STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285141	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birch at Sutherland	333 Maple Street Sutherland, NE 69165

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Licensure Reference Number 175 NAC 12--006.04(F)(i)(5) Based on record reviews and interview, the facility failed to notify the physician of ongoing pain for 1 (Resident 3) of 3 sampled residents. The facility identified a census of 45. Findings are: A record review of an undated facility policy, Notification of Changes, revealed the facility must inform the resident's physician when there are circumstances that require a need to alter treatment or require a new treatment. A record review of a facility policy, Pain Management with a date of 4/1/2024, revealed if assessment findings of a resident's pain indicate the resident's pain is not adequately controlled, staff will notify the physician to consider a revision of the resident's pain regimen. A record review of an admission Record indicated the facility admitted Resident 3 on 1/22/2021. Resident 3 had diagnoses of cognitive communication deficit (difficulties in communication skills), dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), transient ischemic attack (TIA, a mini stroke), and a history of a hip joint replacement. A record review of Resident 3's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 3/5/2025 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 9/15, which indicated Resident 3 had moderate cognitive impairment. The MDS also revealed Resident 3 had received a PRN (as needed) medication and non-pharmacological interventions for pain in the last 5 days. A pain assessment was conducted with Resident 3 and revealed Resident 3 had moderate pain over the last 5 days but was unable to answer how often the pain occurred and whether the pain had interfered with their sleep, therapy activities, or day-to-day activities. It also revealed Resident 3 had displayed indications of pain or possible of non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movement or postures daily within the past 5 days of the assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 3's Care Plan revealed a focus area for pain which was last revised date on 3/26/2025. The focus area revealed Resident 3 was at risk for pain due to poor dentition (teeth conditions) and a recent hip surgery. Resident 3's goals for pain were to not have moderate or severe pain through the next review date and pain to be relieved within a timely manner of receiving pain medications or treatment. An intervention to evaluate the effectiveness of treatment and record/report to the physician any pain that is not at or below the resident's acceptable level of pain had been implemented. A record review of Resident 3's Order Summary Report with an active orders date of 4/8/2025 revealed the following orders: - Tylenol (Acetaminophen) 325 milligrams (mg) with instructions to give two tablets by mouth every six hours as needed for moderate pain with a start date of 1/22/2021. - Tramadol (a pain medication) 50 mg with instructions to give one tablet every eight hours as needed for pain management with a start date of 3/1/2025. A record review of Resident 3's Progress Notes from 3/8/2025-4/6/2025 revealed the following: - On 3/8/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 3/9/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. Additionally, Resident 3 had been documented as continuing to display non-verbal indications of pain following their administration of PRN (as needed) Tramadol. - On 3/10/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 3/11/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 3/13/2025, Resident 3 had a residual pain of 6/10 following the administration of their PRN Tramadol. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/14/2025, Resident 3's PRN tramadol had been documented as ineffective with a residual pain level of 5/10. - On 3/17/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 3/20/205, PRN Tramadol had been documented as ineffective with a residual pain rating of 7/10. A physician had been notified of Resident 3's behavior, but there was no evidence that pain management had been discussed with the physician at this time. Later, Resident 3's PRN Tramadol and PRN Tylenol had been documented as ineffective with a residual pain rating of 10/10. - On 3/21/2025, Resident 3 had a residual pain of 7/10 following the administration of their PRN Tramadol. Additionally, Resident 3 had been document as having moderate pain after the administration of prescribed pain medications. - On 3/24/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 3/26/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. A Physician's Assistant had been in the facility and had evaluated Resident 3. There was no evidence staff had notified the Physician's Assistant of Resident 3's pain. - On 3/27/2025, Resident 3 had been documented as having severe pain after the administration of prescribed pain medications. - On 3/30/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. - On 4/4/2025, Resident 3 had been documented as having moderate pain after the administration of prescribed pain medications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-

On 4/6/2025, Resident 3 had a residual pain of 6/10 following the administration of their PRN Tramadol

A record review of Resident 3's medical record revealed no evidence the facility had notified the physician of Resident 3's pain between 3/6/2025-3/18/2025 or after 3/18/2025.

An interview on 4/9/25 at 10:55 AM with Registered Nurse (RN)-A revealed moderate pain is considered to be rated at a 4-6/10 and severe pain rated at a 7-10/10. RN-B revealed if a resident rated their pain or was found to have indications of pain at a moderate level after a PRN had been administered, RN-B would not consider the PRN medication to have been effective and additional interventions should be implemented and documented. If these do not resolve the pain, the physician should be called at that time. If the resident rated their pain or was found to have indications of pain at a severe level at the PRN follow-up, RN-B would not consider the PRN medication to have been effective and the physician should be called at that time for additional orders.

An interview on 4/9/2025 at 11:30 with the Director of Nursing (DON) confirmed Resident 3's physician should have been notified prior to 3/18/2025 and again after 3/20/2025 of their ineffective pain management regimen.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Licensure Reference 175 NAC 12-006.09(E) Based on record review and interview, the facility failed to develop and implement a comprehensive care plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) regarding pain for 1 (Resident 1) of 3 sampled residents. The facility identified a census of 45. Findings are: A record review of a facility policy, Comprehensive Care Plans with a date of 4/1/2024, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified on the resident's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems). Additionally, the policy revealed all Care Assessment Areas (CAAs) triggered by the MDS will be considered when developing the plan of care. A record review of an admission Record indicated the facility admitted Resident 1 on 2/25/2025. Resident 1 had diagnoses of a history of stroke with paralysis to their right side, chronic pain syndrome, a history of opioid (narcotic pain medication) abuse, anxiety, and depression. A record review of Resident 1's admission MDS with an Assessment Reference Date of 2/28/2025 revealed Resident 1 had received scheduled pain medication, PRN (as needed) medication, and non-pharmacological interventions for pain within the last 5 days. A Pain Assessment Interview was conducted with Resident 1 and revealed Resident 1 had occasional pain within the last 5 days that occasionally interfered with their sleep, rarely affected their therapy sessions, and frequently limited their day-to-day activities. Resident 1 had rated their pain at a 8/10. The CAA Summary revealed the Pain Care Area had been triggered. A record review of Resident 1's Care Plan revealed no focus care area for pain as of 4/8/2025. An interview on 4/9/225 at 10:55 AM with Registered Nurse (RN) - A revealed RN-A would utilize a resident's care plan to know what interventions are effective for resident's pain. An interview on 4/6/2025 at 12:30 PM with the Director of Nursing (DON) confirmed Resident 1's CCP did not include a focus area of pain until today (4/9/2025) and should have due to their diagnoses and ongoing pain since their admission.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Licensure Reference Number 175 NAC 12-006.09(H) Based on record reviews and interviews, the facility failed to assess non-verbal indications of pain, and implement, monitor and revise interventions to manage pain for 1 (Resident 3) of 3 sampled residents. The facility identified a census of 45. Findings are: A record review of a facility policy, Pain Management with a date of 4/1/2024, revealed the following: -To help a resident attain or maintain their highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will. -Recognize when the resident is experiencing pain or activities where the resident may experience pain. -Assess resident for pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. change in behavior, new pain, or an exacerbation of pain). -Manage or prevent pain, consistent with the resident's comprehensive assessment (Minimum Data Set) and care plan (a document outlining a person's healthcare or personal care needs, their medical history, expected outcomes, and the care and support they will receive), current professional standards of practice, and the resident's goals and preferences. -Staff will observe for nonverbal indicators of pain which may indicate the presence of pain, such as increased or recurring restlessness, facial expressions, behaviors (such as resisting care, distressed pacing, irritability), difficulty eating or loss of appetite, weight loss, or negative vocalization (such as groaning, crying, whimpering, screaming). -An assessment of pain should include: -A history of pain and its treatment [including pharmacological (treatments involving medications) and non-pharmacological (treatments to involving medications)] -Key characteristics of the pain (duration, frequency, location, timing, pattern (constant or intermittent), radiation of pain, descriptors (stabbing, aching), what exacerbates the pain, what reduces the pain, the impact of pain on quality of life, current medication regimen, and the resident's goal for pain management. -Based upon assessment of the pain, the facility, in collaboration with the physician and the resident or their representative, will develop, implement, monitor and revise the resident's interventions to prevent or manage each resident's pain beginning at admission. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Staff will reassess the effectiveness of the resident's pain management at established intervals. If the re-assessment findings indicate the resident's pain is not adequately controlled, staff will notify the physician to consider a revision of the resident's pain regimen and will update the resident's care plan with other interventions. A record review of an admission Record indicated the facility admitted Resident 3 on 1/22/2021. Resident 3 had diagnoses of cognitive communication deficit (difficulties in communication skills), dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), transient ischemic attack (TIA, a mini stroke), and a history of a hip joint replacement. A record review of Resident 3's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 3/5/2025 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 9/15, which indicated Resident 3 had moderate cognitive impairment. The MDS also revealed Resident 3 had received a PRN (as needed) medication and non-pharmacological interventions for pain in the last 5 days. A pain assessment was conducted with Resident 3 and revealed Resident 3 had moderate pain over the last 5 days but was unable to answer how often the pain occurred and whether the pain had interfered with their sleep, therapy activities, or day-to-day activities. It also revealed Resident 3 had displayed indications of pain or possible of non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movement or postures daily within the past 5 days of the assessment. Resident 3 received an opioid (narcotic pain medication) within the last 7 days of the assessment. Additionally, the MDS revealed Resident 3 had displayed physical and verbal behaviors towards other 1-3 days and had not exhibited any behaviors of rejection of care within the last 7 days of the assessment. A record review of Resident 3's Care Plan revealed a focus area for pain which was last revised on 3/26/2025. The focus area revealed Resident 3 was at risk for pain due to poor dentition (teeth conditions) and a recent hip surgery. Resident 3's goals for pain were to not have moderate or severe pain through the next review date and pain to be relieved within a timely manner of receiving pain medications or treatment. Resident 3's interventions for pain were as follows: -Administer pain medications and treatments as ordered by the physician and when requested. -Monitor for side effects of pain medication. -Attempt non-pharmacological pain interventions of massage, repositioning, peaceful environment, aroma therapy music, etc. -Evaluate the effectiveness of treatment or medication in a timely manner after administration. Record and report to the physician any pain that is not at or below the resident's acceptable level of pain. -Report to the nurse any changes of sleep, weight loss, withdrawal from activities or relationships, decrease in physical activity or changes in mood/emotions. An additional record review of Resident 3's Care Plan revealed the following: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-As of 3/26/2025, Resident 3 was at risk for a decline in their Activities of Daily Living (ADLs) and at risk for falls due to their pain. -As of 4/18/2024, Resident 3 was at risk of skin breakdown on their feet due to their diabetes with a goal that Resident 3 will experience no foot pain over the next 3 months. -As of 3/26/2025, Resident 3 had a pressure ulcer and was at risk for pain with a goal for Resident 3's pain to be at or below their acceptable level of pain and have no non-verbal indicators of pain throughout the next review date. An intervention to repositioning Resident 3 and administer pain medication as needed for discomfort or pain and prior to dressing changes had been implemented. A record review of Resident 3's Order Summary Report with an active orders' date of 4/8/2025 revealed the following orders: -Assess for pain, document using the numerical scale if verbal or PAINAD (Pain Assessment in Advanced Dementia, a scale used to assess pain in people with advanced dementia or who are unable to communicate their pain verbally) if nonverbal, and document any non-pharmacological interventions implemented. This order had a start date of 11/5/2024. -Apply Polar Ice Machine as needed for pain management with a start date of 3/1/2025. -Tylenol (Acetaminophen) 325 milligrams (mg) with instructions to give two tablets by mouth every six hours as needed for moderate pain with a start date of 1/22/2021. -Tramadol (a pain medication) 50 mg with instructions to give one tablet every eight hours as needed for pain management with a start date of 3/1/2025. -Ativan (a sedative medication) 0.5 mg with instruction to give every six hours as needed for anxiety with a start date of 3/20/2025. -Seroquel (an antipsychotic medication used to manage psychosis and its symptoms, such as delusions, hallucinations, and disorganized thinking) 12.5 mg with direction to give by mouth three times a day for dementia with behavioral disturbances. -Zoloft (an antidepressant) 50 mg with instructions to give 50 mg by mouth one time a day for anxiety with a start date of 4/2/2025. A record review of Resident 3's Progress Notes and Medication Administration Record (MAR) / Treatment Administration Record (TAR) from 3/1/2025 revealed the following: -Progress Notes revealed Resident 3 had returned to the facility after a hospitalization for a left hip fracture and surgical repair. -The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented on dayshift as Resident 3 having a pain level of 9 and no evidence non-pharmacological interventions had been implemented. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-There was no evidence non-pharmacological interventions had been implemented for Resident 9's pain in the Progress Notes. A record review of Resident 3's Progress Notes from 3/5/2025 revealed Resident 3 had moderate pain after the administration of prescribed pain medication. There was no evidence further interventions had been implemented. A record review of Resident 3's Progress Notes and MAR/TAR from 3/6/2025 revealed the following: -The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented on dayshift as Resident 3 having a pain level of 6/10 and no non-pharmacological interventions had been implemented. -The MAR revealed the order for Tylenol 325 mg had been administered at 9:03 AM for a pain level of 6/10. The documented follow-up revealed it had been ineffective. -The MAR revealed the order for Tramadol 50 mg had been administered at 5:52 PM for a pain level of 5/10. The documented follow up revealed it had been ineffective. -The Progress Notes revealed no evidence non-pharmacological interventions had been implemented during dayshift for Resident 3's pain. -The Progress Notes also revealed Resident 3's physician had been contacted for additional pain medication but there was no evidence a new order had been received. A record review of Resident 3's Progress Notes from 3/7/2025 revealed a response from Resident 3's physician had been received but there was no evidence a new order had been obtained for Resident 3's pain. A record review of Resident 3's Progress Notes and MAR/TAR from 3/8/2025 revealed the following: -A Progress Note from 9:28 AM revealed Resident 3 had moderate pain after the administration of prescribed pain medication. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual moderate pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 3/9/2025 revealed the following: -A Progress Note from 2:12 PM revealed Resident 3 had moderate pain after the administration of prescribed pain medications. -A Progress Note from 5:29 PM revealed Resident 3 had been administered PRN Tramadol due to exhibiting pain gestures to their left hip. -A Progress Note from 10:16 PM revealed the PRN Tramadol had been effective, with a residual pain rating of 5/10, but Resident 3 continued to flinch with pain during repositioning. There was no evidence additional interventions had been implemented. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual moderate pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 3/10/2025 revealed the following: -A Progress Note from 3:25 AM revealed Resident 3 had moderate pain after the administration of prescribed pain medication. There was no evidence that additional interventions had been implemented following this. -A Progress Note from 3:10 PM revealed Resident 3 had been evaluated by a healthcare practitioner and had no new orders. There was no evidence that pain management concerns had been discussed with the healthcare practitioner by staff. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual moderate pain but had not been administered. A record review of Resident 3's Healthcare Practitioner's documentation from their visit on 3/10/2025 revealed Resident 3 had denied pain to the Healthcare Practitioner. There was no evidence that the staff had brought forth concerns of pain management with the Healthcare Practitioner. A record review of Resident 3's Progress Notes and MAR/TAR from 3/11/2025 revealed the following: -A Progress Note from 4:06 AM revealed Resident 3 had moderate pain after the administration of prescribed pain medications. -A Progress Note from 7:41 AM revealed a PRN Tramadol follow up that had been documented as effective but Resident 3 had a residual follow up pain rating of 5/10. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual moderate pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 3/13/2025 revealed the following: -A Progress Note from 7:41 AM revealed a PRN Tramadol follow up that had been documented as effective but Resident 3 had a residual follow up pain rating of 6/10. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual pain but had not been administered. A record review of Resident 3's Progress Notes from 3/14/2025 at 8:59 AM revealed PRN Tramadol for Resident 3 had been ineffective with a residual pain level rating of 5/10. A record review of Resident 3's Progress Notes and MAR/TAR from 3/17/2025 revealed the following: -A Progress Note from 1:54 AM revealed Resident 3 had moderate pain after the administration of prescribed pain medications. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-A Progress Note from 1:38 PM revealed Resident 3 had mild pain after the administration of prescribed pain medications. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual pain but had not been administered. A record review of Resident 3's medical record revealed no evidence additional attempts to address Resident 3's pain management with their physician between 3/6/2025 and 3/17/2025 had been made. A record review of Resident 3's Progress Notes and MAR/TAR from 3/18/2025 revealed the following: -A Progress Note from 8:35 AM revealed a PRN Tramadol follow up that had been documented as effective but Resident 3 had a residual follow up pain rating of 5/10. There was no evidence of additional interventions for Resident 3's residual pain. -A Progress Note from 11:17 AM revealed staff had sent a fax to Resident 3's physician requesting alternative pain medication for increased pain. The physician responded that the resident pain was managed by Resident 3's orthopedic physician. Staff had refaxed the request to Resident 3's orthopedic physician. -The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented on dayshift as Resident 3 having a pain level of 5/10 and no non-pharmacological interventions had been implemented. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual pain but had not been administered. A record review of Resident 3's medical record revealed no evidence the facility had received a response from their request for a pain medication alternative for Resident 3 from their orthopedic physician or additional attempts had been made to obtain the alternative. A record review of Resident 3's Progress Notes and MAR/TAR from 3/20/2025 revealed the following: -A Progress Note from 10:26 AM revealed a PRN Tramadol follow up that had been documented as ineffective with a residual pain rating of 7/10. There was no evidence of additional interventions for Resident 3's residual pain. -A Progress Note from 5:52 PM revealed Resident 3 had been grabbing other residents and scratching and grabbing at the Nurse Aides (NA). Resident 3 had also hit the NA twice when the NA had put a pillow between their legs. -A Progress Note from 7:01 PM revealed PRN Tylenol had been administered to Resident 3. -A Progress Note from 7:38 PM revealed Resident 3 had been combative and refused cares. The nurse had attempted to talk with Resident 3 and Resident 3 had yelled to go away. The physician had been contacted and an order for Ativan (a sedative medication) had been obtained for every six hours as needed. There was no evidence that the staff had addressed Resident 3's pain with the physician at this time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Birch at Sutherland	333 Maple Street Sutherland, NE 69165

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-A Progress Note from 7:46 PM revealed a PRN Tramadol and PRN Tylenol follow up had been documented as ineffective with a residual pain rating of 10/10. There was no evidence of additional interventions for Resident 3's residual pain. -The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented for day and night shift that Resident 3 had no pain, and no non-pharmacological interventions had been implemented. -The MAR revealed Resident 3's PRN Tylenol had only been administered once, at 7:01PM, but could have been administered every six hours as needed but was not. -There was no evidence Resident 3's physician had been notified regarding Resident 3's pain. A record review of Resident 3's Progress Notes and MAR/TAR from 3/21/2025 revealed the following: -The MAR revealed Resident 3 had been administered PRN Tramadol and PRN Ativan. -A Progress Note from 9:10 AM revealed a PRN Tramadol follow up had been documented as effective with a residual pain rating of 7/10. -A Progress Note from 3:10 PM revealed a nurse from Resident 3's physician's office had called for an update regarding Resident 3's behaviors. The nurse informed regarding the PRN Ativan order that had been obtained due to Resident 3's increase in agitation and combativeness. An order for Seroquel had been received. There was no evidence the facility had addressed concerns of Resident 3's pain and ineffective results with the physician's nurse at this time. -A Progress Note from 4:56 PM revealed Resident 3 had moderate pain after the administration of prescribed pain medications. A record review of Resident 3's Progress Notes from 3/22/2025 at 1:07 PM revealed Resident 3 had grabbed another resident and had been redirected. There was no evidence Resident 3 had been assessed for pain. A record review of Resident 3's Progress Notes and MAR/TAR from 3/24/2025 revealed the following: -A Progress Note from 3:30 PM revealed Resident 3 had moderate pain after the administration of prescribed pain medications. -The MAR revealed Resident 3 Resident 3 had available PRN Tramadol and PRN Tylenol that could have been administered for Resident 3's pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 3/26/2025 revealed the following: -A Progress Note from 10:37 AM revealed Resident 3 had been screaming and began to have a panic attack when staff had attempted to apply a pillow boot to their left foot to assist with their pressure sore. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-A Progress Note from 11:55 AM revealed Resident 3 had been restless, anxious, and yelling out despite multiple attempts to redirect, food, snack, toileting, and music had been offered. PRN pain medications and anxiety medications had been administered with little effectiveness and continued to have moderate pain after the administration of prescribed pain medication. -A Progress Note from 12:51 PM revealed a Physician's Assistant had been in the facility completing rounds and had evaluated Resident 3. There was no evidence staff had addressed Resident 3's pain with the Physician's Assistant during the rounds. -The MAR revealed Resident 3 had been administered PRN Tramadol at 11:01 AM for pain of 5/10 and PRN Ativan. A record review of Resident 3's Progress Notes and MAR/TAR from 3/27/2025 revealed the following: -A Progress Note from 1:26 PM revealed Resident 3 had been having verbal outbursts and facial grimacing after working with therapy. PRN Pain medication had been administered. -A Progress Note from 4:12 PM revealed Resident 3 had severe pain after the administration of prescribed pain medication. -The MAR revealed Resident 3's PRN Tramadol was last administered at 7:16 AM and could have been administered at 4:12 PM for Resident 3's severe pain but had not been administered. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual severe pain but had not been administered. -There was no evidence that Resident 3's physician had been notified of Resident 3's severe pain continuance after the administration of prescribed pain medications. A record review of Resident 3's Progress Notes and MAR/TAR from 3/30/2025 revealed the following: -A Progress Note from 3:16 PM revealed Resident 3 had moderate pain after the administration of prescribed pain medication. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual moderate pain but had not been administered. -A Progress Note from 10:54 PM revealed Resident 3 had been noted to fake cry and yell at the staff. Resident 3 had demanded staff take them back to their room and be laid down in bed immediately follow supper meal. There was no evidence Resident 3 had been assessed for pain. A record review of Resident 3's Progress Notes and MAR/TAR from 4/1/2025 revealed the following: -A Progress Note revealed new orders to increase Resident 3's Seroquel to 12.5 mg from twice a day to three times a day and add Zoloft 50 mg daily. -A Progress Note at 7:33 PM revealed a PRN Tramadol follow up had been documented as effective but Resident 3 had a residual pain level of 5/10. There was no evidence of additional interventions. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented for day shift that Resident 3 had a 5/10 pain and no non-pharmacological interventions had been implemented. -The MAR revealed Resident 3 had an available PRN Tylenol that could have been administered for Resident 3's residual severe pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 4/3/2025 revealed the following: -A Progress Note from 11:13 PM revealed Resident complains of pain. There was no evidence of interventions for Resident 3's pain. -The MAR revealed Resident 3 had an available PRN Tylenol and PRN Tramadol could have been administered for Resident 3's pain but had not been administered. -The MAR/TAR revealed the order to assess pain, document the rating, and document any non-pharmacological interventions had been documented for night that Resident 3 had a 0/10 pain, and no non-pharmacological interventions had been implemented. A record review of Resident 3's Progress Notes and MAR/TAR from 4/4/2025 revealed the following: -A Progress Note from 4:16 PM revealed Resident 3 had moderate pain after the administration of prescribed pain medication. -The MAR revealed Resident 3 had an available PRN Tylenol could have been administered for Resident 3's residual moderate pain but had not been administered. A record review of Resident 3's Progress Notes and MAR/TAR from 4/6/2025 revealed the following: -A Progress Note from 7:14 AM revealed Resident 3 had been exhibiting behaviors. -A Progress Note from 8:59 AM revealed Resident 3's PRN Tramadol follow up had been documented as effective but had a residual pain level of 6/10. A record review of Resident 3's medical record revealed no evidence the facility had attempted to contact Resident 3's physician again after 3/18/2025 about Resident 3's pain medication regimen as of 4/9/2025. An interview on 4/9/25 at 10:50 AM with NA-B revealed Resident 3's pain appeared to be severe, especially 2-3 weeks ago, stating that Resident 3 could barely be moved or touched due to their pain. NA-B revealed they would assist Resident 3 with laying down, repositioning, and medication, but those interventions only seemed to help some. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview on 4/9/25 at 10:55 AM with Registered Nurse (RN)-A revealed moderate pain is considered to be rated at a 4-6/10 and severe pain rated at a 7-10/10. RN-B revealed if a resident's PRN medication is not available to be administered, non-pharmacological interventions should be implemented and documented. If the resident rated their pain or was found to have indications of pain at a moderate level at the PRN follow-up, RN-B would not consider the PRN medication to have been effective and additional interventions should be implemented and documented. If these do not resolve the pain, the physician should be called at that time. If the resident rated their pain or was found to have indications of pain at a severe level at the PRN follow-up, RN-B would not consider the PRN medication to have been effective and the physician should be called at that time for additional orders. Additionally, RN-B revealed Resident 3 has frequent pain and frequently sits in the hall and yells. An interview on 4/9/2025 at 11:30 with the Director of Nursing (DON) revealed verbal residents are assessed for pain by the nurse asking assessment questions, such as a description of the pain, location, what makes it worse, what makes it better, and level of severity. If the resident is non-verbal, the nurse would assess the resident visually for non-verbal indications of pain, such as restlessness, agitation, tearfulness, frowning, wincing or other behaviors and utilize the PAINAD scale. Residents are assessed at least once a shift and as needed. If a resident is experiencing pain, but it is too early to administer another PRN or one is not available, non-pharmacological interventions should be utilized and documented. The interview also revealed the following: -Resident 3's physician was faxed on 3/18/2025 for concerns regarding pain management, but the facility did not receive a response. There was no evidence staff had attempted to contact the physician again or was brought to the rounding providers attention to address regarding concerns of pain management effectiveness. The DON revealed they would have expected staff to follow up a day or two after if there was no response by telephone. - Confirmed on 3/1/2025 and 3/5/2025 there was no evidence of non-pharmacological interventions for Resident 9's pain had been implemented and should have been. - Confirmed on 3/6/2025 PRN Tramadol and Tylenol had been documented as ineffective and there was no evidence non-pharmacological interventions had been implemented and should have been. - Confirmed on 3/8/2025, Resident 3 had PRN Tylenol available and should have been administered it for their moderate pain. - Confirmed on 3/9/2025, Resident 3 had PRN Tylenol available and should have been administered it for their moderate pain. Additionally, Resident 3's PRN Tramadol would not have been considered effective due to Resident 3 still displaying non-verbal indications of pain. - Confirmed on 3/10/2025, Resident 3 had PRN Tylenol available and should have been administered it for their moderate pain. - Confirmed on 3/11/2025, Resident 3 had PRN Tylenol available and should have been administered it for their residual pain following their PRN Tramadol. - Confirmed on 3/13/2025 Resident 3 had PRN Tylenol available and should have been administered it for their residual pain following their PRN Tramadol. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- The DON also confirmed that staff should have reached out to the Resident 3's physician prior to 3/13/2025 to address Resident 3's pain medication regimen being ineffective. - Confirmed on 3/17/2025, Resident 3's PRN Tramadol pain follow up was documented as 7/10, which would have not been considered as effective due to continuance of severe pain. Resident 3 had PRN Tylenol available and should have been administered it for their residual pain following their PRN Tramadol. - Confirmed on 3/18/2025, Resident 3's had PRN Tylenol available that should have been administered and/or non-pharmacological interventions been attempted. - Confirmed on 3/20/2025, Resident 3's PRN Tramadol and PRN Tylenol had been documented as ineffective and there had been no evidence additional interventions had been implemented. - Confirmed on 3/21/2025, Resident 3's follow-up PRN Tramadol w this would not have been considered effective due to continuance of severe pain. Resident 3 had PRN Tylenol available and should have been administered it for their severe pain. - Confirmed on 3/24/2025, Resident 3 had PRN Tylenol available that should have been administered for Resident 3's moderate pain. - Confirmed on 3/26/2025 there was no evidence the staff had addressed Resident 3's ineffective pain management with the rounding physician. - Confirmed on 3/27/2025, Resident 3 had PRN Tylenol available that should have been administered for Resident 3's severe pain. - Confirmed on 3/30/2025, Resident 3 had PRN Tylenol available and should have been administered it. Additionally, Resident 3 should have been assessed for pain due to their behaviors. - Confirmed on 4/3/2025, there was no evidence of pharmacological or non-pharmacological interventions and should have been implemented for Resident 3's pain. - Confirmed on 4/1/2025, there had been no evidence of non-pharmacological or other interventions implemented and should have been. Resident 3 had PRN Tylenol available and should have been administered it. - Confirmed on 4/3/2025, Resident 3 had been decumulated as having complaints of pain, but there was no evidence of interventions for Resident 3's pain and PRN Tylenol and PRN Tramadol had been available and should have been administered. - Confirmed on 4/4/2025, Resident 3 had PRN Tylenol available and should have been administered it for their residual moderate pain. - Confirmed on 4/6/2025 Resident 3's PRN Tramadol would not have been considered as effective. Additionally, confirmed Resident 3's behaviors could have been related to pain and should have been assessed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Confirmed Resident 3's pain management regimen had not been effective and should have been addressed with the physician. - The DON also confirmed Resident 3 had an increase in behaviors during this time and had the potential to be related to their uncontrolled pain.

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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. Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview, the facility failed to assess and evaluate underlying causes of behavior to prevent the unnecessary use of a psychotropic (medications that affect the mind, emotions, or behavior, often used to treat mental health disorders) medication for 1 (Resident 3) of 1 sampled resident. The facility identified a census of 45. Findings are: A record review of an undated facility policy Use of Psychotropic Medications revealed the following: -Psychotropic medication should only be used to treat the resident's medical symptoms -Underlying medical conditions should be identified and ruled out prior to initiating a psychotropic medication -Non-pharmacological interventions must be attempted to minimize the need for psychotropic medications. A record review of a facility policy, Pain Management with a date of 4/1/2024, revealed staff will observe nonverbal indicators of pain which may indicate the presence of pain, such as increased or recurring restlessness, facial expressions, behaviors (such as resisting care, distressed pacing, irritability), difficulty eating or loss of appetite, weight loss, or negative vocalization (such as groaning, crying, whimpering, screaming). A record review of an admission Record indicated the facility admitted Resident 3 on 1/22/2021. Resident 3 had diagnoses of cognitive communication deficit (difficulties in communication skills), dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior), transient ischemic attack (TIA, a mini stroke), and a history of a hip joint replacement. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 3's admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 3/5/2025 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 9/15, which indicated Resident 3 had moderate cognitive impairment. The MDS also revealed Resident 3 had received a PRN (as needed) medication and non-pharmacological interventions for pain in the last 5 days. A pain assessment was conducted with Resident 3 and revealed Resident 3 had moderate pain over the last 5 days but was unable to answer how often the pain occurred and whether the pain had interfered with their sleep, therapy activities, or day-to-day activities. It also revealed Resident 3 had displayed indications of pain or possible of non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movement or postures daily within the past 5 days of the assessment. Resident 3 received an opioid (narcotic pain medication) within the last 7 days of the assessment. Additionally, the MDS revealed Resident 3 had displayed physical and verbal behaviors towards other 1-3 days and had not exhibited any behaviors of rejection of care within the last 7 days of the assessment. A record review of Resident 3's Order Summary Report with an active orders date of 4/8/2025 revealed the following orders: -Ativan (a sedative medication) 0.5 mg with instruction to give every six hours as needed (PRN) for anxiety with a start date of 3/20/2025. -Seroquel (an antipsychotic medication used to manage psychosis and its symptoms, such as delusions, hallucinations, and disorganized thinking) 12.5 mg with direction to give by mouth three times a day for dementia with behavioral disturbances with a start date of 4/2/2025. -Zoloft (an antidepressant) 50 mg with instructions to give 50 mg by mouth one time a day for anxiety with a start date of 4/2/2025. A record review of Resident 3's Progress Notes from 3/20/2025 revealed: -At 10:26 AM, staff had re-evaluated effectiveness of Resident 3's PRN Tramadol. Resident had a follow-up pain rated at a 7/10. There was no evidence of additional interventions to address Resident 3's pain. -At 5:52 PM, Resident 3 had hit the Nurse Aide (NA) twice when the NA had attempted to place a pillow between the resident's legs. There was no evidence of non-pharmacological interventions attempted. -At 7:01 PM, Resident 3 had been administered PRN Tylenol and PRN Tramadol for pain. -At 7:38 PM, Resident 3 had been combative and resistive with cares. Resident 3 yelled at staff to go away. The on-call provider had been contacted and an order for PRN Ativan was obtained. There was no evidence staff had notified the on-call provider of Resident 3's pain. -At 7:46 PM, Resident 3 had rated their pain at a 10/10 following the administration of their PRN Tramadol and PRN Tylenol. Staff documented the medications as ineffective for Resident 3's pain. There was no evidence of additional pain interventions completed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 3's Progress Notes from 3/21/2025 revealed: -At 9:10 AM, Resident 3 had rated their pain a 7/10 after the administration of their PRN Tramadol. -At 3:09 PM, the nurse from Resident 3's physician requested an update regarding Resident 3's behaviors. This nurse had been informed about the PRN Ativan order received due to increased agitation and combativeness. An order to restart Resident 3's Seroquel had been obtained. There was no evidence staff had notified the physician's nurse of Resident 3's ongoing pain. A record review of Resident 3's Progress Notes from 3/23/2025 revealed Resident 3 had reported minimal pain and had been displaying behaviors of yelling and crying. There was no evidence that interventions had been attempted for the behaviors. A record review of Resident 3's Progress Notes from 3/26/2025 revealed Resident 3 had been restless and anxious. PRN pain and anxiety medication were administered with little effectiveness. A record review of Resident 3's Progress Notes from 3/27/2025 revealed Resident 3 had been displaying verbal outburst and facial grimacing. PRN pain medication had been administered and was effective. A record review of Resident 3's Progress Notes from 3/27/2025 revealed Resident 3 had been fake crying, yelling, and demanding to be laid down in their bed. There was no evidence of interventions that had been attempted for these behaviors. A record review of Resident 3's Progress Notes from 4/6/2025 revealed: -At 8:59 AM, Resident 3 had rated their pain at 6/10 following the administration of their PRN Tramadol. -At 11:12 AM and 9:35 PM, Resident 3 had been attempting to remove the pillow between their legs. An interview on 4/9/25 at 10:50 AM with NA-B revealed Resident 3's pain appeared to be severe, especially 2-3 weeks ago, stating that Resident 3 could barely be moved or touched due to their pain. NA-B revealed they would assist Resident 3 with laying down, repositioning, and medication, but those interventions only seemed to help some. An interview on 4/9/2025 at 11:30 with the Director of Nursing (DON) confirmed Resident 3 had an increase in behaviors during this time and had the potential to be related to their uncontrolled pain. The DON revealed it would have been expected of staff to assess Resident 3 when having behaviors, implement non-pharmacological interventions, notify the physician of ongoing pain, and confirmed no evidence these had been done.