STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285139	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Pierce	515 East Main Street Pierce, NE 68767

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 51391 Licensure Reference Number 175 NAC 12-006.06(A) Based on record review and interviews; the facility failed to notify residents of the resolution for grievances for 2 (Resident 11 and 16) of 21 sampled residents. The facility census was 33. Findings are: A. Review of the facility Grievance Process with a revision date of January 2023 revealed the procedure of the grievance process was that the Grievance Official would: -be responsible for overseeing the grievance process, -receive and track grievances, -lead investigations, and -issue written grievance decisions to the resident. The written grievance would include: -the date the grievance was received, -a summary statement of the resident's grievance, -the steps taken to investigate the grievance, -a summary of the findings regarding the concern, -any corrective action taken by the facility and -the date that the grievance was resolved. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Grievance Form dated 12/10/24 revealed Resident 11 was missing a pink turtleneck shirt. Further review of the form revealed that no pertinent findings were documented. On 12/11/24 Activity Assistant (AA)-P went through the closets of all the resident's and found nothing. The grievance was signed as resolved on 12/11/24. The form revealed that the resident was notified of the resolution on 12/11/24. Review of a Grievance Form dated 12/10/24 revealed Resident 16 was missing a pink shirt and a pair of red leggings with pink flowers on them. No pertinent findings were documented. AA-P on 12/11/23 went through all the resident's closets and found nothing. The grievance was signed as resolved on 12/11/24. The form revealed the resident was notified of the resolution on 12/11/24. Review of a Grievance Form dated 1/7/25 revealed Resident 16 was missing a t-shirt gown and socks. Further review of the form revealed on 1/13/25 the laundry aide documented the resident had complained of the missing items for the last 3 months. No action was taken, and the grievance was signed as resolved on 1/13/25. The grievance form indicated the resident was notified of the resolution, but no date was documented. Interview with Resident 11 on 2/10/25 at 9:15 AM verified that the resident had not been notified if personal items had been found when a grievance had been completed for missing personal items. Interview with Resident 16 on 2/10/25 at 9:15 AM verified that the resident had not been notified if personal items had been found when a grievance had been completed for missing personal items. Interview with AA-P on 2/10/25 at 10:15 AM verified that all resident closets in the facility had been looked through for the missing items for Residents 11 and 16. Interview with Registered Nurse (RN)-M on 2/10/25 at 10:30 AM verified that the facility does not have a policy for resident missing items. Interview with the Activities Director (AD)-I on 2/10/25 at 10:45 AM verified that when missing personal items were reported a grievance form was filled out and then given to the Department Head pertaining to the grievance. Staff checked the resident's room, other resident's rooms and laundry staff were notified of the missing items. Interview with the Social Services Director (SSD)-L on 2/10/25 at 11:45 AM verified that when a resident had missing personal item a grievance form was filled out and given to the laundry staff. Laundry staff had 5 days to look for the missing item, then the form was returned to the Administrator. SSD-L verified that the residents were not notified if the clothing was found or not unless the resident asked.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview; the facility failed to accurately code 2 (Resident 22 and 29) of 12 sampled residents' Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) to accurately reflect their Preadmission Screening and Resident Review (PASRR-federally mandated preadmission screening designed to determine appropriate placement and services for residents with mental illness (MI), intellectual disability (ID), or developmental disability (DD) status.). The facility census was 33. Findings are: A. Review of the Resident Assessment Instrument (RAI)-instruction for accurate completion of Resident MDS revealed the following instructions for completing: - All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness, intellectual disability, developmental disability, or related conditions. - Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State. Steps for Assessment: 1. Complete for Admission assessment, Annual assessments, and Significant Change/Correction Assessments. 2. Review the Level I PASRR form to determine whether a Level II PASRR was required. 3. Review the PASRR report provided by the State if Level II screening was required. Coding Instructions: - Code 0, no: if any of the following apply: - PASRR Level I screening did not result in a referral for Level II screening, or - Level II screening determined that the resident does not have a serious MI and/or ID/DD or related conditions, or (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition. B. Review of Resident 22's PASRR screening completed on 11/11/21 revealed a PASRR Level II was completed, and the resident was found to have an intellectual disability or related condition. The resident was approved for unlimited days of nursing facility care. Review of Resident 22's MDS dated [DATE] revealed the resident was not referred for a Level II screening or have a serious MI/ID/DD or related condition. Further review indicated the resident had diagnosis of bipolar and schizophrenic disorders. Review of Resident 22's Care Plan with a revision date of 11/21/24 revealed the resident had bipolar disorder, major depressive disorder, and schizoaffective disorder. In addition, the resident had impaired cognitive function and Down Syndrome and had a Level II PASRR. During an interview on 2/6/25 at 7:46 AM, the Director of Nursing (DON) confirmed Resident 22 had an intellectual disability and would require a Level II PASRR screening. During an interview on 2/6/25 at 1:09 PM, the DON confirmed Resident 22's PASRR status was not correctly coded on the MDS dated [DATE]. C. Review of Resident 29's PASRR dated 5/28/24 revealed a PASRR Level II was completed, and the resident was found to have a serious mental illness. The resident was found to be appropriate for nursing facility care with 180 days approved. Review of Resident 29's MDS dated [DATE] revealed the resident was not referred for a Level II screening or have a serious MI/ID/DD or related condition. Further review revealed the resident had an anxiety disorder and depressive disorder. Review of Resident 29's Care Plan with a revision date of 9/19/24 revealed the resident took an antidepressant and psychotropic (mind altering) medications and was a Level II PASRR. During an interview on 2/6/25 at 1:56 PM, the DON confirmed the MDS completed on 6/27/24 indicated the resident did not have a Level II assessment, however the resident did have a Level II Assessment and thus the MDS was incorrectly coded.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Based on record review and interview; the facility failed to complete a new Preadmission Screening and Resident Review (PASRR- federally mandated preadmission screening to determine appropriate placement and services for those residents with Mental Illness/Intellectual Disability or Related Disorders (MI/ID/RD)) for 1 (Resident 29) of 2 sampled residents when the initial PASRR approval time expired. The facility census was 33. Findings are: Review of the facility policy for Pre-admission Screening for MR/MI dated ,d+[DATE] revealed the following: -The facility verified that all residents were screened prior to admission to determine whether they had a Mental Illness (MI) or Mental Retardation/Developmental Disability (MR/DD) diagnosis and if the facility was able to meet the specialized needs of the resident. A Level II screen was done to assist the facility in determining the types of services required to care for the resident. -The Social Services staff worked with the interdisciplinary team to arrange for and provide individualized interventions as part of the resident care plan. Review of Resident 29's PASRR Level II determination notification dated [DATE] revealed the resident was found to have a serious mental illness, the resident did require and was appropriate for nursing facility services, was approved for 180 days (through [DATE]), and did not require specialized services at that time. Review of Resident 29's medical record revealed no evidence the facility had completed an updated screen following the approved 180 days. During an interview on [DATE] at 1:56 PM the Director of Nursing (DON) confirmed Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) assessments were being completed by an outside source and confirmed the facility was unaware Resident 29 had a Level II PASRR completed on [DATE] and unaware the resident was approved for only 180 days at that time, The DON was unsure if any further PASRR had been completed. Further interview on [DATE] at 3:13 PM the DON confirmed the facility had not been able to locate any further evidence a new PASRR assessment was completed for resident 29 after the initial assessment expired.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09(J)(i)(1) Based on record review and interview; the facility failed to implement nutritional interventions for the prevention of weight loss for 1 (Resident 21) of 3 sampled residents. The facility census was 33. Findings are: A. Review of the Nutritional Status-Unintended Weight Loss Policy dated 4/2013 revealed the staff were to strive to improve the resident's weight by identifying risk factors associated with weight loss and determining appropriate individualized interventions. Staff were to monitor weight and/or food intake and report to the Registered Dietician (RD) as applicable. Staff then to develop and implement individualized interventions to address unintended weight loss. B. Review of Resident 21's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 11/25/24 revealed the resident was admitted [DATE] with diagnosis of seizure disorder and depression. The resident's cognition was moderately impaired the resident's weight was 223 pounds (lbs.) Review of Weights and Vitals Summary Sheet (document used to record the resident's weights) revealed Resident 21's weight was 232 lbs. on 1/2/25. Review of a Registered Dietician (RD) Progress Note dated 1/27/25 at 3:12 PM revealed the resident's weight was now 212 lbs. (down 20 lbs. or a 9% loss in 3 weeks). The RD interviewed the resident who made a recommendation for the resident to receive Ensure (nutritional drink with added calories and protein) once a day for weight loss. Review of the resident's Medication Administration Record (MAR) dated 1/2025 revealed an order dated 1/28/25 for Ensure supplement once a day for weight loss. Further review of the MAR revealed no indication as to how much supplement the resident was to be given. In addition, on 1/28, 1/29, 1/30 and 1/31 the MAR identified the supplement was not provided for the resident as the supplement was not available. Review of Resident 21's MAR dated 2/2025 revealed on 2/1, 2/2, 2/3, 2/4 and on 2/5 the Ensure nutritional supplement remained unavailable and was not given to the resident. Further review revealed the supplement was discontinued on 2/5/25 and a new order was received for Mighty Shakes 120 cubic centimeters (cc) once a day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the RD on 2/6/25 at 3:03 PM, the RD confirmed the resident had a significant weight loss since admission. The RD had made a recommendation on 1/28/25 for the resident to receive Ensure Supplement once a day for weight loss. The RD confirmed the resident's MAR did not identify how much nutritional supplement the resident was to receive. The RD was also aware the supplement was not given from 1/28 to 2/6 (10 days) despite the resident's significant weight loss. The RD was unaware the facility only offered the Mighty Shake nutritional supplement and did not provide Ensure.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Based on record review and interview; the facility failed to develop and implement individualized interventions to prevent or to minimize the effects of potential trauma triggers for 1 (Resident 23) of 21 residents sampled. The facility census was 33. Findings are: Review of Resident 23's Minimum Data Set (MDS, a federally mandated assessment tools used for care planning) dated [DATE] revealed the resident was admitted [DATE] with diagnoses of: anxiety, depression and post-traumatic stress disorder (PTSD- mental health condition that is caused by an extremely stressful or terrifying event) and the resident was assessed as being cognitively intact. Review of a Trauma Informed Care assessment dated [DATE] at 11:58 AM revealed the resident identified a personal preference for the staff not to approach the resident from behind without warning. In addition, the resident did not like loud slamming noises or doors slamming. When the resident was asked about potential events in the resident's life that might have caused the resident trauma; the resident identified being a survivor of abuse, a history of homelessness and imprisonment, and the traumatic loss of a loved one. The resident also identified drinking self to near death on 5 different occasions. The resident did not like bright flashing lights or violent men's voices. Further review of the assessment revealed no evidence the facility staff developed individualized interventions to alleviate or to lessen the resident's PTSD triggers. Review of Resident 23's current Care Plan dated [DATE] revealed the resident had a diagnosis of PTSD. Further review of Resident 23's care plan revealed there were no indications of what Resident 3's triggers were for the PTSD and what interventions staff were to use to mitigate the triggers. During an interview on [DATE] at 1:35 PM with Resident 23 revealed potential triggers for PTSD but indicated the facility had not addressed triggers with the resident and no interventions were in place to prevent potential triggers. During an interview with the Social Service Director (SSD), the Administrator and the Director of Nursing (DON) on [DATE] at 10:08 AM, the following was confirmed: -the facility did not have a policy related to trauma-informed care. -no interventions were developed and/or implemented to minimize or mitigate potential trauma triggers for Resident 23.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 29638 Based on record review and interview; the facility failed to identify and monitor specific target behaviors, to have documented non-pharmacological interventions to address potential behaviors and to attempt a Gradual Dose Reduction (GDR) and/or have a documented contraindication for the GDR related to use of a psychotropic (a drug or substance that affects how the brain works) medication for 1 (Resident 26) of 5 sampled residents. The facility census was 33. Findings are: A. Review of the facility policy Behavior Management: Psychotropic Medication Management dated 5/2014 revealed residents receiving psychotropic medications to treat behavioral symptoms are to be evaluated, monitored and managed by an Interdisciplinary Team (IDT). The following was identified: -residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. -psychotropic medication included Antipsychotics, antidepressants, anti-anxiety, and hypnotics. -residents and their families were educated on the benefits and risks of psychotropic medications as well as alternate treatments available. -residents who used psychotropic medications received gradual dose reductions, unless clinically contraindicated, to discontinue those medications. -the Physician in collaboration with the Consultant Pharmacist re-evaluated the use of medication and considered whether the medication could be reduced or discontinued. B. Review of Resident 26's Minimum Data Set (MDS- federally mandated comprehensive assessment used to develop resident Care Plans) dated 12/2/24 revealed the resident had diagnoses of: Parkinson's disease and non-Alzheimer's dementia, had severe cognitive impairment, and took an antipsychotic medication. Review of an Order Summary Report for Resident 26 revealed an order dated 2/12/24 for Seroquel (psychoactive medication used to treat schizophrenia, bipolar disorder, and depression) 25 milligrams (mg) to be given twice a day. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a form titled Consultant Pharmacist Recommendation to the Physician dated 8/12/24 revealed a recommendation for a GDR of the resident's Seroquel. The form was returned from the physician on 8/26/24 and the physician ordered continue present medication. Further review of the form revealed no evidence as to why the GDR was clinically contraindicated. Review of the resident's current Care Plan dated 1/2/25 revealed the resident used a psychoactive medication. Interventions included monitoring the effectiveness of the medication and monitoring for adverse side effects, administering the medication as ordered and consulting with the pharmacist and the physician to consider dosage reduction when clinically appropriate. Further review of the resident's care plan revealed no evidence of specific target behaviors and no evidence of non-pharmacological interventions. During an interview on 2/6/25 at 10:29 AM, Nurse Aide (NA)-B indicated the resident did not have behaviors and NA-B was uncertain why the resident was on the antipsychotic medication. Interview on 2/10/25 at 9:18 AM with the Registered Nurse Clinical Consultant and the Director of Nursing revealed the following: -the resident had no target behaviors identified for use of the Seroquel. -the resident's care plan did not list non-pharmacological interventions for use of the Seroquel. -8/26/24 the resident's physician refused a GDR and failed to indicate clinical rationale as to why the GDR could not be attempted.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 51391 Licensure Reference Number 175 NAC 12-006.04(H)(ii)(1) Based on record review and interview; the facility failed to employ a qualified Dietary Manager (DM). This had the potential to affect food service provided to all residents who were served food from the kitchen. The facility census was 33. Findings are: A. Review of the facility Job Description: Director of Dining Services with a revised date of 07/18/2024 revealed the necessary qualification of a Director of Dining Services was to meet State requirements for Dietary Manager. B. A review of an undated staff list revealed DM-N was listed as the Dining Services Manager. During an interview on 2/6/25 at 1:30 PM, the facility Administrator (ADM) verified that the current DM did not have the required training to meet the qualifications for the DM position. ADM also confirmed that the Registered Dietician was not full time at the facility.