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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER: Brookestone Village		STREET ADDRESS, CITY, STATE, ZIP CODE: 4330 South 144th Street Omaha, NE 68137	

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 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** 45613 Licensure Reference Number 175 12-006.09 (F)(III) Based on observation, interview and record review, the facility failed to update the Comprehensive Care Plans (CCP) related to wound care for Residents 7 and 88, anti-anxiety medication use for Resident 87 and targeted behaviors and interventions for Resident 69. The sample size was 5 and the facility census was 132. Findings are: A review of the facility's CCP policy dated [DATE] 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 timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. It further confirmed that the comprehensive careplan will be reviewed and revised by the interdisciplinary team after each comprehensive, quarterly Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) assessment and as needed. A review of the facility's Skin and Wound Management Standard policy reviewed 4/2019 revealed that an assessment should be completed on all skin tears/abrasions/bruises/scrapes/cuts, etc. It further revealed that all actions and interventions will be included in the careplan at the time of identification. A. A record review of Resident 88's facility Admission Record revealed Resident 88 had an admission to the facility on [DATE] with no diagnosis of wounds. A record review of Resident 88's quarterly MDS dated [DATE] revealed a Brief Interview for Mental Status (BIMS- a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) score of 7, which indicates cognitive impairment. It also revealed, in Section M Resident 88 has no wounds but was at risk for developing wounds. A record review of Resident 88's progress notes dated 9/9/2024 revealed an open skin tear to the resident's lower left leg. (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 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A record review of the facility's non pressure skin condition record for Resident 88 dated 9/9/24 revealed a skin tear to left lower leg that measured 1.5 centimeters (cm) length, 1.5 cm width, and 0.2 cm depth.

A record review of Res 88's Treatment Administration Record (TAR) for 9/2024 and 10/2024 revealed an order dated 9/25/24 for the left ankle wound to cleanse with wound cleanser, apply silver alginate (used in the treatment of at risk or infected wounds), apply adaptic dressing (used to help protect the wound while preventing the dressing from adhering to the wound), then cover with ABD pad (an highly absorbent sterile dressing). Change Monday, Wednesday, and Friday and as needed if soaked.

A record review of Resident 88's physician orders dated 9/25/24 revealed an order for the Left ankle wound to cleanse with wound cleanser, apply adaptic dressing with silver alginate over it then cover with ABD pad. Change Monday, Wednesday, and Friday and as needed if soaked.

An observation on 10/16/24 at 9:19 AM Registered Nurse (RN) - H provided wound care to Resident 88's left lower leg as ordered.

A record review of Resident 88's CCP revealed:

-problem for skin impairment due to fragile skin initiated on 2/28/2024

current skin issues:

1) Scabbed area to right temple

2) chin

3) unmeasurable area inside left ear

4) Labia/groin/buttocks redness

5) bruise to left outer aspect of eye

6) Skin tear to right thigh

An interview on 10/16/24 at 9:41 AM with RN - H confirmed that all the resident careplans are supposed to be updated with all new orders and that careplans are periodically reviewed.

An interview on 10/16/24 at 9:47 AM with ADON - B confirmed that the wound to Resident 88's left lower leg is not on the careplan and should have been.

47312

B. Observation on 10/16/24 at 10:37 AM of wound care to Resident 7's right second toe with RN-I revealed after removal of Resident 7's slipper, an approximately pea sized open area to the knuckle area, with soft yellow scabbed center, no drainage or odor. Resident 7's skin around the area was without redness.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's MDS, dated [DATE], revealed the following: -One Stage 2 pressure injury (wound that affects the first two layers of skin) that was not present upon admission or reentry. Review of Resident 7's progress notes, dated 9/16/24 revealed the following: Weekly visual skin check complete. Noted new pressure area to right second toe. 1.1 cm x 1.1 cm in size. Area is non blanching with red and white center and purple skin at the outer edges of circle. No other areas of concern noted at this time. Review of Resident 7's CCP, dated 10/16/24, revealed a focus for potential for skin breakdown related to edema and impaired mobility. History of cellulitis to left lower extremity (LLE); Current skin issues: 1) Pressure injury to right second toe knuckle, revised 9/16/24. Further review of the care plan revealed no revisions were made and no new interventions were put into place after the area to Resident 7's toe was found. Review of the facility policy, Skin and Wound Management, dated 4/2019, revealed the following under Pressure Ulcer/Injury condition: -2. Care plan. All actions/interventions will be included in the care plan in PCC (point click care- electronic health record system) Interview on 10/16/24 at 10:55 AM with ADON-A confirmed that the care plan was not changed after the pressure area to Resident 7's right second toe was found, and Resident 7's care plan should have been updated. C. Review of Resident 87's orders, dated 10/15/24, revealed a new order received on 10/4/24 for Ativan (medication used to treat anxiety) oral tablet 0.5 milligrams (mg), give 0.5 tablet by mouth (PO) as needed (PRN) for anxiety for 30 days, give 0.25 mg PO twice daily PRN. Review of Resident 87's CCP, dated 10/15/24, revealed a focus of: uses psychoactive medications related to: depression, created 9/9/24. Further review of the CCP revealed no revisions or new interventions put into place after Resident 87 was started on an anti-anxiety medication. Interview on 10/16/24 at 7:51 AM with the MDS coordinator confirmed that there were no changes made to Resident 87's CCP after they were started on the anti-anxiety medication and that the CCP should have been updated. 45484 D. A record review of Resident 69's Admission Record printed 10/16/2024 revealed an admitted [DATE], and diagnoses of dementia, mood disorder, psychosis, and obsessive-compulsive disorder (OCD, a mental illness that causes people to have uncontrollable, recurring thoughts [obsessions] and repetitive behaviors [compulsions]). A record review of Resident 69's Quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating the resident was cognitively intact. (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 69's CCP revealed a focus for out-of-character responses due to dementia-related diagnosis. This focus had an initiation date of 06/27/2019 and had no revision dates or mention of specific responses the resident might exhibit. There was no mention in the CCP of the out-of-character responses or behaviors of coughing, looking for spouse, and frequent bathroom visits, or of the interventions of offering hard candy, going for walks, distraction, or offering food or snacks. A record review of Resident 69's Behavior/Intervention Monthly Flow Records for May 2024 to October 15, 2024, revealed the following: -May: Behaviors listed were OCD AEB [as evidenced by] face scratching, sleeplessness, agitation, and OCD AEB obsessed with toileting. A personalized intervention of encourage to come out of bathroom, was listed under OCD AEB obsessed with toileting. -June: Behaviors listed were OCD AEB face scratching, sleeplessness, and OCD AEB obsessed with toileting. There were no personalized interventions listed. -July: Behaviors listed were OCD AEB face scratching, sleeplessness, and OCD AEB obsessed with toileting. There were no personalized interventions listed. -August: Behaviors listed were OCD AEB face scratching and sleeplessness. There were no personalized interventions listed. -September: Behaviors listed were OCD AEB face scratching and sleeplessness. There were no personalized interventions listed. -October: Behaviors listed were OCD AEB face scratching, sleeplessness, and agitation. There were no personalized interventions listed. An interview on 10/16/2024 at 9:45 AM with Nurse Aide (NA) C revealed Resident 69 had behaviors of pacing the halls looking for their spouse, constantly going back and forth to the bathroom, and coughing frequently at meals. NA C stated the staff offered snacks and distraction to Resident 69 when they were pacing in the hall, and that was sometimes effective. NA C stated the coughing was a behavior, and to help with that, staff would take Resident 69 for a walk or offer hard candy. The NA reported there were no current effective interventions to distract Resident 69 from the bathroom. An interview on 10/16/2024 at 9:55 AM with NA D revealed Resident 69 had behaviors of going back and forth to the bathroom frequently. Reported that sometimes when the resident does that, they will forget they have eaten, so staff will save a tray for the resident. An interview on 10/16/2024 at 10:00 AM with NA E revealed that Resident 69 had behaviors of looking for their spouse, frequent bathroom trips, and coughing. NA E stated that staff attempted to redirect the resident or change the subject when Resident 69 was looking for their spouse and that going for walks and offering hard candy helped with the coughing. NA E further stated the resident's family member had suggested to have Resident 69 blow through a straw because that had helped in the past. NA E stated that there were no current effective interventions when the resident was going back and forth to the bathroom. NA E confirmed that the interventions of blowing in a straw, offering hard candy, and going for walks were not on the care plan. (continued on next page)

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