STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Estates of Kenesaw, LLC	100 West Elm Avenue Kenesaw, NE 68956

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613 Licensure Reference Number 175 NAC 12-006.09B Based on observation, record review and interview the facility failed to ensure accuracy of the Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) assessment for 2 (Residents 33 and 16) of 6 sampled residents related to Stage 2 pressure injury wounds (loss of partial thickness of the skin including epidermis and part of the superficial dermis) for (Resident 33) and for hospice services for (Resident 16). The facility census was 62. Findings are: A. A review of Resident 33's Admission Record revealed an admitted to the facility of 11/20/2020. A review of Resident 33's MDS dated [DATE] revealed that in Section C a Brief Interview for Mental Status (BIMS - a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 15 which suggests the resident is cognitively intact. In an interview on 07/29/24 at 2:17 PM with Resident 33 revealed Resident 33 reported having a sore on (gender) bottom and the sore had been there for a few months. A review of Resident 33's Comprehensive Careplan (CCP - written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) revealed: -Focus area date initiated 4/19/2021 and last revision date of 7/25/2024 revealed right lower posterior pressure injury area. An observation on 07/31/2024 at 8:35 AM of Resident 3's wound care to the left buttock with Licensed Practical Nurse (LPN)-C revealed a red opened area to left buttocks that was bleeding. In an interview on 7/31/2024 at 8:39 AM LPN-C reported that the sore was a pressure wound and that Resident 33 had the wound for a while. A review of Resident 33's MDS dated [DATE] revealed in Section M: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device not indicated. - Does this resident have one or more unhealed pressure ulcers/injuries? Answered as no. A review of Resident 33's Weekly Skin assessment dated [DATE] revealed two Stage 2 Pressure areas to the resident's left buttock. A review of the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual v1.18.11 dated October 2023 revealed: -if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer. -code 1, yes if the resident had any pressure ulcer/injury -pressure ulcer/injury should continue to be classified at the higher numerical stage until healed. In an interview on 07/31/24 at 4:05 PM the Administrator confirmed that Resident 33's Stage 2 pressure ulcer was not coded on the MDS dated [DATE] and should have been. 51122 B. A review of Resident 16's Admission Record revealed an admitted to the facility of 1/18/2022. Record review of Resident 16's Annual MDS dated [DATE] Section O, hospice was marked No. An interview on 7/31/2024 at 10:39 AM with the Hospice RN revealed the resident was admitted to their services on 7/19/2022. Review of Resident 16's physician orders revealed an order dated 7/19/2022 to admit resident to Hospice services. An interview on 7/31/2024 at 9:19 AM with the Director of Nursing (DON) confirmed the resident is on hospice. The DON stated the discrepancy was due to changes in MDS staffing during that time.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Licensure Reference Number 175 NAC 12-006.09(H)(v) Based on record review, interview and observation the facility failed to provide restorative therapy and an assistance device for contractures (abnormal shortening of muscle tissue making it highly resistant to stretching and eventually causing permanent disability) for 1 (Resident 58) of 3 sampled residents. The facility census was 62. Findings are: Record review of Resident 58's Admission Record revealed resident admitted to the facility on [DATE] with a diagnosis of Muscle Wasting and Atrophy, not elsewhere classified, unspecified site, Generalized Muscle Weakness, Hemiplegia (paralysis of one side of the body) and Hemiparesis (one-sided muscle weakness) following other nontraumatic intracranial hemorrhage (bleeding on the brain causing a stroke) affecting unspecified side. Record review of Resident 58's care plan with admitted [DATE] printed on 07/29/2024 revealed the following: -The resident had deficits in Activities of Daily Living related to Hemiplegia and Hemiparesis and needed one staff assistance for bathing, bed mobility, dressing, eating, mobility, and transfers. -Resident wears right hand splint, assisted by staff to apply daily and off at hour of sleep for contracted hand. An observation and interview with Resident 58 on 07/30/2024 at 2:32 PM revealed that they are unable to open contracted fingers on right hand, unable to move right wrist, and can extend elbow approximately 30 degrees. Resident 58 denied ever having any brace for right hand. An interview with COTA (Certified Occupational Therapy Assistant) on 07/31/2024 at 2:25 PM confirmed Resident 58 was not receiving any restorative therapy and that the therapy department was not aware of Resident 58's contractures. An interview with DON on 08/01/2024 at 9:01 AM confirmed that Resident 58 had limited range of motion to the right arm and had a contracture to the right hand and that an orthotic device was not provided to help reduce contractures. An interview with DON on 08/01/2024 at 10:42 AM confirmed that the facility does not have a restorative program for Resident 58. A record review of facility policy Restorative Nursing- Contracture Prevention and Management Program Original dated 5/14/2014 revealed: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assisting a resident/patient to attain and/or maintain joint mobility promotes independence, prevents or reduces contractures, preserves range of motion for use of prostheses, stimulated circulation and enhances muscle strengthening. A resident/patient requiring passive range of motion, active range of motion and/or splint/brace application and removal are considered for this restorative program. Restorative programs including range of motion and splint/brace application are provided by trained nursing assistants or licensed nurses. -Procedures #4. Review any recommendations from therapy on providing range of motion or splint/brace application. #5. Complete the nursing evaluation, Range of Motion Data Collection. #6. Develop the Restorative Program Plan and Summary with recommendations from the interdisciplinary team and the resident/patient and family responsible party.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51122 Licensure Reference Number 175 NAC 12-006.09(I) Based on observations, interviews, and record review, the facility failed to evaluate a Broda chair (a specialty wheelchair that can be used for positioning and can be placed in a reclining position with the foot rest up) for safety prior to use for 1(Resident 16) of 1 sampled resident. The facility staff identified a census of 62. Findings are: Record review of Resident 16's admission record revealed the resident was admitted to this facility on 1/18/22. Record review of Resident 16's physician orders dated 07/19/22 revealed the resident was placed on Hospice on 7/19/22 with a diagnosis of senile degeneration. Record review of Resident 16's annual Minimum Data Set (MDS) (a federally mandated assessment used to identify a resident's functional capabilities and health needs) with an Assessment Reference Date (ARD) of 7/9/2024, revealed under Section C, Resident 16's Cognitive Skills for Daily Decision Making are Moderately impaired. Section GG revealed the following: use of a wheelchair, transfers including bed to chair and toilet scored at a 2 which indicates substantial assistance. Section P under Restraints and Devices revealed no devices were marked for restraints or alarms. The quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 4/8/24, also revealed Resident 16's Cognitive Skills for Daily Decision Making are Moderately impaired. Record review of Resident 16's care plan with a last target date of 7/8/2024 revealed under the Focus problem: Resident has potential for falls related to (r/t) confusion, gait/balance problems, incontinence, unaware of safety needs as evidenced by history of falls with injuries. Gets out of bed at different times and is unsteady when first getting out of bed. Interventions are: -Anticipate and meet the resident's needs. Keep needed items, water, etc., in reach. Date initiated 01/26/2022. - Broda chair per Hospice due to unstable core daily. Date Initiated: 10/25/2023. An observation on 7/29/24 at 10:30 AM revealed Resident 16 was trying to climb out of a reclined Broda chair and calling out for help. Further observation on 7/29/2024 at 10:30 AM revealed facility staff at a desk did not intervene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A continuous observation from 07/29/24 at 2:09 PM until 2:44 PM revealed Resident 16 sitting in a Broda chair in the west dining room with several other residents gathered for a group activity at the table. The resident sat back several feet from the table, attempting to sit up but both legs were elevated due the wheelchair being reclined. Further observation on 7/29/2024 revealed the following: -At 2:11 PM the resident called out the daughter's name, also asking for someone to move the stuff out of the way so the resident could get up. The resident continued trying to sit up more in the chair, talking to the back of the person sitting in front of the resident. -At 2:15 PM the resident had both legs over the left side of the reclined Broda chair, still attempting to get someone's attention by talking. -At 2:18 PM the resident had both feet extenders of the wheelchair folded up, still talking loudly with no staff responding. -At 2:44 PM the resident yells, I can't go anywhere, and was still trying to get up out of the Broda chair. Resident then yelled, Does anyone want to help me? without staff responding. An observation on 07/29/24 at 3:50 PM revealed Resident 16 sitting in the Broda chair in an upright position and was pushed up to a table in the west dining room, the brakes were engaged on the Broda chair. Resident 16 was talking to them self and calling out. There were no staff in dining area to monitor Resident 16. An observation on 7/31/24 11:00 AM of Nurse Aide/Medication Aide F (NA/MA F) and Nurse Aide E (NA E) revealed Resident 16 was transferred from bed to the Broda chair to the toilet and then place back into the Broda chair. An interview on 7/31/2024 at 11:10 AM with NA E revealed Resident 16 had previously used a regular wheelchair but Resident 16 kept falling because (gender) frequently stood up from wheelchair. A continuous observation on 07/31/2024 from 1:34 PM until 1:54 PM revealed Resident 16 sitting in a reclined Broda chair in the [NAME] dining room calling out, Somebody help me. Further observation on 7/31/2024 at 1:34 PM revealed Resident 16's leg was extended up in the air, talking to self and was holding on to a foot. An observation on 7/31/24 at 3:02 PM revealed Resident 16 was in the [NAME] dining room trying to sit up in the reclined Broda chair. Staff sitting beside the resident did not set Resident 16 up in the Broda chair up to visit. An interview on 7/31/24 at 9:14 AM with the Registered Nurse with Hospice (Hospice RN) revealed that Resident 16 was admitted to their services on 7/19/22. Hospice RN reported when Resident 16 is in the Broda chair the recommendations are supervision, redirection and if needed antianxiety medications. Hospice RN also stated, If the resident had a regular wheelchair, (the resident) would try to get up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Licensed Practical Nurse (LPN) C on 7/31/24 at 12:20 PM revealed when asked about Resident 16's previous level of functioning, LPN C stated the resident used to walk with a walker. When the facility tried a wheelchair, the resident was falling out of it, so the facility had to go to the Broda chair right away. An interview on 07/31/24 at 1:46 PM was conducted with Resident 16's Family Member (FM). During the interview Resident 16's FM reported seeing Resident 16 flip around in the Broda chair with the residents head at the foot pedals and feet at the head area. An interview on 7/31/24 at 12:32 PM with the Director of Nursing (DON) revealed the following the Broda chair is being used to prevent falls and because Resident 16 has a weak core. The DON confirmed the facility had not evaluated Resident 16 for the use of the Broda chair. During the interview with the DON on 7/31/24 at 12:35 PM the Corporate Registered Nurse verbalized that maybe there should be an assessment by occupational therapy for the Broda chair.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42861 Licensure Reference Number 175 NAC 12-0006.09(H) Based on interviews and record reviews the facility failed to ensure non-pharmacological interventions were provided prior to administering the PRN (as needed) Xanax (a medication used to treat anxiety) for one (Resident 53) of 5 sampled residents. The facility identified a census of 62. Findings Are: A record review of the Admission Record ran on 7/30/24 revealed Resident 53 had been accepted into the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of Sepsis (an infection trigger inflammation throughout the body) and Pulmonary Embolism with Acute Cor Pulmonale (a blood clot gets stuck in an artery in the lung). A record review of the MDS (Minimum Data Set, a comprehensive assessment of each resident's physical and mental functional capabilities) dated 7/5/24, Section C, revealed Resident 53 had a BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function, while scores of 00 or 99 indicate total confusion) score of 15. A record review of current orders list ran on 07/30/24 at 02:20 PM revealed Resident 53 had the following orders; Alprazolam 0.5mg (milligrams) give 1 tab by mouth (po) twice (BID) daily as needed for anxiety or sleep (Related Diagnoses: Anxiety Disorder, Unspecified) Alprazolam 0.5mg 1 tab po three (TID) times daily as needed for sleep (Indications for Use: Anxiety/Insomnia) (Additional Directions: DNE (do not exceed): 3 tablets in 24 hour period) A record review of the running Comprehensive Care Plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) for Resident 53 revealed the following goal and interventions related to anxiety; -Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 06/13/2024. -Monitor/record/report to MD prn mood patterns s/sx (signs/symptoms) of depression, anxiety, sad mood as per facility behavior monitoring protocols. Date Initiated: 06/13/2024. A record review of the MAR (Medication Administration Record) dated July 2024 revealed Resident 53 had been given the PRN Xanax 54 times between 7/1/24 and 7/30/24 with no non-pharmacological interventions documented. (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 the Progress Notes dated 7/1/24 through 7/30/24 revealed no documentation of non-pharmacological interventions surrounding the PRN Xanax administration. An interview on 8/1/24 at 9:10 AM with the facility Administrator, after review of the MAR dated July 2024 for Resident 53, confirmed that the facility expectation was to attempt non-pharmacological interventions prior to administering the PRN Xanax and that no indications of non-pharmacological interventions existed for Resident 53 and should have. A record review of the facility policy titled Behavior Management, dated 5/2014, revealed the following guidance related to non-pharmacological interventions; -Non-pharmacological interventions are the first choice in management of behavioral symptoms, when possible.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51122 LICENSURE REFERENCE NUMBER NAC 175 ,d+[DATE].11(E) The facility failed to ensure foods were not outdated and were labeled to prevent the potential for food-borne illness for all 62 residents served out of the kitchen. The facility identified a census of 62. An observation on [DATE] from 8:35 AM to 9:15 AM during the initial kitchen tour revealed the following: - 5 bags of opened cereal on a metal cart that with no label or date on them. - The upright refrigerator with 12 half chicken salad sandwiches with no label or date, and Med Pass nutritional shake open without a date with the manufacturers label instructing to use within 4 days of opening. -The dry storage room with 1 can of dented mandarin oranges on the shelf for use, a large bag of taco seasoning open with no date, 1 container of chicken bouillon cubes with best by date of ,d+[DATE], and 1 bag of semi-sweet chocolate chips open with no date. -The walk in refrigerator with 1 plastic container of pears with a use by date of [DATE],and 1 plastic container of sliced jalapeno labeled with an open date of [DATE] and no use by date. An interview with the Dietary Supervisor (DS) on [DATE] at 9:10 AM confirmed the 12 half chicken salad sandwiches had not label or date, the can of mandarin oranges was dented and available for use, the taco seasoning had no open date, the chicken bouillon cubes were expired, the bag of chocolate chips had no open date, and the plastic containers of pears and jalapeno were expired. Record review of the Nutrition services manual: Sanitation: Storage- Dry Storage revealed: Number 8 states: Pour contents of open canned goods into plastic container with label and date and place into refrigerator storage. Dry goods may be placed in plastic bags and sealed or placed in plastic containers. Number 9 states: Follow expiration date for all packaged goods.