STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285220	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wauneta Care and Therapy Center	427 Legion Street Wauneta, NE 69045

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49263 Licensure Reference 175 NAC 12-006.09C Based on record review and interviews; the facility failed to develop and implement comprehensive care plans for 4 (Residents 19, 23, 26, and 32) of 12 sampled residents. The facility census was 32. The Findings Are: A record review of the facility policy Comprehensive Care Plans with a last revised date 5/15/2024 revealed the facility will develop a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing, mental, and psychosocial needs based off the resident's needs as identified in the resident's comprehensive assessment. A. A record review of facility policy Pain Management with reviewed/revised date of 5/15/24 revealed the facility would observe for nonverbal indicators which may indicate the presence of pain and that the facility would use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The policy also revealed that the interventions for pain management would be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. A record review of Resident 19's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), dated 4/9/24 revealed in Section C that the resident had short- and long-term memory loss, and moderately impaired cognitive skills for daily decision making. Section J revealed the resident did receive routine and PRN pain medications and did not receive any non-medication interventions for pain during the prior 5 days, and that the staff assessment for pain indicated the resident had non-verbal sounds of pain every day during the prior 5 days. A record review of Resident 19's active physician's orders revealed the following pain-related orders: - Arthritis Pain Extended Release (ER) 650 MG, give one caplet BID. This order had a start date of 5/13/22 and did not have a diagnosis or indication listed on the order. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ask resident every shift if having pain, if yes- refer to pain assessment sheet. This order had a start date of 1/9/22. According to the documentation on the order, the resident had no pain between April 1, 2024, and May 14, 2024. - Tylenol (an analgesic used to treat minor aches and pains) 325 MG, give two tablets every 4 hours as needed for pain. This order had a start date of 3/16/21. This medication was given to the resident two times in April 2024 and three times between May 1st and May 15th, 2024. A record review of Resident 19's care plan, dated 3/5/24 revealed a Problem Statement of Resident 19 has a history of dementia which has greatly increased this past quarter. An intervention in this section stated, Assess for pain when Resident 19 is yelling out, restless, anxious, tearful. The care plan did not address Resident 19's potential for pain or interventions to utilize when the resident had symptoms of pain. An interview on 5/15/24 at 10:29 AM with Director of Nursing (DON) revealed the facility used the FACES pain scale or would ask the resident if they were having pain and document it using the 0-10 pain scale. The DON revealed the facility had no alternate scale to be used for residents who were not cognitively intact. The DON confirmed Resident 19 was taking five psychotropic medications on a routine basis, two PRN (as needed) psychotropic medications that were being utilized frequently, and a PRN pain medication that had been used minimally over the last two months. The DON confirmed that the resident continued to have behavioral symptoms despite the frequent use of PRN psychotropics and the routine psychotropics and that this could be due to the root cause of the resident's problem not being addressed. An interview on 5/15/24 at 11:22 AM with Licensed Practical Nurse (LPN)-G confirmed that Resident 19's pain assessment order stated to ask the resident if they were having pain and that the pain scale attached to the order was the 0-10 pain rating scale. LPN-G stated that it was hard to tell if Resident 19 was having pain and that their most frequent behaviors were repetitive statements of I'm sick or I hurt. 49766 B. A record review of a facility Face Sheet indicated the facility admitted Resident 23 on 1/15/2024 with diagnoses of heart failure, Chronic Obstructive Pulmonary Disease (COPD,) hypertension (high blood pressure,) and edema (swelling.) A record review of a quarterly MDS with an Assessment Reference Date of 4/9/2024 indicated that Resident 23 had a Brief Interview for Mental Status (BIMs) score of 11/15, which indicated Resident 23 had moderate cognitive impairment. The MDS also indicated Resident 23 had diagnoses of heart failure, hypertension, COPD and was currently taking an anticoagulant (blood thinner) and a diuretic (medication that reduces fluid buildup in the body.) A record review of Resident 23's Care Plan revealed no care focus for Resident 23's heart failure, COPD, or anticoagulant and diuretic use. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 5/14/2024 at 11:24 AM with the MDS Nurse confirmed Resident 23's Care Plan was not comprehensive to address Resident 23's medical conditions. C. A record review of a facility Face Sheet indicated the facility admitted Resident 26 on 3/22/23 with diagnosis of Type 1 Diabetes. A record review of an annual MDS with an Assessment Reference Date of 2/13/2024 indicated Resident 26 had a BIMs score of 7/15, which indicated Resident 26 had severe cognitive impairment. The MDS also indicated Resident 26 had Diabetes Mellitus and was currently taking insulin. A record review of Resident 26's Care Plan revealed no care focus for Resident 26's Diabetes Mellitus and insulin use. An interview on 5/14/2024 at 3:07 PM with the MDS Nurse confirmed Resident 26's Care Plan was not comprehensive to address Resident 26's medical conditions. The MDS Nurse confirmed all care plans were not comprehensive and needed work. 50253 D. A record review of Resident 32's History and Physical dated 10/6/2023 sent to the facility from the discharge hospital confirms the presence of pressure ulcers and arterial stasis ulcers on both feet. A record review of Resident 32's Care Plan revealed no focus of care for Resident 32's arterial stasis ulcers or pressure ulcers from admission which were present upon admission. In an interview with MDS Nurse on 05/14/24 at 2:36 PM confirmed Resident 32's Care Plan was not comprehensive and did not address Resident 32's medical condition of pressure ulcers or arterial stasis ulcers. In an interview with DON on 05/14/24 at 2:38 PM. Confirms that the care plans do not include information regarding the pressure ulcers on both heels. Resident 32 entered the facility with pressure ulcers on his coccyx, both heels, the tip of one toe, and arterial stasis ulcers on both feet.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference 175 NAC 12-006.09 Based on record review, observations, and interviews; the facility failed to identify and treat 1 (Resident 19) of 2 sampled resident's pain. The facility census was 32. The findings are: A record review of facility policy Pain Management with reviewed/revised date of 5/15/24 revealed the facility would observe for nonverbal indicators which may indicate the presence of pain and that the facility would use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The policy also revealed that the interventions for pain management would be incorporated into the components of the comprehensive care plan, addressing conditions or situations that may be associated with pain or may be included as a specific pain management need or goal. A record review of facility policy Behavioral Assessment, Intervention and Monitoring with revised date of March 2019, revealed Behavioral or Psychological Symptoms of Dementia ([NAME]) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. Appropriate assessment and treatment of behavioral symptoms requires differentiating between behavioral symptoms that can be managed by treating underlying factors and those that cannot. A record review of Resident 19's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning), dated 4/9/24 revealed in Section C that the resident had short- and long-term memory loss, and moderately impaired cognitive skills for daily decision making. Section J revealed the resident did receive routine and PRN pain medications and did not receive any non-medication interventions for pain during the prior 5 days, and that the staff assessment for pain indicated the resident had non-verbal sounds of pain every day during the prior 5 days. A record review of Resident 19's paper Care Plan, dated 3/5/24 revealed a Problem Statement of Resident 19 has a history of dementia which has greatly increased this past quarter. An intervention in this section stated, Assess for pain when Resident 19 is yelling out, restless, anxious, tearful. The Care Plan did not have a section which specifically addressed Resident 19's potential for pain. A record review of Resident 19's active Physician's Orders revealed the following orders: - Observe for individualized behaviors such as pacing, statements of I'm sick, crying, pacing, general anxiety, yelling out, repeated questions, excessive worrying. This order had a start date of 11/7/23 and did not provide guidance on how to address any behaviors identified during observation. - Sertraline HCl (an antidepressant medication) 25 Milligram (MG) tablet, give one tablet by mouth daily for generalized anxiety disorder. This order was increased from 12.5 MG daily to 25 MG daily on 5/3/24. (continued on next page)

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	285220	A. Building B. Wing	05/16/2024

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- Risperdal (an antipsychotic medication) 0.5 MG tablet, give one tablet by mouth twice a day (BID) at 8am and 8pm for unspecified dementia, unspecified severity with mood disturbances. This order had a start date of 4/16/24. - Buspirone HCl (an anxiolytic medication used to treat anxiety) 7.5 MG tablet, give one tablet by mouth three times a day (TID). The order stated to hold for sedation and listed potential side effects of dizziness, drowsiness, headache, nausea, nervousness, lightheadedness, restlessness, blurred vision, tiredness, and trouble sleeping. The order had a start date of 4/12/24 and did not have a diagnosis or indication listed on the order. - Divalproex Sodium Delayed Release (DR) (an anticonvulsant medication that can also be used to treat the manic phase of bipolar disorder) 125 MG, give one capsule TID for severe dementia. This order had a start date of 3/2/24. - Trazadone (an antidepressant medication often used to treat symptoms of insomnia, which causes difficulty sleeping) 50 MG tablet, give one half tab (25mg) by mouth at bedtime for insomnia. This order had a start date of 4/3/24. - Arthritis Pain Extended Release (ER) 650 MG, give one caplet BID. This order had a start date of 5/13/22 and did not have a diagnosis or indication listed on the order. - Ativan (an anxiolytic medication used to treat anxiety) 1 MG tablet, give every 6 hours as needed for anxiety. This order had a start date of 3/17/24. This medication was given to the resident 43 times in April 2024 and 19 times between May 1st and May 15th, 2024. - Hydroxyzine HCl (an antihistamine medication often used to treat symptoms of anxiety) 25 MG tablet, give every 6 hours as needed for anxiety. This order had a start date of 3/2/24. This medication was given to the resident 29 times in April 2024 and 9 times between May 1st and May 15th, 2024. - Ask resident every shift if having pain, if yes- refer to pain assessment sheet. This order had a start date of 1/9/22. According to the documentation on the order, the resident had no pain between April 1, 2024, and May 14, 2024. - Tylenol (an analgesic used to treat minor aches and pains) 325 MG, give two tablets every 4 hours as needed for pain. This order had a start date of 3/16/21. This medication was given to the resident two times in April 2024 and three times between May 1st and May 15th, 2024. An observation on 5/13/24 at 11:13 AM revealed Resident 19 sitting in their wheelchair in their room with Nurse Aide (NA)-C. The overhead light in the room was turned off, with dim natural lighting in the room coming from the window and there was soft music playing. Resident 19 was fidgeting with their hands and attempting to stand up repetitively. An interview on 5/13/24 at 11:13 AM with NA-C revealed Resident 19 had been agitated all morning and NA-C was sitting with the resident in their room providing a quieter environment and soft music for the resident to listen to in an attempt to decrease Resident 19's agitation. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An observation on 5/14/24 at 7:15 AM revealed Resident 19 sitting in their wheelchair near the nurse's station and next to Medication Aide (MA)-B who was working at the medication cart. Resident 19 was attempting to stand up intermittently and had facial grimacing. Resident 19 was making repetitive distressed vocalizations. The Activities Supervisor (AS)-E approached Resident 19 and told the resident they would go to the dining room after they got their medication. AS-E held Resident 19's hand and attempted to make conversation with the resident but did not ask the resident what was wrong or if they were having any pain. An observation on 5/14/24 at 8:36 AM revealed NA-D pushed Resident 19 in their wheelchair from the dining room to the sitting area outside the nurse's station and parked the resident in their wheelchair. Resident 19 used their feet to wheel themselves to this surveyor and stated ma'am, ma'am I don't feel good. My head hurts. Resident 19 was observed to have facial grimacing at that time. The surveyor moved away from Resident 19 after assuring the resident that there would be staff nearby soon. An observation on 5/14/24 at 8:39 AM revealed NA-D approached Resident 19, moved the resident's foot pedals to the sides of the wheelchair, and then walked away from the resident. Resident 19 was holding their forehead with one hand. Resident 19 then attempted to self-propel their wheelchair with their feet, could not get chair moving, and stopped attempting. Resident 19 placed both hands on their forehead and had slight facial grimacing. An observation on 5/14/24 at 8:41 AM revealed Resident 19 stating ma'am, ma'am, ma'am numerous times each time someone walked past the resident. Resident 19 resumed attempting to wheel self, only making about 1 foot of progress. NA-D approached Resident 19 at 8:42 AM, turned their wheelchair and stated, are you okay? NA-D then walked away from Resident 19 without waiting for the resident to respond. An observation on 5/14/24 at 8:44 AM revealed the Director of Nursing (DON) approached Resident 19 and held the resident's hand while the resident used their feet to self-propel their wheelchair across the room. NA-D approached a few seconds later and Resident 19 grabbed NA-D's hand with their other hand. Resident 19 continued to propel their wheelchair with their feet while holding both staffs' hands. Resident 19 had facial grimacing, was intermittently stating ma'am, ma'am, and was softly moaning. The DON walked away at 8:46 AM and NA-D continued to hold Resident 19's hand. At 8:27 AM, Resident 19 started crying. NA-D asked the resident what was the matter and Resident 19 responded, stating I'm sick. NA-D asked the resident what was hurting. Before Resident 19 was able to respond, another staff walked up, stated where ya headed?, and then walked away. Resident 19 continued to repeat Ma'am, ma'am and had their hand on their forehead. NA-C walked up to Resident 19 at 8:49 AM and put the resident's feet on the wheelchair pedals and then NA-C and NA-D took Resident 19 into a community bathroom and closed the door. None of the staff identified that the resident was having pain to their head during this time period. An observation on 5/14/24 at 8:52 AM revealed Resident 19 being assisted out of the bathroom by NA-C in a Merry-Walker (a walker that a person can be secured into and that has a seat on it). NA-C remained at Resident 19's side and the resident continued to have facial grimacing and repetitive moaning. NA-C held Resident 19's hand and rubbed the resident's back with their fingers. At 8:55 AM, Resident 19 was wiping their eyes with a Kleenex and moaning, NA-C rubbed the resident's back again for a few seconds and then resumed holding the resident's hand. Resident 19 continued to have facial grimacing. At 8:56 AM, NA-C had still not asked Resident 19 what was wrong. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An observation on 5/14/24 at 9:32 AM revealed Resident 19 had just received a bath and was sitting in their regular wheelchair at the nurse's station facing one of the staff, who was using a computer. Resident 19 did not have facial grimacing, was holding [gender] forehead with [gender] hand. An observation on 5/14/24 at 10:58 AM revealed Resident 19 sitting in their wheelchair outside the nurse's station holding their forehead with both hands. NA-F was standing next to the resident but did not acknowledge the resident. An observation on 5/14/24 at 1:38 PM revealed Resident 19 being pushed up the 200 hallway in [gender] wheelchair by NA-D and was fidgeting with [gender] hands. An observation on 5/15/24 at 1:45 PM revealed Resident 19 sitting in [gender] wheelchair in [gender] room, with [gender] child sitting on [gender] bed next to them and holding their hand. Resident 19 was rocking back and forth in the wheelchair and making repetitive moaning sounds. An interview on 5/15/24 at 10:29 AM with DON revealed the facility used the FACES pain scale or would ask the resident if they were having pain and document it using the 0-10 pain scale. The DON revealed the facility had no alternate scale to be used for residents who were not cognitively intact. The DON confirmed Resident 19 was taking five psychotropic medications on a routine basis, two PRN (as needed) psychotropic medications that were being utilized frequently, and a PRN pain medication that had been used minimally over the last two months. The DON confirmed that the resident continued to have behavioral symptoms despite the frequent use of PRN psychotropics and the routine psychotropics and that this could be due to the root cause of the resident's problem not being addressed. An interview on 5/15/24 at 11:22 AM with Licensed Practical Nurse (LPN)-G confirmed that Resident 19's pain assessment order stated to ask the resident if they were having pain and that the pain scale attached to the order was the 0-10 pain rating scale. LPN-G also revealed that with residents who were not able to verbalize their pain, the facility would usually utilize the FACES pain scale. LPN-G stated that it was hard to tell if Resident 19 was having pain and that their most frequent behaviors were repetitive statements of I'm sick or I hurt. A record review of website, wongbakerfaces.org revealed the Wong-Baker FACES Pain Rating Scale was a self-assessment tool that must be understood by the patient, so they would be able to choose the face that best illustrated the physical pain they were experiencing. The website also stated it was not a tool to be used by a third person, parents, healthcare professionals, or caregivers, to assess the patient's pain. A record review of the website geriatricpain.org revealed an assessment tool titled Pain Assessment in Advanced Dementia (PAINAD) Scale, which was a pain behavior tool used to assess pain in older adults who have dementia or other cognitive impairment and are unable to reliably communicate their pain. Based on the observations of Resident 19 on 5/14/24, the resident's pain would have been rated at a 7 (on the PAINAD scale of 0-10), with positive responses in the negative vocalization, facial expression, body language, and consolability sections of the assessment tool.

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	285220	A. Building B. Wing	05/16/2024

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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. 50253 LISCENSURE Reference Number 175 NAC 12-006.09D Based on record reviews and interviews; the facility failed to ensure that all psychotropic medications (medications that are given for a variety of mental health disorders including psychosis, depression, anxiety, and sleep) given only when needed (PRN) are reviewed and reordered every 14 days for 1 (Resident 32) of 1 sampled resident. The facility census was 32. Findings are: In an interview with Resident 32 on 5/13/24 at 1:35 PM in Resident 32's room. Resident 32 revealed admission to this facility last year after being discharged from the hospital. Resident 32 confirms [gender] has meetings with some people by video (Telemedicine, the ability to visit a physician from home by using a television, computer, or other audio visual equipment) about every other week about how [gender] feels and about anxiety and depression. In an interview with Social Services Director (SSD) on 5/14/24 at 9:30 AM revealed Resident 32 is usually seen every one or two weeks with telemedicine for psychiatric care. In an interview with Minimum Data Set Nurse (MDS) on 5/14/2024 at 2:10 PM confirmed Resident 32 receives Mental Health Telemedicine every two weeks and has seen much improvement since the resident was admitted . In an interview with Infection Control Nurse (ICN)-A on 5/14/2024 at 2:15 PM confirmed that Resident 32 no longer receives Mental Health Telemedicine weekly as those appoints are now every two weeks. The facility staff have seen many changes and much improvement in the mental health of Resident 32. ICP-A further revealed staff receive the orders from the Telemedicine professionals. In an interview with the Director of Nurses (DON) on 5/15/24 at 1:45 PM confirmed Resident 32 is cared for by psychiatry using telemedicine. The resident was very sick and extremely depressed upon admission. Over the past few months (we) have watched Resident 32 come out of a shell and move mountains with all of the improvement. The ability to connect with psychiatric counsels and psychiatrists treat Resident 32's psychiatric behaviors and major depressive disorder has been incredible for everyone especially this resident. Telemedicine writes the orders for the psychiatric cares. A record review of the Mental Health Telemedicine document dated 1/9/2024 revealed an order change for the medication Clonazepam for Resident 32. New order reads Clonazepam 0.5 mg (milligrams) by mouth once daily as needed at bedtime for anxiety. The order did not reveal a stop date for Clonazepam. (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 Medication Administration Record dated February 2024 revealed that Resident 32 has an order for Clonazepam 0.5 mg (milligram) tablet daily at bedtime as needed for anxiety. The medication has an order date and a start date of 1/09/2024 with no stop date. Resident 32 received this medication on 2/3/24, 2/4/24, 2/8/24, 2/11/24, 2/12/24, 2/13/24, and 2/22/24. A record review of psychiatric telemedicine visit dated 2/1/2024 at 1:10 PM, revealed the chief complaint for the visit stated Resident 32 has been taking clonazepam less frequently - only once or twice a week. The document revealed that Resident 32 has an order for Clonazepam 0.5 mg tablet one tablet by mouth as needed at bedtime for anxiety. The medication list was reviewed by facility staff and psychiatric professionals during the telemedicine conference. The treatment plan revealed a new order for a different medication, continue monitoring psychiatric symptoms, continue to monitor therapeutic effects of psychiatric medications and for possible adverse effects. There is no 14-day renewal order for the clonazepam as needed order. A record review of Mental Health Telemedicine visit dated 2/7/2024 at 1:10 PM, revealed the chief complaint for the visit revealed Resident 32 has been taking clonazepam less frequently - only once or twice a week. The document revealed that Resident 32 has an order for Clonazepam (a medication) 0.5 mg tablet one tablet by mouth as needed at bedtime for anxiety. The medication list was reviewed by the staff hosting the telemedicine conference. There is no 14-day renewal order for the clonazepam PRN order. A record review of Mental Health Telemedicine visit dated 2/15/2024, documentation revealed Resident 32 has an order for Clonazepam (a medication) 0.5 mg tablet one tablet by mouth as needed at bedtime for anxiety. The medication list was reviewed by the staff hosting the telemedicine conference and this treatment plans states there are no medication changes at this visit. There is no specific 14-day renewal order for the PRN clonazepam. A record review of Mental Health Telemedicine visit dated 2/29/2024, documentation revealed Resident 32 has an order for Clonazepam (a medication) 0.5 mg tablet one tablet by mouth as needed at bedtime for anxiety. The medication list was reviewed by the staff hosting the telemedicine conference and this treatment plans states there are no medication changes at this visit. There is no specific 14-day renewal order for the PRN clonazepam. A record review of the Medication Administration Record dated March 2024 revealed that Resident 32 has an order for Clonazepam 0.5 mg (milligram) tablet daily at bedtime as needed for anxiety. The medication has an order date and a start date of 1/09/2024. Resident 32 received this medication on 3/6/24, 3/11/24, 3/20/24, 3/21/24, 3/25/24, and 3/26/24. A record review reveals there was no Mental Health Telemedicine review on 3/14/24 that addressed the as needed administration of clonazepam. (continued on next page)

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	285220	A. Building B. Wing	05/16/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of psychiatric telemedicine visit dated 3/28/2024, documentation revealed Resident 32 has an order for clonazepam 0.5 mg tablet one tablet by mouth as needed at bedtime for anxiety. The medication list was reviewed by the staff hosting the telemedicine conference and this treatment plans states there are no medication changes at this visit. The chief complaint for the telemedicine visit reveals Resident 32 has been receiving clonazepam PRN three times weekly during the late-night hours for restless sleep. Orders reveal that facility staff are to continue to monitor psychiatric symptoms and the therapeutic effects of the medications. Clonazepam is not addressed in the orders or treatment plan and no specific 14-day renewal order for the PRN clonazepam. Record Review of the facility policy and procedure for Use of Psychotropic Medication dated 1/24/2024 states on paragraph 9 that for all psychotropic drugs the medications necessary to treat a diagnosed specific condition that is documented in the clinical record, and used only for a limited duration of 14 days, the prescribing practitioner will document the rationale for use in the medical record and indicate the duration for the PRN (as needed only) order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285220	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wauneta Care and Therapy Center	427 Legion Street Wauneta, NE 69045

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49766 Licensure Reference 175 NAC 12-006.10D Based on record reciews, observations, and interviews; the facility failed to ensure medications that could not be crushed were not crushed for 1 (Resident 16) of 4 sampled residents and failed to ensure the medication error rate was less than 5%. The medication error rate was 16.67%. The facility census was 32. Findings are: A record review of a facility policy Medication Administration with a last revised date of 9/13/2023 revealed the following: - Crush medications as ordered. Do not crush medications with do not crush instructions. - Do not crush slow release or enteric coated medications. A record review of a facility Face Sheet revealed the facility admitted Resident 16 on 5/7/2019 with diagnoses of atrial fibrillation, heart failure, hypertension, Gastro-esophageal reflux disease, iron deficiency, and overactive bladder. A record review of Resident 16's Physician Orders dated May 2024 revealed the following: - ferrous sulfate 325 milligrams (mg) - take 1 tablet daily - without instruction of do not crush. - pantoprazole 40 mg - take 1 capsule twice a day - without instruction of do not crush. - potassium 20 milliequivalents - take 1 tablet daily - without instruction of do not crush. - solifenacin 10 mg - take 1 tablet daily - without instruction of do not crush. - carvedilol 6.25 mg - take 1 tablet in the morning - without instruction of do not crush. An observation on 5/14/2024 at 7:26 AM revealed Medication Aide (MA)-B had crushed Resident 16's ferrous sulfate, pantoprazole, potassium chloride, solifenacin, and carvedilol. An interview on 5/14/2024 at 7:32 AM with MA-B confirmed MA-B had crushed Resident 16's medications. A follow-up interview on 5/14/2024 at 9:30 AM with MA-B confirmed Resident 16's crush order was not in the computer nor were there direction of which medications could not be crushed. MA-B was unaware of medications that could not be crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Institute for Safe Medication Practices document Oral Dosage Forms That Should Not Be Crushed revealed potassium chloride, ferrous sulfate, pantoprazole, solifenacin, carvedilol was included on the list to not be crushed.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49263 Based on record review and interview; the facility failed to submit their Payroll Based Journal (PBJ) data for Quarter 1 of 2024 as required. This had the potential to affect all residents residing within the facility. The facility census was 32. The Findings Are: A record review of the PBJ report from CMS revealed no direct care nursing staff (Registered Nurses, License Practical Nurses, Medication Aides, and Nurse Aides) data was submitted for the first quarter of fiscal year 2024, from 10/1/2023 through 12/31/2023. An interview on 5/15/24 at 1:46 PM with the Administrative Assistant (AA) confirmed the AA was responsible for submitting the facility's PBJ Data and that they did not submit the data for 2024 Quarter 1. The AA stated they attempted to log onto the site the evening of the due date and entered an incorrect password too many times, causing themselves to get locked out of the system and therefore unable to submit the required data.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49766 Licensure Reference 175 NAC 12-006.17B Licensure Reference 175 NAC 12-006.17D Based on record reviews, observations, and interviews; the facility failed to don (put on) the required personal protective equipment (PPE) of a gown for enhanced barrier precautions during catheters cares for 1 (Resident 4) of 1 sampled resident and failed to ensure hand hygiene was completed as required and medications were not contaminated during medication pass for 3 (Residents 16, 19, and 31) of 4 sampled residents. The facility census was 32. Findings are: A. A record review of the facility's policy Enhanced Barrier Precautions with a date implemented of 3/26/2024 revealed PPE of gowns and gloves is necessary when performing high-contact care activities, including urinary catheter care. A record review of a Face Sheet indicated the facility admitted Resident 4 on 4/18/2023 with diagnoses of left hip fracture and hydronephrosis (a condition that occurs when a kidney swells and can't get rid of urine like it should.) A record review of Resident 4's Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date of 3/26/2024 revealed Resident 4 required maximal assistance with toileting hygiene. The MDS also revealed Resident 4 had an indwelling urinary catheter. An observation on 5/15/2024 at 7:50 AM revealed Resident 4's door had a sign on the door alerting staff enhance barrier precautions were in effect and staff must gown and glove during high-contact care activities. An observation on 5/15/2024 at 7:55 AM Nurse Aide (NA)-J had donned gloves, but no gown then proceeded to provide catheter care for Resident 4. An interview on 5/15/2024 at 8:17 AM with NA-J confirmed [gender] was aware but did not follow guidelines of PPE for enhanced barrier precautions by donning a gown. B. A record review of the facility's policy Handwashing/Hand Hygiene last revised October 2023 revealed hand hygiene is indicated before and after touching a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 5/14/2024 at 7:10 AM revealed Medication Aide (MA)-B had completed a medication pass for Resident 28. MA-B did not perform hand hygiene prior to beginning a medication pass for Resident 31. An observation on 5/14/2024 at 7:20AM revealed MA-B had been preparing Resident 19's medication. MA-B had questions regarding a medication and had been awaiting the nurse for clarification. MA-B dug out the medication with MA-B's bare hand without the benefit of a glove. An observation on 5/14/2024 at 7:26 AM revealed MA-B had completed a medication pass for Resident 19. MA-B touched MA-B's hair then proceeded to begin a medication pass for Resident 31. MA-B did not perform hand hygiene after touching hair or beginning the medication pass. An interview on 5/14/2024 at 7:39 AM with MA-B confirmed hand hygiene should be performed between residents and when touching personal body. MA-B also confirmed MA-B should have donned a glove before touching Resident 19's medications.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49263 Licensure Reference 175 NAC 12-006.04B2a Based on record review and interview; the facility failed to ensure Nurse Aide (NA)-H completed 12 hours of ongoing training per year as required. This had the potential to affect all residents who resided within the facility. The facility census was 32. The Findings Are: A record review of a Relias (an online training program utilized by long term care facilities) Transcript for NA-H dated 5/14/24, revealed NA-H had completed two 0.5-hour training courses for a total of 1.0 hour of training in the prior 12 months. A record review of a Relias Transcript for NA-H dated 5/15/24, revealed NA-H had completed five training courses on 5/14/24 for a total of 1.85 hours of training. An interview on 5/15/24 at 9:19 AM with the Administrative Assistant (AA) confirmed that NA-H had completed only 2.85 hours of training on Relias and had not attended any of the in-person facility in-services over the last twelve months.