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	04/21/2026

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

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(A) Based on record review and interview, the facility failed to ensure Resident 7's Pre-admission Screening and Resident Review (PASRR-screening used to determine if a person had or was suspected of having Mental Illness (MI), Intellectual Disability (ID), or a Related Condition (RC)) was completed accurately. The sample size was 2 and the facility census was 36. Findings are:Review of Resident 7's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of resident care plans) dated 3/17/26 revealed the following;-admitted on [DATE],-was not considered by the state PASRR to have MI, ID, or RC, and-had diagnoses of major depressive disorder and schizophrenia (a range of problems affecting thinking, behavior, and emotions). Review of Resident 7's Diagnosis Report dated 7/26/22 revealed the following diagnoses; Adjustment Disorder with mixed anxiety and depression (the development of emotion and or behavior symptoms related to a stressor but out of proportion to the stressor) and Schizoaffective Disorder, bipolar type (a chronic mental health condition characterized by symptoms of schizophrenia, such as delusions and hallucinations and symptoms of mood disorders such as mania or depression).Review of Resident 7's PASRR completed by the hospital on [DATE] revealed the resident had no suspected or known mental health diagnosis, intellectual disability or related condition.Review of Resident 7's current Care Plan with a revision date of 4/17/25 revealed the resident had diagnosis of Schizophrenia with physically aggressive behaviors and the resident took psychotropic (drugs that affect a person's mental state) medications.During an interview on 4/20/26 at 9:59 AM, the Director of Nursing (DON) confirmed the resident's admission PASRR was completed by the hospital and the assessment did not identify the resident's diagnosis of Schizophrenia and Major depressive disorder. The PASRR had been completed incorrectly and did not accurately reflect the residents' MI diagnoses. In addition, due to the incorrect level 1 PASRR screen a level 2 PASRR was not completed.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Licensure Reference Number: 175 NAC 12-006.09(H)Based on record review and interview; the facility failed to provide monitoring and treatment related to changes in bowel elimination for Resident 13. The sample size was 4 and the facility census was 36.Findings are: Review of a Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) for Resident 13 dated 4/13/26 revealed the resident was cognitively intact with diagnoses of stroke, high blood pressure, peripheral vascular disease, diabetes, hemiplegia (paralysis of one side of the body), anxiety and depression. The resident was always involuntary of bowel and required substantial to maximal assistance with toileting.Review of Resident 13's current Care Plan with revision date of 5/12/2025 revealed the resident was at risk for constipation due to decreased mobility, poor oral intakes, and refusal at times to take medications to promote bowel movements. Interventions included the following:-monitor medications for potential side effects of constipation and keep the resident Primary Care Practitioner (PCP) informed.-monitor for changes in mental status, confusion, sleepiness, inability to maintain posture, slow pulse, abdominal distension, vomiting, bowel sounds and abdominal tenderness, rigidity or guarding as potential complications of constipation.-monitor and document bowel movement patterns each day.-administer medications as ordered. Review of the facility form titled Bowel Movement Needs List (updated 5/10/2023) revealed staff were to identify all residents who had not had a bowel movement in the last 2, 3, 4 or 5 days. Interventions were to be implemented with assessments and results documented. Further review revealed the following interventions if the resident did not have a bowel movement:-on day 2 the staff were to offer the resident prune juice.-on day 3 the staff were to offer the resident Milk of Magnesia.-on day 4 the staff were to administer a Bisacodyl suppository.-on day 5 with no bowel movements the staff were to administer a Fleets enema. Staff were to monitor/document results with interventions and were to assess bowel sounds every shift. Review of the resident's documented bowel eliminations from 3/1/26 to 3/31/26 revealed the resident had no documented bowel movement from 3/7/26 to 3/12/26 (5 days). Review of the resident's Medication Administration Record (MAR) for 3/2026 revealed Resident 13 had the following orders:-Miralax one scoop daily which the resident was to receive daily.-Bisacodyl Delayed Release tablets 5 milligrams (mg) to be given every 24 hours as needed for constipation. The resident was not offered and/or administered the Bisacodyl throughout the month. -Dulcolax suppository 10 mg to give one every 24 hours as needed for constipation which was not offered and/or administered throughout the month. -Milk of Magnesia 30 milliliters (ml) to be given every 24 hours as needed for constipation which was not offered and/or administered throughout the month. Review of the resident's medical record revealed the resident did not have a bowel movement from 3/7/26 to 3/12/26; the resident was not offered prune juice on 3/9 when the resident went 2 days with no bowel movement, was not offered Milk of Magnesia on 3/10 after the resident went 3 days with no bowel movement and was not offered a Bisacodyl suppository on 3/11 after the resident had gone 4 days without a bowel movement. In addition, there was no evidence that the staff completed an assessment of bowel sounds. Review of the resident's documented bowel eliminations from 4/1/26 to 4/30/26 revealed the resident had no documented bowel movement from 4/1/26 to 4/4/26 (4 days), 4/4/26 to 4/10/26 (6 days) and from 4/10/26 to 4/14/26 (4 days). Review of the residents' MAR for 4/2026 revealed the resident was given the as needed Bisacodyl 5 mg on 4/9/26 and the staff documented the results as ineffective, the as needed Milk of Magnesia 30 ml on 4/7/26 and on 4/9/26 and both times administration was charted as ineffective. Review of the resident's medical record revealed the following regarding Resident 13:-went 4 days with no documented bowel movement from 4/1/26 to 4/4/26. No documentation that the resident: was offered prune juice on 4/2 when the resident went 2 days without a bowel movement, was offered the Milk of Magnesia on 4/3 after the resident went 3 days without a bowel movement. In addition, there was no evidence that the staff completed an assessment of bowel sounds during this time.-went 6 (continued on next page)

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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 - Few	days with no documented bowel movement from 4/4/26 through 4/09/26. No documentation that the resident: was offered prune juice on 4/6 when the resident went 2 days without a bowel movement, was given Milk of Magnesia 30 ml on 4/7 (day 3) but staff documented this was ineffective and was then given a Bisacodyl tablet and Milk of Magnesia on 4/9/26 (day 5) which were both documented as ineffective. There was no evidence that the facility assessed the resident's bowel sounds or notified the resident's PCP the resident had been without a bowel movement for 6 days. -went 4 days without a bowel movement from 4/11/26 through 4/13/26. The resident was not offered prune juice on 4/12 (day 2), and/or was not offered Milk of Magnesia on 4/13/26, 3 days with no bowel movement. In addition, there was no evidence that the staff completed an assessment of bowel sounds. During an interview on 4/20/26 at 1:00 PM, the Director of Nursing (DON) confirmed the resident did have ongoing episodes of constipation but would frequently refuse when the staff offered as needed medications for constipation. However, the refusal of the offered as needed medications were not always documented. In addition, the staff should have documented assessment of the resident when the resident went 4-6 days with no bowel movement to ensure no potential complications. During an interview on 4/21/26 at 1:44 PM, Licensed Practical Nurse (LPN)-E reported the direct care staff were to document the residents' bowel movements each shift and then a list was made each day of the residents who had not had bowel movements for 2, 3, 4 and 5 days. LPN-E confirmed the staff were to follow the interventions listed on the Bowel Movement Needs List to prevent complications related to ongoing constipation.