 sampled residents to ensure the safe use of a power lift chair recliner (lift chair)(a motorized chair that reclines and lift upward to assist the resident to stand up) to prevent accidents. The facility census was 52. Findings are: A record review of the facility's undated Fall Policy revealed it was the policy of the facility to provide a safe and healthful living environment for all residents. Fall risk assessments were to be completed by nursing staff following a fall event. The Care Plan would be reviewed/revised to determine effectiveness of current interventions and/or add additional interventions to prevent future falls. A record review of the facility's undated Fall Risk Prevention policy revealed it was the policy of the facility to review and identify residents at risk for falls. Upon admission, quarterly, and when there was a change of condition, a Fall Risk Assessment would be completed. If the resident was identified as high risk (a score greater than 10) a prevention protocol would be initiated immediately to include -Evaluation in the care planning process as a potential or actual problem. -Request for Evaluation by Physical Therapy (PT) or Occupational Therapy (OT) for interventions such as positioning, strengthening, assistive devices, coordination, education, as needed. -Evaluation of the resident's environment. -Evaluation for predisposing factors. -Evaluation for needed safety alarm devices. 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 12's Resident Census dated 10/30/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 12's SNF (Skilled Nursing Facility) Continuity of Care Document (CCD) dated 10/30/2024 revealed the resident had diagnoses of Repeated falls, Dizziness and giddiness (off-balance and surroundings moving or spinning), Orthostatic hypotension (blood pressure drop after standing), Restless Leg Syndrome (disorder that causes uncomfortable legs and an urge to move them), Acute on chronic systolic (congestive) heart failure, Chronic kidney disease, Benign prostatic hyperplasia (enlarged prostate), and Irritable bowel syndrome. A record review of Resident 12's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 05/22/2024 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 12 out of 15 which indicated the resident was moderately cognitively impaired (confused). The resident required partial/moderate assistance with toileting, upper body dressing, and oral and personal hygiene (cleaning). The resident was substantial/maximal assistance with bathing, lower body dressing, and footwear. The resident needed partial/moderate assistance with rolling, lying, and sitting on side of bed, sit to stand positioning, toilet transfer, and chair to bed transfers. The resident used a walker and a wheelchair. The MDS revealed the resident had fallen in the last month. A record review of the facility's Monthly Patient Fall Tracking Record dated 01/01/24 - 10/22/2024 revealed Resident 12 had falls on 05/11/2024 and 06/09/2024 from the lift chair. A record review of Resident 12's Progress Note dated 05/11/2024 revealed Resident 12 was found on the floor in the room sitting in front of the lift chair. When asked what happened Resident 12 stated they raised the lift chair all the way up to help stand up. When Resident 12 raised the lift chair up, the resident's slid on the carpet and the resident slowly sat down on the floor. Resident 12 was assisted back to the lift chair with 2 staff members using the Hoyer lift (a full body lift). The immediate intervention was to place new gripper socks on the resident's feet and then a sign was placed on the dresser to remind the resident to wear gripper socks or shoes when the resident was up. A record review of the facility's Post Fall Observation for Resident 12 dated 05/11/2024 revealed: The detailed description of Resident 12's fall was the resident raised the lift chair all the way up to help the resident stand. The resident previously had gripper socks on, and the resident removed them and put regular socks on. When the resident raised the recliner up, the resident's feet slid on the carpet and slowly sat down on the floor. The resident was assisted back to the lift chair with 2 staff using the Hoyer lift. The resident was normally an assist of 1 staff with/without device for ambulation. A summary of potential factors that could have contributed to the fall was regular socks sliding on the carpet. A description of measures to be taken to prevent further falls was a sign placed on dresser to remind the resident to wear gripper socks or shoes while up. A record review of the facility's Falls Investigation Form for Resident 12 dated 5/11/2024 revealed an intervention of gripper socks placed on the resident. Resident 12 was putting recliner up and slid down to the floor. The lift chair was all the way up. The resident reported the resident was moving the resident's seat up and slowly slipped. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 12's Progress Note dated 06/09/2024 revealed Resident 12 fell from the recliner. The resident was sitting on the floor in front of the lift chair which was in the high raised position. The chair alarm was sounding, and the resident had gripper socks on. Resident 12 was helped back into the lift chair with a Hoyer lift. The staff added Dycem (a non-slip material) to the lift chair to prevent sliding and staff was to check on resident frequently. A record review of the facility's Post Fall Observation dated 06/09/2024 revealed: The detailed description of Resident 12's fall was the resident slid from the lift chair. The resident's usual ambulatory status was a staff assist of 1 with/without a device. It did not reveal there was a pattern to the resident's falls. The resident had raised the lift chair causing the resident to slide. A description of measures to be taken to prevent further falls was Dycem placed in the lift chair and staff was to check on resident frequently. A record review of the facility's Falls Investigation Form dated 06/09/2024 did not reveal an immediate measure put into place to protect the resident and ensure safety. Resident 12 stated the resident slid out of the lift chair. The lift chair tipped up and staff suggested keep chair controller out of reach, check on the resident frequently, and keep Dycem under the resident to prevent sliding. A record review of Resident 12's EMR and paper chart did not reveal a safety assessment had been completed to assess the resident's ability to safely use the lift chair. An observation on 10/30/2024 at 1:18 PM revealed Resident 12 was reclined in the lift chair with the resident's legs elevated. An observation on 10/31/2024 at 11:12 AM revealed Resident 12 was sleeping while reclined in the lift chair with the resident's legs elevated. The remote was in reach. In an interview on 10/30/2024 at 1:18 PM, Resident 12 confirmed the resident had a lift chair, the remote was in reach, and the resident was not supposed to use it, the resident was to call staff if needed. In an interview on 10/30/2024 at 3:27 PM, Registered Nurse (RN)-E confirmed the admitting nurse went over the room education with the resident but was unaware of any education provided to the resident on how to safely use the lift chair. In an interview on 10/31/2024 at 3:18 PM, RN-G confirmed that when a resident was admitted to the facility, the staff would ensure the resident was able to use a walker but didn't make ensure a resident knew how to use the lift chair controller. In an interview on 10/30/2024 at 11:28 AM, Occupational Therapist (OT)-F confirmed OT did not do safety assessments on the resident's ability to safely use a lift chair unless the facility specifically requested it. In an interview on 10/30/2024 at 1:34 PM, the Director of Nursing (DON) confirmed the staff did not complete safety assessments on the residents to ensure the residents were able to safely use a lift chair. B. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 7's Face Sheet dated 10/30/2024 revealed the resident was admitted to the facility on [DATE]. The resident had diagnoses of Bilateral primary osteoarthritis of knee (knee joint disease), Other forms of scoliosis, lumbar region (spine deformity of the lower back), Postural kyphosis, site unspecified (hunching of the back), Unspecified abnormalities of gait (walking pattern), and Alzheimer's disease (mental deterioration). A record review of Resident 7's MDS dated [DATE] revealed the resident had a BIMS score of 3 out of 15 which indicated the resident was severely cognitively impaired (confused). The resident required partial/moderate assistance with bathing, oral, and personal hygiene. The resident was substantial/maximal assistance with dressing and was dependent on staff for toileting and footwear. The resident needed substantial/maximal assistance with rolling, lying, and sitting on side of bed, sit to stand positioning, toilet transfer, and chair to bed transfers. The resident used a walker and a wheelchair. A record review of the facility's Monthly Patient Fall Tracking Record dated 01/01/24 - 10/22/2024 revealed Resident 7 had fallen on 10/27/2024 from the lift chair. A record review of Resident 7's Progress Note dated 10/27/2024 revealed Resident 7 had increased confusion overnight and kept getting out of bed and looking for the resident's spouse. The staff were eventually able to settle the resident in the lift chair. At 4:30 AM the resident's chair alarm sounded. The resident had slid out of the lift chair. The resident did not understand what the controller was and put the chair all the way up. Throughout the assessment process, the resident remained confused and kept asking what happened that the chair kept going up. The resident was assisted up with 2 assist, gait belt (belt that fastened around a resident for staff to hold to keep from falling), and walker. The staff was unable to use the Hoyer lift, as resident's legs were pushed up against the dresser and the staff was unable to get the Hoyer into place. The resident would be monitored for safety every hour in addition to the 5 R (reposition, restroom, rate pain, reach, and refresh) checks for 3 days. A record review of the facility's Post Fall Observation dated 10/27/2024 revealed: The detailed description of Resident 7's fall was the resident slid out of the recliner and did not understand the resident was raising it up with the controller. The resident landed on the buttocks with legs out in front of the resident, partially bent at the knees. The resident was normally an assist of 1 staff with/without device for ambulation. A summary of potential factors that could have contributed to the fall was the resident was confused and did not understand the resident was pushing the controller to raise the chair. A description of measures to be taken to prevent further falls was in addition to 5 R checks, safety checks to be done every hour for 3 days. A record review of the facility's Falls Investigation Form dated 10/27/2024 revealed an intervention of add every hour safety check to 5's for 3 days. Resident 7 said it just kept going up and that the resident was confused and didn't understand the resident raised the chair with the controller. The fall was unwitnessed. A record review of Resident 7's EMR and paper chart did not reveal a safety assessment had been completed to assess the resident's ability to safely use the lift chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 10/28/2024 at 10:38 AM revealed Resident 7 was reclined in the lift chair with the resident's legs elevated, feet were off the end of the lift chair and the lift chair controller was on the floor. An observation on 10/29/2024 at 11:21 AM revealed Resident 7 was sitting reclined in the lift chair with the resident's legs elevated. The remote was on the floor. In an interview on 10/28/2024 at 1:34 PM, Resident 7's Power of Attorney (POA) confirmed the resident had a lift chair and slid out of the lift chair on Saturday, 10/27/2024. The intervention Resident 7's POA was told was the facility was going to place an alarm in the lift chair and bed. In an interview on 10/30/2024 at 3:27 PM, Registered Nurse (RN)-E confirmed the admitting nurse went over the room education with the resident but was unaware of any education provided to the resident on how to safely use the lift chair. In an interview on 10/31/2024 at 3:18 PM, RN-G confirmed that when a resident was admitted to the facility, the staff would ensure the resident was able to use a walker but didn't make sure a resident knew how to use the lift chair controller, but if the resident had to stand up, they had to use the lift chair. In an interview on 10/30/2024 at 11:28 AM, Occupational Therapist (OT)-F confirmed OT did not do safety assessments on the resident's ability to safely use a lift chair unless the facility specifically requested it. In an interview on 10/29/2024 at 1:19 PM, the Director of Nursing (DON) confirmed they do not have a safety assessment on Resident 7, and one was not done following the fall from the lift chair recliner. In an interview on 10/30/2024 at 1:34 PM, the DON confirmed the staff did not complete safety assessments on the residents to ensure the residents were able to safely use a lift chair. C. A record review of Resident 15's Resident Census dated 10/30/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 15's SNF CCD dated 10/30/2024 revealed the resident had diagnoses of Acute lymphangitis of right lower limb (infection in right leg), Acquired absence of limb (arm or leg removal), Unsteadiness on feet, Muscle weakness, Peripheral vascular disease (low blood flow in arms or legs), Need for assistance with personal care, and Chronic Obstructive Pulmonary Disease (COPD). A record review of Resident 15's MDS dated [DATE] revealed the resident had a BIMS score of 14 out of 15 which indicated the resident was cognitively aware. The resident required substantial/maximal assistance with bathing, oral, and personal hygiene. The resident was dependent on staff for toileting, dressing, and footwear. The resident was dependent on staff for all mobility and transfer needs. The resident used a wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Monthly Patient Fall Tracking Record dated 01/01/24 - 10/22/2024 revealed Resident 15 had fallen on 09/07/2024 from the lift chair. A record review of Resident 15's Progress Note dated 09/07/2024 revealed at 10:45 PM the Nursing Assistant (NA) called the RN into Resident 15's room and the resident was on the floor. The call light was on, and the NA went to answer it. The lift chair was elevated, and the resident was laying on the resident's left side. The resident's face had several cuts and was bleeding and the resident's nose was bleeding. The resident stated the resident was messing with the blanket and with what was on it. The chair was found elevated and tilted forward. The emergency room (ER) was called, and the facility got orders to transport to the hospital. A record review of the facility's Post Fall Observation dated 09/07/2024 revealed: The detailed description of Resident 15's fall was the resident fell out of lift chair onto their left face. It did not reveal any measures were in use at the time of the fall. The resident was normally an assist of 1 staff with/without device for ambulation. A summary of potential factors that could have contributed to the fall was the resident was messing with the blanket and what was on it (chair remote was on it) and the resident's lift chair was elevated when observed. A description of measures to be taken to prevent further falls was blank. A record review of the facility's Falls Investigation Form dated 09/07/2024 revealed Resident 15 had a significant injury and was sent to ER. The chair was lifted up, the resident was on the resident's left side, left face/eye/nose were bleeding because of a skin tear. The resident was attempting to grab the lift chair remote. The resident said the resident leaned to mess with chair remote and blanket and toppled over and hit her face on the floor. Immediate measure put in place to protect the resident and ensure safety was ER called. A record review of Resident 15's Rehabilitation Screen dated 09/09/2024 revealed following the fall, OT assessed the resident and recommended a non-lift recliner to prevent the risk of falls. A record review of Resident 15's EMR and paper chart did not reveal a safety assessment had been completed to assess the resident's ability to safely use the lift chair. An observation on 10/30/2024 at 12:26 PM revealed Resident 15's had a power recliner but was not a lift chair. In an interview on 10/30/2024 at 3:27 PM, Registered Nurse (RN)-E confirmed the admitting nurse went over the room education with the resident but was unaware of any education provided to the resident on how to safely use the lift chair. In an interview on 10/31/2024 at 3:18 PM, RN-G confirmed that when a resident was admitted to the facility, the staff would ensure the resident was able to use a walker but didn't make sure a resident knew how to use the lift chair controller. In an interview on 10/30/2024 at 11:28 AM, Occupational Therapist (OT)-F confirmed OT did not do safety assessments on the resident's ability to safely use a lift chair unless the facility specifically requested it. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/30/2024 at 1:34 PM, the DON confirmed the staff did not complete safety assessments on the residents to ensure the residents were able to safely use a lift chair. D. A record review of Resident 47's Resident Census dated 10/30/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 47's SNF CCD dated 10/30/2024 revealed the resident had diagnoses of Peripheral vascular disease, Muscle weakness, Unsteadiness on feet, Acquired absence of left toe, Fracture of unspecified part of neck of right femur (right hip), and Other abnormalities of gait. A record review of Resident 47's MDS dated [DATE] revealed the resident had a BIMS score of 6 out of 15 which indicated the resident was severely cognitively impaired. The resident required supervision/touching for oral and personal hygiene. The resident required partial/moderate assistance for bathing and upper body dressing. The resident required substantial/maximal assistance for lower body dressing and was dependent on staff for toileting and footwear. The resident needed substantial/maximal assistance to move from sit to lying and lying to sitting. The resident was dependent on staff for sit to stand, chair, toilet, and tub/shower transfers. The resident used a wheelchair. A record review of the facility's Monthly Patient Fall Tracking Record dated 01/01/24 - 10/22/2024 revealed Resident 47 had fallen on 10/05/2024 from the lift chair. A record review of Resident 47's Progress Note dated 10/05/2024 revealed the resident was found in the room sitting on the floor. The resident was positioned in front of the recliner. The resident states that the resident did not hit the resident's head, the resident slid on the buttocks. The recliner remote was underneath the resident, which caused the chair to raise up. A record review of the facility's Post Fall Observation dated 10/05/2024 revealed: The detailed description of Resident 47's fall was the Recliner remote was underneath of the resident, the recliner up button was being pushed. The resident slid to the resident's bottom. It did not reveal that any measures were in use at the time of the fall. The resident was normally an assist of 1 staff with/without device for ambulation. A summary of potential factors that could have contributed to the fall was blank. A description of measures to be taken to prevent further falls was make sure the recliner remote is not underneath the resident to make sure the resident did not hit the up button. A record review of the facility's Falls Investigation Form dated 10/05/2024 revealed the following -Resident 47 said I slid out of my chair. -Resident was attempting to continue sitting in recliner. Recliner tilted up. Sat on remote tip up button. Resident sat on remote slid under bottom over time and hit tilt-up button and slid out of chair. -Intervention was to make sure resident don't sit on recliner remote. It did not reveal immediate measure were put in place to protect the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 47's EMR and paper chart did not reveal a safety assessment had been completed to assess the resident's ability to safely use the lift chair. An observation on 10/30/2024 at 10:18 AM revealed Resident 47's had a lift chair. In an interview on 10/30/2024 at 3:27 PM, Registered Nurse (RN)-E confirmed the admitting nurse went over the room education with the resident but was unaware of any education provided to the resident on how to safely use the lift chair. In an interview on 10/31/2024 at 3:18 PM, RN-G confirmed that when a resident was admitted to the facility, the staff would ensure the resident was able to use a walker but didn't make sure a resident knew how to use the lift chair controller, but if the resident had to stand up, they had to use the lift chair. In an interview on 10/30/2024 at 11:28 AM, Occupational Therapist (OT)-F confirmed OT did not do safety assessments on the resident's ability to safely use a lift chair unless the facility specifically requested it. In an interview on 10/30/2024 at 1:34 PM, the DON confirmed the staff did not complete safety assessments on the residents to ensure the residents were able to safely use a lift chair. E. A record review of Resident 205's Resident Census dated 10/30/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 205's SNF CCD dated 10/30/2024 revealed the resident had diagnoses of Unilateral Primary Osteoarthritis, right hip. Idiopathic scoliosis (curvature of spine without reason), Presence of right artificial hip joint, Alzheimer's disease, Unspecified dementia (confusion), Muscle weakness, Unsteadiness on feet, and Other abnormalities of gait. A record review of Resident 205's MDS dated [DATE] revealed the resident had a BIMS score of 6 out of 15 which indicated the resident was severely cognitively impaired. The resident required partial/moderate assistance for oral hygiene. The resident required substantial/maximal assistance for dressing and personal hygiene and was dependent on staff for toileting, bathing, and footwear. The resident needed substantial/maximal assistance for tub/shower transfers. The resident was partial/moderate assistance for mobility, toilet, and chair transfers. The resident used a walker. A record review of the facility's Monthly Patient Fall Tracking Record dated 01/01/24 - 10/22/2024 revealed Resident 205 had fallen on 02/10/2024 from the lift chair. A record review of Resident 205's Progress Note dated 02/10/2024 revealed the NA noted the resident was sitting on the floor in front of the lift chair. The leg rest of the lift chair was raised. The resident was sitting with the resident's back to the recliner, knees slightly bent in front and to the left. The resident was barefoot with sandals beside the lift chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the facility's Post Fall Observation dated 02/10/2024 revealed: The detailed description of Resident 205's fall was the resident was sitting on the floor in front of the recliner. The footrest was up. The resident's legs were partially bent and toward the left. Bare feet. It did not reveal that any measures were in use at the time of the fall. The resident was normally an assist of 1 staff with/without device for ambulation. A summary of potential factors that could have contributed to the fall was the footrest of lift chair was raised, the resident scooted off of it. A description of measures to be taken to prevent further falls was Footrest not to be raised. A record review of Resident 205's EMR and paper chart did not reveal a Falls Investigation Form or a safety assessment had been completed to assess the resident's ability to safely use the lift chair. In an interview on 10/30/2024 at 3:27 PM, Registered Nurse (RN)-E confirmed the admitting nurse went over the room education with the resident but was unaware of any education provided to the resident on how to safely use the lift chair. In an interview on 10/31/2024 at 3:18 PM, RN-G confirmed that when a resident was admitted to the facility, the staff would ensure the resident was able to use a walker but didn't make sure a resident knew how to use the lift chair controller, but if the resident had to stand up, they had to use the lift chair. In an interview on 10/30/2024 at 11:28 AM, Occupational Therapist (OT)-F confirmed OT did not do safety assessments on the resident's ability to safely use a lift chair unless the facility specifically requested it. In an interview on 10/30/2024 at 1:34 PM, the DON confirmed the staff did not complete safety assessments on the residents to ensure the residents were able to safely use a lift chair.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Based on record review and interviews, the facility failed to ensure side effects for Adderall XR (a stimulant medication-a class of drugs that increase the activity of the brain) XR (extended release) were monitored for Resident 33. This affected 1 of 5 residents sampled for unnecessary medication use. The facility census was 52. Findings are: A review of Resident 33's Continuity of Care Document created 10/29/2024 revealed the resident was admitted on [DATE] with diagnoses of a stroke with left side weakness and paralysis, multiple sclerosis (a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), high blood pressure, and narcolepsy (a nervous system problem that causes extreme sleepiness and attacks of daytime sleep). A review of Resident 33's Quarterly Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 10/03/2024 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 14, indicating intact cognition. A review of Resident 33's Orders printed 10/31/2024 revealed an order for Adderall 5 milligrams (mg) orally once a day at 11:30 AM with a diagnosis of narcolepsy. Further review of the Orders revealed no instruction to monitor for side effects (SE) of stimulant medications. A review of Resident 33's Comprehensive Care Plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) in the Electronic Health Record (EHR) and of the printed working care plan at nurse's station revealed no mention of Adderall XR, stimulants, or of the SE of that medication or class of medications to monitor. A review of the website https://www.webmd.com/drugs/2/drug-63163/adderall-oral/details under the Side Effects tab revealed that some SE of Adderall XR may be loss of appetite, weight loss, nausea/vomiting, dizziness, headache, nervousness, and elevated blood pressure. More serious SE listed were blood flow problems in the fingers and toes, mood/mental status changes such as agitation and aggression, and fast or pounding heartbeat. An interview on 10/31/2024 at 12:00 PM with the Director of Nursing (DON) confirmed that monitoring SE of medications was only documented in the Medication Administration Record and in the CCP, and that SE of a stimulant/Adderall was not listed in either place. The DON further confirmed that they should be monitoring for the SE of a stimulant medication. An interview on 10/31/2024 at 12:12 PM with Registered Nurse (RN) B confirmed the RN did not know the side effects of Adderall XR and that they were not listed on the MAR. An interview on 10/31/2024 at 12:23 PM with Medication Aide (MA) C confirmed the MA did not know what the side effects of a stimulant medication were. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285126	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Nebraska City	1800 14th Avenue Nebraska City, NE 68410

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/31/2024 at 12:35 PM with RN E confirmed the RN did not know the side effects of a stimulant/Adderall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285126	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Nebraska City	1800 14th Avenue Nebraska City, NE 68410

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484 Licensure Reference Number 175 NAC 12-006.18(B) Based on record review, observation, and interviews, the facility failed to put Enhanced Barrier Precautions (EBP) into place for Resident 43 to prevent the potential for cross contamination. This affected 1 of 4 residents sampled for skin conditions. The facility census was 52. Findings are: A review of the undated list titled Ambassador Health of Nebraska City Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes. EBP involves wearing a gown and gloves during high-contact resident care activities, such as wound care, for residents known to be colonized or infected with a MDRO as well as residents at increased risk of MDRO acquisition [for example, residents with wounds or indwelling medical devices]) provided by the facility on 10/28/2024 revealed three residents in EBP: Resident 15 for a wound, Resident 26 for a catheter, and Resident 9 for a feeding tube. Resident 43 was not on the list. A review of Resident 43's Continuity of Care Document created 10/29/2024 revealed the resident was admitted on [DATE] with diagnoses of heart failure, an irregular heartbeat, high blood pressure, and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of Resident 43's Significant Change of Status Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities) dated 09/10/2024 revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 11, indicating moderate cognitive impairment. A review of the Event Report dated 09/13/2024 revealed the facility had recorded an open area to Resident 43's gluteal cleft (the groove that runs between the upper buttocks) on 09/13/2024, and that the area remained open through 10/29/2024. A review of the facility's Enhanced Barrier Precautions policy dated 4/2024 revealed that EBP are indicated for a resident with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. An observation made on 10/31/2024 at 7:22 AM revealed no signage for EBP outside Resident 43's room and no gowns available for use either inside or outside the resident's room. An observation made on 10/31/2024 at 8:55 AM of Licensed Practical Nurse (LPN) A performing wound care for Resident 43 revealed no use of a gown during the procedure. An interview on 10/31/24 at 7:40 AM with Registered Nurse (RN) B confirmed the facility did not have Resident 43 in EBP because the wound was not draining, and the resident always had a brief on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285126	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Ambassador Nebraska City	1800 14th Avenue Nebraska City, NE 68410

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 10/31/24 at 7:40 AM with the Director of Nursing (DON) confirmed the facility did not have Resident 43 in EBP because they were looking at the area as a short-term wound that would heal. An interview on 10/31/2024 at 1:37 PM with the DON confirmed that Resident 43 should be in EBP.