STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285213	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mid-Nebraska Lutheran Home	109 North 2nd Street Newman Grove, NE 68758

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 review and interviews; the facility failed to notify Resident 1's Primary Care Practitioner of changes in the resident's condition related to behaviors, increased confusion, and back pain. The sample size was 5 and the facility census was 30. Findings are: A record review of the undated facility policy Change in a Resident's Condition or Status revealed the following; -the facility promptly notified the resident, the attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status, -the nurse would notify the resident's attending physician or on-call physician when there had been, accident/incidents involving the resident, injuries or unknown source, adverse reactions to medications, a significant change in the resident's condition, a need to significantly alter the resident's medical treatment, refusal of medication or treatments 2 or more consecutive times, or a need to transfer or discharge the resident, -prior to notifying the physician the facility nurse would make detailed observations and gather relevant and pertinent information for the provider, -except in emergencies notifications would be made within 24 hours of a condition change, and -a nurse would record in the resident's medical record information relative to the change in the resident's condition. A record review of Resident 1's MDS (Minimum Data Set, a federally mandated comprehensive assessment tool used for care planning) dated 3/21/25, revealed the resident was admitted with diagnoses of cancer, anemia, dementia, seizure disorder, anxiety, depression, and psychotic disorder. The following was assessed for Resident 1: -moderate cognitive impairment. -behaviors which included rejection of cares and verbal behaviors directed toward others. (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	-required staff assistance with transfers, bed mobility, dressing, toileting, and personal hygiene. -frequently incontinent of urine. -one fall without injury since previous assessment. A record review of Resident 1's Nursing Progress Notes revealed the following: -4/7/25 at 5:17 AM the resident had a fall at 4:30 AM outside of the resident's bathroom. The resident had been incontinent of urine and had a 2 centimeter (cm) superficial cut to the back of the resident's head. The resident was complaining of back pain which the resident had rated at an 8 out of 10. -4/7/25 at 7:06 PM the resident continued to complain of back pain with little relief from the as needed Tramadol (medication used to treat pain). -4/7/25 at 5:10 PM the resident was having lower back pain and had a headache. The resident received Ultram (medication used to treat pain) 50 milligrams (mg). -4/7/25 at 6:53 PM the resident's pain was a 7 out of 10 and the Ultram given at 5:10 PM was ineffective. The resident was also complaining of neck pain. -4/10/25 at 11:42 AM the resident was complaining of back pain and was unable to turn in bed without yelling in pain. -4/11/25 at 9:05 AM (4 days after the resident's fall) the resident was found slumped in the recliner. The resident was lethargic and unable to follow simple commands. The resident's pupils were fixed and did not respond to light. -4/11/25 at 9:07 AM the resident had a dark purple bruise on the back of the resident's head. -4/11/25 at 9:34 AM the resident was transferred by ambulance to the Emergency Room. -4/11/25 at 1:01 PM the resident was transferred to a hospital in Omaha due to a brain bleed. During an interview on 4/24/25 at 2:00 PM, the Director of Nursing (DON) confirmed the resident had a history of falls with the resident's last fall happening on 4/7/25 at 4:30 AM. The resident also had a history of moderate back pain.After the resident's fall on 4/7/25, the resident had increasing pain to the resident's back. A record review of Resident 1's medical records revealed no evidence that the facility staff had notified the resident's PCP of the resident's complaints of increased back pain until 4/11/25 (4 days after the resident's fall) when the resident was hospitalized .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Licensure Reference Number 175 NAC 12-006.09D Based on record review and interviews; the facility failed to monitor and to assess Resident 1 for a change of condition after a fall with injury. The sample size was 4 and the facility census was 30. Findings are: A record review of the undated facility policy Change in a Resident's Condition or Status revealed the following; -the facility promptly notified the resident, the attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status, -the nurse would notify the resident's attending physician or on-call physician when there had been, accident/incidents involving the resident, injuries or unknown source, adverse reactions to medications, a significant change in the resident's condition, a need to significantly alter the resident's medical treatment, refusal of medication or treatments 2 or more consecutive times, or a need to transfer or discharge the resident, -prior to notifying the physician the facility nurse would make detailed observations and gather relevant and pertinent information for the provider, -except in emergencies notifications would be made within 24 hours of a condition change, and -a nurse would record in the resident's medical record information relative to the change in the resident's condition. A record review of Resident 1's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated 3/21/25, revealed the resident was admitted with diagnoses of cancer, anemia, dementia, seizure disorder, anxiety, depression and psychotic disorder. The following was assessed for Resident 1: -moderate cognitive impairment. -behaviors which included rejection of cares and verbal behaviors directed toward others. -required staff assistance with transfers, bed mobility, dressing, toileting and personal hygiene. -frequently incontinent of urine. -one fall without injury since previous assessment. A record review of Resident 1's Nursing Progress Notes revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/18/25 at 10:52 AM the resident was alert and oriented to self with periods of confusion. Resident 1 had increased weakness and required 2 staff to assist with transfers. -3/19/25 at 1:51 PM the resident was alert and oriented with periods of confusion. -3/27/25 at 2:15 PM the resident was found lying on their right side on the floor of the resident's room. The note indicated the resident had ongoing issues with back pain. -4/7/25 at 5:17 AM the resident had a fall at 4:30 AM outside of the resident's bathroom. The resident had been incontinent of urine, had a 2 centimeter (cm) superficial cut to the back of the resident's head. The resident was complaining of back pain which the resident had rated at an 8 out of 10. -4/7/25 at 7:06 PM the resident continued to complain of back pain with little relief from their as needed Tramadol (medication used to treat pain). -4/7/25 at 5:10 PM the resident was having lower back pain and had a headache. The resident received Ultram (medication used to treat pain) 50 milligrams (mg). -4/7/25 at 6:53 PM the resident's pain was a 7 out of 10 and the Ultram given at 5:10 PM was ineffective. The resident was also complaining of neck pain. -4/10/25 at 12:03 AM the resident had increased behaviors, tried to walk in the corridor with a walker, and struck out at staff and tried to ram staff with the wheelchair when attempted to redirect. -4/10/25 at 5:51 PM the resident was showing signs of confusion with behavioral issues. In addition, the resident refused to allow staff to assist with care. -4/10/25 at 11:42 AM the resident was complaining of back pain and was unable to turn in bed without yelling in pain. -4/11/25 at 9:05 AM (4 days after the resident's fall) the resident was found slumped in their recliner. The resident was lethargic and unable to follow simple commands. The resident's pupils were fixed and did not respond to light. -4/11/25 at 9:07 AM the resident had a dark purple bruise on the back of the resident's head. -4/11/25 at 9:34 AM the resident was transferred by ambulance to the Emergency Room. -4/11/25 at 1:01 PM the resident was transferred to a hospital in Omaha due to a brain bleed. During an interview on 4/24/25 at 2:00 PM, the Director of Nursing (DON) confirmed the resident had falls on 3/16/25 at 5:08 AM, 3/27/25 at 2:15 PM and on 4/7/25 at 4:30 AM. The resident had been complaining of increased back pain, had increased confusion, and behaviors. In addition, the resident required 2 assists for transfers. Further interview revealed no assessments were completed and/or documented regarding the resident's back pain, increased confusion, or behaviors.