STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285212	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Manor Nursing Home	318 N 3rd Street Hay Springs, NE 69347

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC ,d+[DATE].04(F)(i)(5) Based on record reviews and interviews, the facility failed to notify the physician of a significant decline for 1 (Resident 45) of 1 sampled resident. The facility identified a census of 43. Findings are: A record review of a facility policy Notification of Changes with a last revised date of [DATE], under compliance guidelines, indicated the facility must inform the resident's physician within one hour of a change, such as a significant change in the resident's physical condition, such as deterioration or that require a need to alter treatment. A record review of Resident 45's Face Sheet revealed the facility admitted Resident 45 to the facility on [DATE] with Congestive Heart Failure and chronic respiratory failure. It also indicated Resident 45 was discharged due to death on [DATE]. A record review of Resident 45's Orders with a date of [DATE] revealed an order for continuous oxygen at night set at 2 liters per minute (LPM.) A record review of a Resident 45's Progress Notes with a date of [DATE] at 10:01 PM, written by Licensed Practical Nurse (LPN) - A revealed Resident 45 had not been feeling well. Resident 45 had been sitting in their recliner with their oxygen on at 2 LPM. LPN-A checked Resident 45's oxygen saturation and found it to be 73%. LPN-A increased Resident 45's oxygen to 3.5 LPM. The progress note states at 6:50 PM, two nurses got Resident 45 ready for bed and laid Resident 45 in their bed. At 7:15 PM, Resident 45 was found deceased . The progress note indicated the Assistant Director of Nursing (ADON), the Administrator, funeral home, priest, and family were notified. The progress note did not indicate the physician had been notified at any time during Resident 45's decline. A record review of Resident 45's chart revealed no evidence the physician had been notified of Resident 45's significant change of condition. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on [DATE] at 9:55 AM with LPN-A revealed on [DATE] around 3:30 PM Resident 45's family wanted Resident 45 to be checked on. LPN-A found Resident 45 to have their mouth open and breathing heavy. LPN-A confirmed the physician had not been notified on [DATE] of Resident 45's decline. An interview on [DATE] at 2:15 PM with the Assistant Director of Nursing confirmed the physician should have been notified of Resident 45's decline.

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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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference Number 175 NAC 12-006.09(B) Based on record reviews and interviews, the facility failed to ensure the accuracy of Minimum Data Sets (MDS - a federally mandated comprehensive assessment tool used for care planning) of Resident 16's Activities of Daily Living (ADLs) and Resident 10 and 27's anticoagulant use. This affected 3 of 12 sampled residents. The facility identified a census of 43. Findings are: A. A record review of the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual v1.18.11, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities with a date of October 2023 indicated functional status is based on the need for assistance when performing self-care and mobility activities and to record the resident's usual ability to perform these activities within the last 7 days. A record review of Resident 16's Progress Notes with a date of 5/31/2024 revealed Resident 16 required total assistance with dressing, grooming, oral cares, and toileting. Resident 16 required extensive assistance with eating. A record review of Resident 16's Progress Notes with a date of 6/1/2024 revealed Resident 16 required total assistance with all cares. It also indicated staff feed Resident 16 at both meals during this day. A record review of Resident 16's Progress Notes with a date of 6/2/2024 revealed Resident 16 required total assistance with dressing, grooming, bathing, and toileting and extensive assistance with eating this day. A record review of Resident 16's Progress Notes with a date of 6/3/2024 revealed Resident 16 required total assistance with dressing, grooming, bathing, and toileting and extensive assistance with eating this day. A record review of Resident 16's quarterly MDS with a date of 6/6/2024 indicated Resident 16 was independent with eating, oral hygiene, toileting, and bathing. It also indicated that Resident 16 required max assist with upper body dressing and partial assistance with lower body dressing. An interview on 9/24/2024 at 1:28 PM with the MDS Coordinator confirmed the ADL section of Resident 16's MDS were coded incorrectly and should have been coded as dependent, not independent. 45613 B. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual v1.18.11 dated October 2023 indicated to code aspirin under antiplatelet medication and warfarin or heparin under anticoagulant if the resident had taken within 7 days of the assessment. A record review of Resident 10's Admission Record revealed an original admitted to the facility of 6/19/2017. A record review of Resident 10's MDS dated [DATE] in Section N revealed the resident had been taking an anticoagulant and was not marked for taking an antiplatelet. A record review of Resident 10's Order Summary revealed an open ended order for Aspirin with a start date of 11/17/2022. A record review of Resident 10's CCP revealed an approach with a start date of 7/10/2020 that aspirin will be administered everyday. In an interview on 09/24/24 at 2:50 PM the MDS nurse confirmed that aspirin was coded as an anticoagulant, it was further confirmed that the RAI manual is used to ensure MDS accuracy. In an interview on 09/24/24 at 3:59 PM the ADM confirmed there was no MDS Policy, and that the RAI manual is used to confirm MDS accuracy. C. A record review of the MDS 3.0 Resident Assessment Instrument (RAI) User's Manual v1.18.11 dated October 2023 indicated to code aspirin under antiplatelet medication and warfarin or heparin under anticoagulant if the resident had taken within 7 days of the assessment. A record review of Resident 27's Admission Record revealed an admitted to the facility on [DATE]. A record review of Resident 27's MDS dated [DATE] in Section N revealed the resident had been taking an anticoagulant and was not marked for taking an antiplatelet. A record review of Resident 27's Order Summary revealed an open ended order for Aspirin with a start date of 1/11/2023. A record review of Resident 27's CCP revealed an approach with a start date of 11/28/2022 that medications will be administered as prescribed. In an interview on 09/24/24 at 2:50 PM the MDS nurse confirmed that aspirin was coded as an anticoagulant, it was further confirmed that the RAI manual is used to ensure MDS accuracy.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC 12- 006.09(F)(iii) Based on record reviews and interviews, the facility failed to ensure the comprehensive care plans (CCP-sets client goals, identifies activities or action steps needed to achieve these goals, expected dates for each action step, and any resources or support needed to complete the Care Plan) were updated regarding hospice care services for 2 (Resident 30 and 33) of 12 sampled residents. The facility identified a census of 43. Findings are: A. A record review of a facility policy Care Plan Policy with a last reviewed date of 3/2023 revealed services provided or arranged by the facility are to be included as part of the comprehensive care plan. A record review of Hospice-Nursing Facility Agreement Chadron Community Hospital-Hospice with an initial term agreement of 6/11/20215, revealed the agreement is between [NAME] Community Hospital - Hospice and Pioneer Manor. Under section 9.2 Integration of Hospice Plan of Care and Facility Plan of Care indicated the facility is responsible for integrating the Hospice Plan of Care into the facility care plans. A record review of Nursing Home Hospice Admission/Transfer Orders with a date of 8/6/2024 revealed Resident 33 was admitted to Hospice Services on 8/6/24 with medical conditions related of abnormal weight loss, multiple myeloma, pressure ulcer-unstageable, chronic pain, and atrial fibrillation. A record review of Resident 33's undated Care Plan revealed no evidence of Hospice services. An interview on 9/25/2024 at 3:33 PM with the Assistant Director of Nursing (ADON) confirmed Resident 33's care plan did not include Hospice services and should have been updated to include that Resident 33 was receiving Hospice services. 45613 B. A record review of Resident 30's Admission Record revealed an admitted to the facility of 2/21/23. A record review of Resident 30's Progress Note dated 9/5/24 indicated the resident was admitted to hospice care. A record review of Resident 30's Home Health and Hospice Plan of Care revealed an admitted [DATE] with a primary diagnosis of Abnormal weight loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Record review of Resident 30's undated facility CCP revealed no mention of hospice. Record review of a facility policy Care Plan Policy with a last reviewed date of 3/2023 revealed services provided or arranged by the facility are to be included as part of the comprehensive care plan. In an interview on 09/25/24 at 04:25 PM the ADON confirmed that Resident 30's careplan had not been revised after the resident was placed on hospice and it should have been.