

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285212	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Pioneer Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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** Licensure Reference Number 175 NAC 12-006.09(B) Based on record review and interview, the facility failed to accurately code the use of antibiotics on the 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) for 1 (Resident 11) of 1 sampled resident. The facility census was 39. Findings are: A record review of the facility policy Maintaining MDS Assessments dated 3/2023 revealed the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity. A record review of Resident 11's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE]. The MDS also revealed in Section N that the resident was taking an antibiotic (a medication used to treat infections) at the time of the assessment. A record review of Resident 11's Medication Administration Records for September and October 2025 revealed no evidence that the resident had been taking an antibiotic during this timeframe. An interview on 12/30/2025 at 4:00 PM with the MDS Coordinator confirmed Resident 11 was not taking an antibiotic during the 10/16/2025 MDS assessment period and it should not have been coded as such.		

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(E) Based on record review and interview, the facility failed to ensure the care plan was comprehensive for 2 (Residents 11 and 36) of 12 sampled residents. The facility census was 39. Findings Are: A record review of the facility policy Care Plan Policy dated 7/2/2025 revealed it is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A.A record review of Resident 11's undated care plan revealed the resident was admitted to the facility on [DATE] and on page 1, a section labeled Diagnosis which included a diagnosis of constipation. A record review of Resident 11's December 2025 Medication Administration Record (MAR) revealed the following bowel medication orders:-Dulcolax suppository 10 milligrams (MG) suppository to be given once daily as needed. This medication was administered one time on 12/24/2025.-Milk of Magnesia 400 mg/5 milliliters (mL), give 15-30 mL twice a day as needed. This medication was given on 12/1/2025, 12/7/2025, 12/9/2025, and on 12/21/2025. -Senna tablet 8.6 mg, give 1-3 tablets twice a day as needed. This medication was given on 12/1/2025, 12/5/2025, 12/7/2025, 12/8/2025, 12/9/2025, 12/10/2025, twice on 12/13/2025, 12/18/2025, 12/24/2025, 12/25/2025, and on 12/29/2025. Further review of Resident 11's care plan revealed no evidence of their ongoing problem of constipation or interventions that were in place to assist in treating the constipation. An interview on 12/30/2025 at 4:20 PM with the Director of Nursing (DON) confirmed Resident 11 had ongoing constipation and this problem and the need for interventions were not in the care plan but should have been. B.A record review of Resident 36'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) dated 12/11/2025 revealed the resident was admitted to the facility on [DATE], had a diagnosis of depression and was taking antidepressant medication. A record review of Resident 36's Orders dated 12/30/2025 revealed there resident had an order for sertraline (an antidepressant) with a start date of 9/17/2025. A record review of Resident 36's undated care plan revealed no evidence of the resident's diagnosis of depression or their need for interventions related to this diagnosis. An interview on 12/30/2025 at 4:20 PM with the DON confirmed Resident 36's care plan did not reflect the resident's depression or their need for an intervention related to this diagnosis and treatment with an antidepressant medication.		

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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. Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on record review and interview, the facility failed to review and revise the care plan for 1 (Resident 11) of 1 sampled resident's antidepressant medication use. The facility census was 39. Findings Are: A record review conducted on 12/30/2025 of Resident 11's undated care plan revealed a Problem section dated 4/23/2025, which had been edited on 7/30/2025, that stated I am at risk for disturbed thought process due to confusion from Parkinson's and a diagnosis of depression and anxiety. I receive scheduled Celexa (citalopram, an antidepressant medication). This section had an intervention stating staff would monitor the resident for side effects of the Celexa. There was an additional Problem section dated 7/10/2025, which had been edited on 8/5/2025, that stated I have a diagnosis of depression related to depressive symptoms. I am currently taking Citalopram to help with depressive symptoms. There was an intervention in this section that stated the resident would like their nurse to administer Citalopram and monitor them for adverse reactions to the medication. A record review of Resident 11's Progress Note dated 12/12/2025 revealed the resident was seen by their provider for a 60-day visit. The provider gave an order to discontinue the citalopram as it could be contributing to the resident's tremors. An interview on 12/30/2025 at 4:20 PM with the DON confirmed Resident 11's care plan still reflected the resident as taking citalopram despite this medication being discontinued on 12/12/2025. The DON confirmed the care plan should have been updated with the change in medication.		