STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of North Platte	2900 West E Street North Platte, NE 69101

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5) Based on record reviews and interviews, the facility failed to follow their bowel protocol to prevent constipation (a condition characterized by infrequent or difficult bowel movements, resulting in hard, dry, and difficult-to-pass stools) for 3 (Residents 9, 11, and 16) of 6 sampled residents. The facility identified a census of 56. Findings are: A record review of the facility's Bowel Movement Needs List with a date of 5/10/2023 revealed that the night shift nurse is to record all residents who have not had a bowel movement in the last 2, 3, 4, or 5 days and give this list to the next shift. Interventions, assessments, and results will be initiated and recorded by the day and night shift nurses. A record review of an undated facility document, Accura HealthCare Bowel Protocol revealed the following: - Day 3 - MiraLAX 17 grams (g) with morning medications and prune juice at breakfast. - Day 4 - Milk of Magnesia with morning medications. - Day 5 - rectal suppository in the morning - Fax primary care physician upon admission for orders of bowel protocol medications. A. A record review of an Admission Record revealed the facility admitted Resident 9 on 6/4/2024 and had diagnoses of chronic pain and non-infectious gastroenteritis and colitis (inflammation of the stomach and intestines that is not caused by an infection.) (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 9's quarterly 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 3/18/2025 revealed Resident 9 had a Brief Interview for Mental Status (BIMS, a brief screening that aids in detecting cognitive impairment) score of 15/15, which indicated Resident 9 was cognitively intact. Additionally, the MDS revealed Resident 9 was dependent for toileting and was frequently incontinent of bowel. A record review of Resident 9's Documentation Survey Report v2 (a report of past documentation that includes documented bowel movements) for January 2025- March 2025 revealed Resident 9 had no documented bowel movement on the following dates: - 1/19/2025-1/22/2025, which was 4 days without a bowel movement. - 2/23/2025-2/26/2025, which was 4 days without a bowel movement. - 2/28/2025-3/7/2025, which was 8 days without a bowel movement. A record review of Resident 9's Medication Administration Record (MAR) for January 2025 and February 2025 revealed no evidence of orders for constipation management. A record review of Resident 9's Medication Administration Record (MAR) for March 2025 revealed no evidence that constipation management orders had been placed until 3/24/2025. A record review of Resident 9's Progress Notes for January 2025 - March 2025 revealed no evidence that interventions had been implemented or that the physician had been contacted regarding Resident 9's constipation during 1/19/2025-1/22/2025, 2/23/2025-2/26/2025, or 2/28/2025-3/7/2025. An interview on 4/2/2025 at 10:45 AM with Registered Nurse (RN)-A revealed the facility's process for constipation management is the night shift nurse prints a report of what residents have not had a bowel movement for how many days and what interventions have been done and then places these on the medication carts for the day shift nurses, so the day shift nurses can implement the interventions. An interview on 4/2/2025 at 4:00 PM with the Administrator confirmed Resident 9 was in the facility on 1/19/2025-1/22/2025, 2/23/2025-2/26/2025, and 2/28/2025-37/7/2025 and had no evidence Resident 9 had had a bowel movement. An interview on 4/3/2025 at 8:10 AM with the Director of Nursing (DON) confirmed the facility had not implemented any intervention for Resident 9's constipation on 1/19/2025-1/22/2025, 2/23/2025-2/26/2025, and 2/28/2025-37/7/2025 and interventions should have been implemented per the facility's protocol. B. A record review of an Admission Record revealed the facility admitted Resident 11 on 2/14/2025. A record review of Resident 11's admission MDS with an ARD of 2/18/2025 revealed Resident 11 had a BIMS score of 5/15, which indicated Resident 11 had severe cognitive impairment. Additionally, the MDS revealed Resident 11 required supervision with toileting and was always continent of bowel. (continued on next page)

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	285165	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of North Platte	2900 West E Street North Platte, NE 69101

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 11's Care Plan Report revealed a focus area for Resident 11's pain with an initiated date of 2/14/2025. An intervention to monitor and document for side effects of pain medication, such as constipation, and report occurrences to the physician had been added. A record review of Resident 9's Documentation Survey Report v2 for February 2025- March 2025 revealed Resident 11 had no documented bowel movement on the following dates: - 2/19/2025-2/26/2025, which was 8 days without a bowel movement. - 3/10/2025-3/14/2025, which was 4 days without a bowel movement. - 3/23/2025-3/27/2025, which was 5 days without a bowel movement. A record review of Resident 9's Progress Notes from 2/19/2025-3/27/2025 revealed no evidence interventions for Resident 9's constipation had been implemented, or the physician had been notified of the constipation episodes. A record review of Resident 9's MAR for February 2025 revealed no evidence of orders for constipation management. A record review of Resident 9's MAR for March 2025 revealed MiraLAX and Milk of Magnesia were started on 3/11/2025 but had not been administered in the month of March 2025. An interview on 4/2/2025 at 4:00 PM with the Administrator confirmed Resident 11 was in the facility on 2/19/2025-2/26/2025, 3/10/2025-3/14/2025, and 3/23/2025-3/272025 and had no evidence Resident 11 had had a bowel movement. An interview on 4/3/2025 at 8:10 AM with the DON confirmed the facility had not implemented any intervention for Resident 11's constipation on 2/19/2025-2/26/2025, 3/10/2025-3/14/2025, or 3/23/2025-3/272025. The DON stated Resident 11 does ambulate unassisted to the bathroom, but would have expected the staff to implement the interventions per the facility protocol or follow up with Resident 11 and document a Progress Note. 49263 C. A record review of Resident 16's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 5/28/2025 revealed Resident 16 was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 4/15, which indicated the resident had severe cognitive impairment. The MDS also revealed that Resident 16 was always incontinent of their bowels and was dependent on staff for the provision of the toileting and personal hygiene. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 16's undated 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) revealed the resident was at risk for constipation related to decreased mobility and medication side effects. The resident had a goal to have a normal bowel movement at least every three days. There were interventions in place to administer laxative medications per physician's orders, to follow facility bowel protocol for bowel management, and to record the resident's bowel movement on the ADL (activities of daily living) flow record every shift. A record review of Resident 16's Bowel Task documentation for the month of January 2025 revealed the following dates with no bowel movements documented: -1/11/25 through 1/13/25; which was three days, -1/26/25 through 1/29/25; which was four days. A record review of Resident 16's Bowel Task documentation for the month of February 2025 revealed the following dates with no bowel movements documented: -2/4/25 through 2/7/25; which was four days, -2/9/25 through 2/14/25; which was six days, -2/17/25 through 2/23/25; which was seven days, and -2/26/25 through 2/28/25; which was three days. A record review of Resident 16's Bowel Task documentation for the month of March 2025 revealed the following dates with no bowel movements documented: -3/22/25 through 3/24/25; which was three days, -3/26/25 through 3/28/25; which was three days, and -3/30/25 through 4/1/25; which was three days. A record review of Resident 16's physician's orders revealed the following as needed bowel medication orders: -Polyethylene Glycol (Miralax) 17 grams once daily as needed for constipation, -Bisacodyl Suppository 10 milligrams (MG), insert 1 suppository rectally daily as needed for constipation. -Milk of Magnesia 30 milliliters (ML) twice daily as needed for constipation. A record review of Resident 16's Medication Administration Record (MAR) for January 2025 revealed none of the resident's as needed bowel medications had been administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 16's Medication Administration Record (MAR) for February 2025 revealed none of the resident's as needed bowel medications had been administered. A record review of Resident 16's Medication Administration Record (MAR) for March 2025 revealed none of the resident's as needed bowel medications had been administered. A record review of Resident 16's Progress Notes from January 1, 2025 through April 2, 2025 revealed no evidence of Resident 16's bowel status being assessed or of any as needed bowel medication administrations being attempted. An interview on 4/3/25 at 9:59 AM with the Director of Nursing (DON) revealed that the nurse aides document resident bowel movements in the Task section of their electronic medical records every shift. Each night, the nurse runs a report of resident who had not had a bowel movement, these reports are then given to the day shift staff that are working on the medication carts the following morning. It is then the day shift staff's responsibility to follow the facility's bowel protocol for each resident. The DON confirmed that for each of the timeframes when Resident 16 had not had a bowel movement documented for 3 or more days, there should have either been an as needed bowel medication given or documentation in the resident's progress notes regarding why an intervention was not implemented.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49766 Based on record reviews and interview, the facility failed to ensure the physician had documented a clinical rationale for not taking action regarding the pharmacist's identified medication irregularity as required of 1 (Resident 11) of 5 sampled residents. The facility identified a census of 56. Findings are: A record review of the facility's undated policy Medication Regimen Review Policies and Procedures defined Medication Regimen Review (MRR) as a thorough evaluation of the medication regimen of a resident by a consultant pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. Additionally, the policy revealed a report of the MRR with any irregularities will be sent to the Director of Nursing (DON), the Medical Director, and the Attending Physician. The policy did not include information regarding the response required by the Attending Physician when an irregularity had been identified by the pharmacist. A record review of an Admission Record revealed the facility admitted Resident 11 on 2/14/2025. A record review of Resident 11's Order Summary Report with a date of 4/2/2025 revealed the following orders: - Famotidine 40 milligrams (mg) with direction to take 1 tablet by mouth every bedtime for an indicated use of acid reducing. This medication was started on 3/10/2025. - Pantoprazole 40 mg with direction to take 1 tablet by mouth once daily for an indication for use of gastro-esophageal reflux disease (GERD, a chronic condition where stomach acid flows back up into the esophagus, causing symptoms like heartburn and regurgitation). This medication had a start date of 3/11/2025. Additional record review of Resident 11's Admission Record, under Diagnosis Information, revealed no evidence of diagnosed GERD or similar conditions. A record review of a Note To Attending Physician/Prescriber with a date of 2/21/2025 revealed the pharmacist identified Resident 11 had two orders for acid-suppressing medications: pantoprazole and famotidine. Additionally, the pharmacist wrote, This appears to be a duplication of therapy. Please provide the rationale for this resident requiring both Proton-pump inhibitor and H-2 blocker therapy for treatment of acid reflux. Alternatively, may consider discontinuing one of the two orders. On 3/6/2025, the Attending Physician wrote not right now without evidence of a clinical rationale for not taking action regarding the pharmacist's identified medication irregularity. An interview on 4/2/2025 at 11:15 AM with the DON confirmed the Attending Physician had not provided a clinical rationale for not taking action regarding the pharmacist's identified medication irregularity as required.