STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285140	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows at Ashland	1700 Furnas Street Ashland, NE 68003

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 - Actual harm Residents Affected - Few	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** Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview, and record review, the facility failed to implement interventions to prevent falls for 3 (Residents 1, 2, and 3) of 4 sampled residents. The facility census was 82. Findings are: A record review of the facility's Fall Risk Assessment dated 8/2023 revealed it was the policy of the facility to provide an environment that was free from accident hazards over which the facility had control and provide supervision and assistive devices to prevent avoidable accidents. The falls care plan would include interventions, to include supervision, in order to reduce the risk of an accident. A. A record review of Resident 1's Clinical Census dated 03/03/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's Medical Diagnosis dated 03/03/2025 revealed the resident had diagnoses of Unspecified Fracture Of Left Femur (left hip), Muscle Weakness, Other Abnormalities Of Gait and Mobility (walking and moving disorders), History of Falling, Muscle Wasting And Atrophy (loss of muscle tissue), Unspecified Dementia (confusion), Cerebral Infarction (stroke), Bipolar Disorder (mental condition), Unspecified Dementia (confusion), and Schizophrenia (mental condition). A record review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 12/20/2024 revealed the resident had a BIMS of 00 which indicated the resident was unable to complete the interview. The resident required supervision or touching assistance with eating, substantial/maximal assistance for upper body dressing and personal and oral hygiene (cleaning), a was dependent on staff for toileting, bathing, lower body dressing, and footwear. Functional abilities of sit to stand and chair/bed-to-chair transfer was not attempted due to medical or safety concerns. The resident had not fallen since admission, re-entry, or the prior assessment. A record review of Resident 1's Progress Notes (PN) dated 03/03/2025 revealed: (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 0689 Level of Harm - Actual harm Residents Affected - Few	-12/13/2024 - the resident fell in the resident's restroom, the resident was transferred to the hospital and had surgery for a left hip fracture. -01/27/2025 - a late entry was put in that the resident had a fall in the dining room, but did not have injuries. Monitoring was to be continued per the care plan. -01/30/2025 - Interdisciplinary Team (IDT) fall meeting. Resident fell 01/27/2025 with no injury. The care plan was reviewed, and an intervention was added to not leave the resident alone in the small dining room. -01/31/2025 - the resident was seen laying in the dining room on the resident's right side. When the staff rolled the resident, the resident grabbed the right hip/leg and moaned, and it was noted to be internally rotated (rotated inward). The resident was sent to the hospital -02/04/2025 - the resident was discharged to another type of facility on 041/31/2025 A record review of the facility's unwitnessed Fall without Injury report dated 01/27/2025 revealed the resident fell but did not have injuries. The resident was oriented (knew) person, situation, and the time. There was nothing marked under Mental Status, no Predisposing Environmental Factors (causes from furniture, lighting, wet floor, or other), no Predisposing Physiological Factors (confusion, weakness, gait imbalance, impaired memory, or other), no Predisposing Situation Factors (ambulating with or without assist, during transfer, not using walker), and no Other Information (Info) was completed. A record review of Resident 1's Care Plan with an admission date of 08/09/2024 revealed the resident had the potential for falls related to muscle wasting, deconditioning (decline in physical function), psychotropic (medications for mental diagnoses) drug use, and cognitive deficit (impairment in thinking). The Care Plan interventions included: -Transfers: sit to stand lift as needed. 1-2 staff assist for stand pivot transfer using grab bar in bathroom, Date Initiated 01/28/2025, Revision on: 02/10/2025 -Video monitoring to help prevent falls, Date Initiated 12/31/2024, Revision on: 02/10/2025 -Do not leave resident alone in the dining room, Date Initiated 01/28/2025, Revision on: 02/10/2025 A record review of Resident 1's AS- Post Fall Assessment dated 02/05/2025 for the 01/31/2025 fall revealed an immediate intervention to prevent further falls was to lay down between meals. The cause of the fall was the resident was left alone in the dining room. An intervention or system change was don't leave alone in the dining room. A record review of the facility's Accidents investigation report form dated 02/06/2025 completed by the Administrator revealed Resident 1 fell on [DATE] while attempting use the restroom. The resident complained that the right hip was painful and that the resident hit their head. The resident had a Comminuted, Intertrochanteric Right Hip Fracture with Impaction (break in the right hip's thighbone and the bone is shattered into multiple pieces). The resident was transferred to the hospital where it (right hip) was surgically repaired. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/03/2025 at 4:01 PM, Licensed Practical Nurse (LPN)-D confirmed LPN-D was the nurse on duty when Resident 1 fell, and the Activities Director (AD) was the staff member that found the resident after the fall in the small dining room. LPN-D confirmed the small dining room is a highly visible area were to put the resident so the staff could watch the resident. LPN-D reported following the fall LPN-D could tell right away the resident had a broken right hip. LPN-D confirmed the only interventions LPN-D was aware of prior to the fall was to make sure to offer the restroom after meals and offer snacks. LPN-D confirmed the resident was in the small dining room, LPN-D went to the restroom, and there were no other staff members in the small dining room at the time when Resident 1 fell. In an interview on 03/04/2025 at 11:57 AM, the facility's AD confirmed the AD was in the small dining room putting items away from an earlier activity in the main dining room. The AD confirmed when the AD entered the small dining room Resident 1 was sitting in the wheelchair unattended and had just finished eating. The AD had the AD's back to the resident and happened to turn around and see Resident 1 slide out of the wheelchair. The wheelchair brakes were not locked and the wheelchair slid out from behind the resident and the resident hit the floor. The AD stayed with the resident until the nursing staff arrived and the resident was transferred to the hospital. The AD confirmed the that when the AD entered the small dining room, the resident was in there and there were no staff in the area. In an interview on 03/04/2025 at 10:00 AM, Physical Therapist Assistant (PTA)-C confirmed Therapy had been working with Resident 1 and that the resident was struggling with rehab. PTA-C confirmed that the resident had been released for staff to do a 1-2 staff assist with grab bar transfer or sit to stand transfer. PTA-C confirmed Resident 1 was very impulsive and was not safe to be in the dining room alone. In an interview on 03/04/2025 at 2:25 PM, the Director of Nursing (DON) confirm Resident 1 should not have been left in the dining room alone. In an interview on 03/05/2025 at 2:58 PM, the AD confirmed Resident 1 was in the dining room without other staff in the area when the AD entered. The AD confirmed that the AD was not asked to monitor or keep an eye on Resident 1. B. A record review of Resident 2's Clinical Census dated 03/03/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 2's Medical Diagnosis dated 03/03/2025 revealed the resident had diagnoses of Bimalleolar Fracture of the Left Lower Leg (both lower leg bones in the ankle), History of Falling, Unspecified Dementia (confusion), Cerebral Infarction (stroke), Muscle Weakness, Need For Assistance With Personal Care, Unilateral Osteoarthritis Diffuse (worsening joint condition on one side), and Morbid Obesity (severely overweight). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of Resident 2's MDS dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 11 which indicated the resident was moderately cognitively impaired. The resident required supervision or touching assistance with eating and oral hygiene (cleaning), substantial/maximal assistance for upper body dressing, and was dependent on staff for toileting, bathing, lower body dressing, and footwear. Functional abilities of sit to stand and chair/bed-to-chair transfer was not attempted due to medical or safety concerns. The resident had not fallen since the prior assessment. A record review of Resident 2's Care Plan with an admission date of 02/13/2025 revealed the resident was at risk of falls related to impaired mobility and other disease processes with a revision date of 9/19/2024. The resident had increased risk for actual/potential limitations in the ability to perform Activities of Daily Living (ADLs) related to the resident diagnoses. The Care Plan interventions identified the following information: -For toilet use Resident 2 was dependent, with an initiation date 10/29/2024 and revised on 10/29/2024 -Resident 2 was dependent for transfers and used a Hoyer lift with a initiation date of 10/29/2024 and revised on 02/14/2025. -Resident 2 was dependent for transfers and used a sit stand lift. The initiation date was 10/29/2024 and revised on 10/29/2024. A record review of Resident 2's Progress Notes(PN) dated 02/07/2025 at 10:26 AM revealed the resident was a 2 person staff assist with transfers and 1 person assist with ADLs. A record review of the facility's AS-Admission/readmission Assessment - V 3 dated 01/27/2025 revealed the fall risk assessment section indicated Resident 2 had not fallen in the last 6 months, the resident was incontinent of urine (lack of bladder control), had intact safety awareness, and required assistance or supervision for mobility or transfers. A record review of the facility's AS- Post Fall Assessment dated 02/09/2025 completed by the Charge Nurse, Registered Nurse (RN)-A revealed Resident 2 was alert, standing upright, was transferring, had limited range of motion, and had not fallen in the last 6 months. The identified root cause of the fall was the resident needed to toilet and the Nursing Assistants (NA) were busy, so the resident tried to self-transfer. The intervention was to remind the resident to wait for help. A record review of Resident 2's PN dated 02/09/2025 at 1:46 PM revealed Resident 2 was attempting to self-transfer from the wheelchair to the toilet. According to Resident 2's PN dated 2/09/2025, NA-B went in to assist Resident 2, however, Resident 2, could not pivot and was lowered to the bathroom floor. Further review of Resident 2's PN dated 2/09/2025 revealed RN-A responded to a call for help from the roommate, and Resident 2 was found sitting on the floor. NA-B was bent over Resident 2, supporting the resident from falling. Resident 2's PN dated 2/09/2025 revealed 3 more NAs came to help and lowered the resident completely to the floor. Further review of Resident 2's PN dated 2/09/2025 revealed a Hoyer lift was used to lift the resident off the floor and in the process, the resident's left foot appeared to twist against the wall and with Resident 2 reporting pain. RN-A assessed the situation and had the staff proceed with caution of the ankle and transferred Resident 2 into bed. The doctor was notified with an order for an X-ray to the left foot. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A record review of the facility's Fall sheet dated 2/9/2025 prepared by RN-A revealed Resident 2 was attempting to pivot transfer (move someone from one surface to another by spinning while bearing weight on one or both legs) onto the toilet when a NA went in to assist Resident 2. According to the Fall sheet dated 2/09/2025 Resident 2 reported to the NA that Resident 2 was a pivot transfer. Further review of the Fall sheet dated 2/09/2025, while trying to get the resident onto the toilet, the resident's legs gave out and the resident was lowered to the floor resting on the resident's buttocks with feet outstretched in front. When 3 NAs tried to assist Resident 2 off the floor with the Hoyer lift (a full body lift), the resident's ankle was against the wall and looked like it was twisted. A record review of Resident 2's PN dated 02/09/2025 at 8:06 PM revealed the left ankle was swollen, had a black bruise, and was painful and were waiting on X-ray to arrive. A record review of Resident 2's PN dated 02/09/2025 at 11:45 PM revealed the resident's left ankle was swollen and bruised, and the resident was informed the X-ray would not be until 02/10/2025. According to Resident 2's PN dated 2/09/2025, Resident 2 refused to go to the Emergency Department (ED). A record review of Resident 2's PN dated 02/10/2025 at 10:28 PM revealed the X-ray had been completed and sent to the provider who ordered the resident to be sent to the ED. Further review of Resident 2's PN dated 2/10/2025 revealed Resident 2 was sent to the hospital. A record review of Resident 2's PN dated 2/11/2025 revealed the resident had a fall with fracture, an X-ray was ordered, and the resident was sent to the hospital on [DATE]. A record review of Resident 2's PN dated 02/16/2025 at 4:11 PM revealed Resident 2 was re-admitted from the hospital with a left ankle fracture that was surgically repaired. An observation on 03/04/2025 at 7:50 AM revealed Resident 2 was lying in bed with a large cast on the left lower leg wrapped with a brown elastic wrap. An observation on 03/04/2025 at 9:51 AM revealed Resident 2 was lying in bed with a large cast on the left lower leg wrapped with a brown elastic wrap. In an interview on 03/04/2025 at 7:50 AM, Resident 2 confirmed that on 02/09/25, the resident had to use the restroom, so the resident used the call light to get staff. A NA entered the room and followed the resident to the restroom. The resident confirmed that the resident thought the resident could get up and use the toilet, the wheelchair moved, and down the resident went. The resident confirmed the NA was in the room, followed the resident to the restroom to help with a pivot transfer, but it didn't work, and the resident fell. During the interview Resident 2 reported the NA did not attempt to stop the resident from transferring. The resident did not recall having a gait belt (a belt used to steady a resident when transferring). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/04/2025 at 9:51 AM, Resident 2 confirmed that on 02/09/25, there was a NA in the room to assist with a pivot transfer to the toilet, the resident fell, and the wheelchair went sliding with the brakes on. The resident confirmed that it was not a normal transfer, usually the staff used a sit to stand lift, but the resident had been practicing pivot disk transfers. The resident confirmed there was not a pivot disk in the room at the time of the fall and the NA did not try and stop the resident and get a pivot disk. Therapy was teaching the staff for to transfer the resident with the pivot disk, and everyone had lessons on it. The resident confirmed that before Therapy started working with the resident on the pivot disk, the resident rarely went to the restroom. The resident confirmed the NA was with the resident the whole time and knew what the resident was going to do, and did not try to stop the resident. The resident did not remember if the NA had a gait belt on the resident or if the NA was touching the resident because it happened so fast. In a telephone interview on 03/04/2025 at 10:25 AM, RN-A confirmed RN-A was the charge nurse that was on at the time of the fall. RN-A confirmed that RN-A was not in the room at the time of the fall, but NA-B was in the room at the time of the transfer to help the Resident 2. RN-A reported Resident 2 fell because the resident was trying to pivot transfer. RN-A confirmed 3 other staff entered the room to assist with the Hoyer lift transfer following the fall and that was when Resident 2's ankle got caught against the wall and broke. RN-A confirmed the resident complained of pain when the ankle was touched or moved and progressively swelled and bruised before an X-ray was performed and the resident transferred to the hospital. In a follow up interview on 03/04/2025 at 11:02 AM, Resident 2 confirmed the resident thought the fractures happened when the resident fell due to the extreme pain when the resident hit the floor. In an interview on 03/04/2025 at 2:25 PM, the DON confirmed that Resident 2 was a sit to stand transfer at the time of the fall. The DON confirmed the staff should not have transferred or allowed Resident 2 to self-transfer and the staff should have stopped the resident from attempting to stand from the wheelchair. C. A record review of Resident 3's Clinical Census dated 03/03/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 3's Medical Diagnosis dated 03/03/2025 revealed the resident had diagnoses of Muscle Weakness, Other Abnormalities Of Gait and Mobility, History of Falling, Muscle Wasting And Atrophy, Generalized Anxiety Disorder, and Adjustment Disorder (strong emotional and behavioral reaction to a stressful event) With Depressed Mood. A record review of Resident 3's MDS dated [DATE] revealed the resident had a BIMS of 15 which indicated the resident was cognitively aware. The resident required supervision or touching assistance with eating, partial/moderate assistance with oral and personal hygiene, substantial/maximal assistance for upper body dressing, a was dependent on staff for toileting, bathing, and footwear. Functional abilities of sit to stand and chair/bed-to-chair transfer was not attempted due to medical or safety concerns. The resident had 1 fall with injury since admission, re-entry, or the prior assessment. A record review of the facility's un-named, incident log report dated 09/06/2024 - 02/17/2025 revealed that Resident 3 had a fallen on: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-09/28/2024,11/04/2024,12/16/2024,01/24/2025 and 02/14/2025. A record review of Resident 3's PN dated 03/03/2025 revealed the following: -09/28/2024 - The resident fell in the resident's room without injury. -10/03/2024 - IDT (interdisciplinary team) meeting for 9/28/2024 fall and intervention of visual cues to use call light and ask for assistance. -11/04/2024 - the resident was found on the floor, resident sent to the hospital, no IDT meeting note. -12/16/2024 - Resident was found on floor wrapped with bedding and call light on. Resident said the resident was trying to reach the urinal, no injury. Resident was repositioned with call light in reach and surrounding was clutter free with adequate lighting. -12/19/2024 - IDT fall meeting. Resident fell 12/15/2024 with no injury. Intervention was offering assistance with urinal at rounds. -01/24/2025 - the resident was found lying on the floor in the room. The resident was picking the remote up off the floor. The resident had a laceration (cut) to the left eye and facial bruising. Resident was sent to the hospital. -01/25/2025 - The hospital called the facility, and the hospital placed sutures above the left eye. -01/30/2025 - IDT fall meeting for 1/24/2024 fall with minor injury. Care plan was reviewed and an intervention added to get a basket for resident to store the television (TV) remote in. -02/14/2025 - the resident was found on the floor and stated the resident was getting out of bed to use the phone at the nurse's station. -02/20/2025 - IDT meeting to discuss fall, and intervention added to have phone charged and near the resident. A record review of Resident 3's Care Plan with an admission date of 04/04/2024 revealed the resident had the potential for falls related to generalized weakness, muscle wasting and atrophy, history of falls, pain to left knee, use of psychotropic (medications for mental diagnoses) medications, and hypertension (high blood pressure). The Care Plan interventions included: -Adhere basket to bedside table for TV remote -Anticipate and meet the resident's needs. Place items frequently used by the resident within easy reach when in the room -Pancake call light (flat, easy to push call light) attached to bed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Place the resident's call light within reach and encourage the resident to use it for assistance as needed. An observation on 03/04/2025 at 8:10 AM revealed Resident 3 was sleeping in bed with the bed in the lowest position. The call light was on the floor at the foot of the bed on the resident's left side and was not a pancake call light. The overbed table had a basket mounted without TV remote in the basket. The overbed table was positioned where the basket was on the opposite side and out of reach of the resident. The urinal was hanging on a basket that had been mounted on the vertical post of the bedside table and out of reach of the resident. An observation on 03/04/2025 at 8:21 AM with the DON revealed the resident was sleeping in bed, the bed was in the lowest position. The call light was on the floor at the foot of the bed on the resident's left side. The call light was not a pancake call light. The overbed table had a basket mounted on it but the TV remote was not in it and the resident would not have been able to reach the basket because it was on the opposite side of the overbed table. The urinal was hanging on a basket that had been mounted on the vertical post of the bedside table and the resident would not have been able to reach it because it was on the opposite side of the table from the resident. In an interview on 03/04/2025 at 8:21 AM, the DON confirmed the call light was on the floor at the foot of the bed on the resident's left side and the resident would not have been able to reach it. The call light was not a pancake call light. The basket on the overbed table, did not have the TV remote in it, and the resident would not have been able to reach the basket because it was on the opposite side of the overbed table. The urinal was hanging on a basket that had been mounted on the vertical post of the bedside table and the resident would not have been able to reach it because it was on the opposite side of the table from the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12-006.18(B) Based on observation, interviews and record reviews, the facility failed to prevent cross contamination related to: 1. staff not wearing masks, 2. staff not wearing masks correctly, 3. staff carrying dirty linens next to their uniforms, and 4. reusable items potentially contaminated were not handled in a way to prevent the spread of COVID. The sample size was 5 and the facility census was 80. Findings are: A record review of facility policy titled Infection Prevention and Control dated 4/1/25 revealed: - reusable items potentially contaminated with infectious materials shall be placed in a plastic bag -soiled linen shall be collected at the bedside and placed in a linen bag. A record review of facility policy titled Personal Protective Equipment (PPE) dated 4/1/24 revealed that PPE refers to a variety of barriers used alone or in combination to protect skin and/or clothing from contact with infectious agents. It includes gloves, gowns, and face protection. A record review of Centers for Disease Control (CDC) sequence for putting on PPE revealed that a mask is to be fit snug to face and above the nose and below the chin. A. An observation on 5/14/2025 at 7:05 AM revealed Nursing Assistant (NA) - F not wearing a mask while serving breakfast to residents in the main dining room. During an interview on 5/14/2025 at 7:10 AM Licensed Practical Nurse (LPN) - E confirmed that everyone has to be wearing a mask due to a COVID outbreak in the facility. During an observation on 5/14/2025 at 8:05 AM of resident cares in a resident's room Medication Aide (MA) - B took down (gender) mask when speaking. During an interview on 5/14/25 at 8:10 AM MA - B confirmed that (gender) should not have taken down (gender) mask when speaking during cares. An observation on 5/14/2025 at 12:24 PM revealed MA - D with mask under (gender) chin. Interview on 5/14/2025 at 12:25 PM MA - D confirmed that the mask should be above (gender) nose and below (gender) chin covering mouth and nose. During an interview on 5/14/2025 at 12:29 PM the Director of Nursing (DON) confirmed that all staff need to be wearing a mask during a COVID outbreak and that masks should be worn over the nose and below the chin. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/2025 at 2:47 PM the Infection Preventionist confirmed that masks were supposed to be worn above the nose and below the chin. B. An observation on 5/14/2025 at 8:05 AM revealed MA - B removed the bed linens off the residents bed and carried them against (gender) uniform down the hall to the laundry room. During an interview on 5/14/25 at 8:10 AM MA - B confirmed that (gender) should have used a plastic bag to put the dirty laundry in to take to the laundry room and should not of been held against the uniform. During an interview on 5/14/2025 at 12:29 PM the DON confirmed that dirty linens should not be touching any uniforms and should be in a plastic bag when transporting them in the hallway. C. During an observation on 5/14/2025 at 9:14 AM MA - B brought breakfast dishes out of a COVID positive resident room and placed them in the dining room on the table/counter. During an interview on 5/14/2025 at 12:29 PM the DON confirmed that reusable dishes coming out of a COVID room should not be placed in the resident dining room near other food and drink.