

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  The Cedars at Broadwell		STREET ADDRESS, CITY, STATE, ZIP CODE  800 Stoeger Drive Grand Island, NE 68803	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>49382</p> <p>Licensure Reference Number 175NAC 12-0006.09(H)(iii)(1)</p> <p>Licensure Reference Number 175NAC 12-006.09(H)(iii)(2)</p> <p>Based on observation, record review, and interview; the facility failed to provide care and services to prevent pressure related skin conditions and promote the healing of pressure related skin conditions for 1 resident (Resident #1) of 3 sampled residents. The facility census was 50.</p> <p>Review of the facility policy titled Skin Assessment and not dated revealed that a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The section labeled documentation of skin assessment stated documentation should include date and time of assessment observations, type of wound, description of wound, and if the resident refused the assessment and why.</p> <p>Review of the facility policy titled Pressure Injury Prevention Guidelines and dated 01/05/2024 revealed that individualized interventions will address specific factors identified including nutritional deficit and impaired mobility. Interventions will be documented in the care plan and communicated to all staff. Under the section labeled nutrition and hydration it states to develop and individualized nutritional care plan for each resident with or at risk for a pressure injury.</p> <p>Review of the facility policy titled Notification of Changes and dated 11/29/2023 revealed to promptly inform or consult the residents physician when there is a change requiring notification including circumstances that require a need to alter treatment including a new treatment.</p> <p>Review of an Admission Record dated 09/26/2024 revealed the facility admitted Resident #1 on 07/18/2024 with diagnoses of: Spinal Stenosis (a condition where the spinal canal narrows putting pressure on the spinal cord and nerves), Spinal Cord Injury (which is damage to part of the spinal cord often resulting in lack of feeling and use of the body below the damaged area), Diabetes (which is when the body has trouble controlling blood sugar and using it for energy, Peripheral Vascular Disease(a condition that occurs when blood vessels narrow or become blocked reducing blood flow to the body parts they supply), and Dementia(the impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admission/Comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning), dated 07/22/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment), score of 13 indicating the resident was cognitively intact. The resident was coded to have the behavior of rejection of care 1 to 3 days during the lookback period. Resident #1 had functional limitations to range of motion of both lower extremities and utilized a wheel chair for mobility. The resident was independent with the task of eating, dependent on staff assistance with bed mobility, transfers, and toilet use. The resident was at risk for pressure related skin conditions and had no pressure related skin conditions coded on the MDS. Treatments were pressure reducing device to chair and bed, surgical wound care and application of ointments and medications other than to feet.</p> <p>Review of Resident #1 Care Plan dated 09/26/2024 revealed a focus of Pressure ulcer risk stating the resident has the potential for the development of a pressure ulcer and currently has wounds to both buttocks and the left heel dated 07/18/2024. Interventions were listed as left heel boot on at all times dated 08/17/2024, reposition frequently or more often as needed dated 07/30/2024, check frequently for wetness and soiling every two hours and provide care dated 07/30/2024, apply moisture barrier with each incontinent changed dated 07/30/2024, encourage and assist the resident to suspend heels when in bed with pillows dated 07/30/2024, maintain the bed as flat as possible dated 07/30/2024. No interventions for dietary changes, heel boots to both feet at all times, and resident seeing wound care were listed on the residents care plan.</p> <p>Review of Resident #1 Progress Notes revealed the following:</p> <p>-07/21/2024 Resident #1 developed multiple open areas around the anus. Zinc ointment was applied.</p> <p>-07/24/2024 The Registered Dietitian recommended to add 30 Milliliters(MI) of ProStat (a dietary supplement to provide additional calories and protein which assists with weight management and wound healing).</p> <p>-07/25/2025 Resident #1 was documented to have multiple open areas on skin around anus and on both inner buttocks. Zinc ointment was applied.</p> <p>-08/13/2024 Resident #1 was documented to have a deep tissue injury/pressure related skin condition present to the left heel and an open area on the left inner buttock. Heel protector boots were applied and were ordered to be used at all times.</p> <p>-08/25/2024 Documentation that wounds are worsening. No description of the wounds provided in the documentation.</p> <p>-08/30/2024 Resident was seen at the wound clinic and new treatment orders for wounds were obtained. A wound to the right plantar/bottom of the foot was also identified.</p> <p>-09/16/2024 Registered Dietitian recommends the addition of ProStat 30 ML twice daily to aide with wound healing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1 Physican Orders for the Month of July, August, and September 2024 revealed no order for ProStat. Physician Orders for the Month of October 2024 revealed and order for ProStat 30ML twice daily dated 10/01/2024.</p> <p>Review of Resident #1 Electronic Medical Health Record revealed Resident #1 had a skin assessment documented on 07/18/2024, 08/03/2024, 08/12/2024, 08/19/2024, 08/30/2024, and 09/07/2024. The resident did not have documented skin assessments on a weekly basis during this time frame.</p> <p>In an observation on 10/08/2024 at 8:55 AM Resident #1 was observed lying on their back in bed with the head of the bed greater then 35 degrees. The resident stated that they did not have there boots on there feet like they were supposed to and pointed to the chair on the other side of the room. A pair of blue lift boots were observed to be sitting in the chair. The resident pulled the blanket off of their legs exposing their feet and said see. The resident's feet were noted to be flat on the mattress with out items under legs providing flotation of feet and or heels from the surface of the mattress to prevent pressure to the resident's feet.</p> <p>In an observation on 10/08/2024 at 11:20 AM Resident #1 remained flat on their back lying in bed with the head of the bed greater then 35 degrees and both feet touching the surface of the mattress of the bed.</p> <p>In an interview on 10/08/2024 at 11:26 AM with Licensed Practical Nurse E (LPN-E), LPN-E confirmed that Resident #1 did not have foam boots on both of their feet. The nurse confirmed that the resident was to have the boots on their feet at all times.</p> <p>In an interview on 10/08/2024 at 2:30 PM with the Director of Nursing (DON), the DON confirmed that the registered dietitian had recommended ProStat for Resident #1 on 07/24/2024 and on 09/16/2024 and that the ProStat was not started until 10/01/2024. The DON confirmed that the residents skin conditions progressed or worsened during this time. The DON confirmed that residents are to have documented weekly skin assessments and that Resident did not have weekly skin assessments documented for the month of July, August, and September 2024 and the residents skin conditions progressed or worsened during this time.</p>		