STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285245	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Manor	607 North Main Street Stuart, NE 68780

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 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. 45739 Licensure Reference Number 175 NAC 12-006.09(A) Based on record review and interview; the facility failed to ensure Resident 4's as needed antipsychotic (a type of medication which alters chemicals in the brain to effect changes in behavior, mood and emotion) medication was reviewed for continued need and renewed every 14 days as required. The sample size was 5 and the facility census was 27. Findings are: Review of the facility policy Antipsychotic Drug Use Policy, last revised 10/10 revealed the following: -all residents having antipsychotic drug orders would have a proper diagnosis, -resident behaviors would be monitored daily, -the Pharmacy would routinely monitor and request appropriate dose reductions, -the facility would utilize the lowest effective dose based on behaviors, -residents would have interventions on their care plans to assist in redirecting undesired behaviors, and -the resident's responsible party and/or the resident would be educated on the medication, diagnosis, dose changes, and side effects of the medications. Review of Resident 4's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 12/4/24 revealed the resident had severe cognitive impairment, didn't exhibit any behaviors, was dependent with toileting, dressing, and hygiene, and had a diagnosis of dementia, anxiety and depression. Review of Resident 4's Care Plan last revised 1/2/25 revealed the following: (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the resident had delusions and hallucinations, -was socially inappropriate at times, -had impaired cognitive function due to dementia, -used Haloperidol (an antipsychotic medication) for behavior management, and -required assistance with toileting, dressing, and hygiene. Review of the facility form Physician Orders for Resident 4 revealed the resident had an order for Haloperidol 5 milligrams (mg) by mouth every 8 hours as needed for agitation with a start dated of 11/25/24. Review of an email the Consulting Pharmacist sent to the Director of Nursing (DON) dated 11/26/24 revealed Resident 4 had an order for Haloperidol as needed with a stop date of 5/7/25. Recommendations were that since the Haloperidol is an antipsychotic medication, it was limited to 14 days, the resident would need to be seen by the provider for an evaluation every 14 days, and a follow-up visit was needed by 12/10/24. Review of the Consultant Pharmacist's Medication Regimen Review dated 1/15/25 revealed the last documented administration of the Haloperidol 5mg as needed was on 11/28/24. Review of the facility forms for Physician Visits revealed the following: -on 10/29/24 a Physician recertification visit had an order for Haloperidol 5mg every 8 hours as needed for agitation, -a visit on 11/12/24 revealed no documentation that the as needed Haloperidol was addressed (14 days after order), -a Physician visit on 11/19/24 revealed no documentation that the as needed Haloperidol was addressed (21 days after order), -a Physician visit on 12/24/24 revealed the Physician wrote to continue the as needed Haloperidol 5 mg every 8 hours as needed for dementia with psychosis (56 days after original order), but did not document a resident specific rationale, -a Physician recertification visit on 1/7/25, the Physician wrote to continue the Haloperidol 5 mg every 8 hours as needed for psychosis but did not document a resident specific rationale, -a visit on 1/21/25 the Physician wrote the Resident still needs Haloperidol and to continue Haloperidol as needed for dementia with psychosis but did not document a resident specific rationale, -a visit on 1/28/25 the Physician wrote Haloperidol 5 mg every 8 hours as needed for diagnosis of dementia with psychosis, but did not document a resident specific rationale, -a visit on 2/4/25 there was no documentation that the as needed Haloperidol was addressed, and (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-a visit on 2/11/25 there was no documentation that the as needed Haloperidol was addressed (14 days since it was last renewed). Interview on 2/19/25 at 12:50 PM with Registered Nurse (RN)-C confirmed the resident had not been seen every 14 days as required for the as needed Haloperidol. Further interview confirmed the resident had not had any adverse behaviors, the resident did not need to use the medication, and had not received the medication since 11/28/24. Interview on 2/19/25 at 1:45 PM with RN-C and the DON confirmed Resident 4 was not seen every 14 days for the as needed Haloperidol.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51391 Licensure Reference Number 175 NAC 12.006(D)(vi) Based on observation, record review and interview; the facility failed to ensure insulin pens were dated when opened to ensure safe administration of insulin for Resident 17 and Resident 129. The sample size was 4 and the facility census was 27. Findings are: A. Review of the facility policy Insulin Administration with a revised date of [DATE] revealed the following: -The purpose of the Insulin Administration policy was to provide guidelines for the safe administration of insulin to residents with diabetes. -Check expiration date, if drawing from an opened multi-dose vial. If opening a new vial, record expiration date and time on the vial. Review of Resident 129's February 2025 medication administration record (MAR) revealed an order for Aspart (rapid acting insulin)10 units in the morning. An observation on [DATE] at 7:35 AM with Licensed Practical Nurse (LPN)-G obtained Resident 129's insulin pen out of the medication cart for administration. The Aspart Insulin did not have an open date or expiration date documented. Inspection of the medication cart on [DATE] at 11:30 AM revealed Resident 17's Toujeo (long-acting insulin) insulin pen did not have an open date or expiration date documented. Review of Resident 17's February 2025 physician orders revealed an order for Toujeo 24 units at bedtime. Interview on [DATE] at 7:35 AM with LPN-G verified that the insulin pen for Resident 129 was not dated when opened or dated when expired and insulin pens were to be dated when opened and expired. Interview on [DATE] at 11:30 AM with LPN-G verified that the insulin pen for Resident 17 was not dated when opened or dated when expired.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51391 Licensure Reference Number 175 NAC 006.18(B) Based on observation, record review, and interview the facility failed to Covid 19 test 6 of 6 sampled residents (Resident 10, 11, 14, 17, 21, and 26) when respiratory illness symptoms were displayed and failed to implement isolation procedures for Resident 10 when respiratory symptoms were displayed. The facility failure had the potential to effect all residents in the building. The sample size was 6 and the census was 27. Findings are: A. Review of the facility policy Upper Respiratory Illness with a revision date of 9/4/24 revealed the following: -The facility made every attempt to prevent the transmission of any upper respiratory illness from entering the facility and also reduce the transmission of illness with the facility. -To reduce the transmission of upper respiratory illness mask and sanitizer was available at the main entrances, visitors were asked to use hand sanitizer before visiting residents, staff strictly adhered to hand, respiratory, and cough hygiene, and vaccinations were offer to all staff and residents. -To reduce the transmission of upper respiratory illness within the facility staff strictly adhered to hand respiratory and cough hygiene and were encouraged to report symptoms on themselves and/or others as soon as possible, precautions were instituted in rooms where there were suspected or confirmed cases of any transmissible respiratory illness, and any person/s that had fever or symptoms of transmissible respiratory illness including but not limited to COVID and influenza, isolated for at least 5 days from onset of symptoms or the first day of positive test results. -Infected residents were isolated and closely monitored and positive cases were investigated and tracked for case origination. The Director of Nursing (DON) or designee determined who needed to be tested and to determine outbreak testing. -Staff having signs and symptoms of COVID should test to determine if they need to isolate. B. Review of Resident 10's Progress Notes revealed the following: -2/14/2025 at 9:52 AM Resident 10 was confused and required increased assistance with getting dressed and completing cares. Oxygen level was 80% on room air. Oxygen per nasal cannula was applied at 2 liters per nasal cannula. (No follow up oxygen level was charted.) -2/15/25 at 8:00 PM revealed Resident 10 had a harsh cough was noted and both eyes had yellow color drainage. Oxygen level was 91% with oxygen at 2 liters per nasal cannula. -2/16/25 at 7:00 PM revealed Resident 10 continued with a harsh moist cough. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2/17/25 9:25 AM revealed Resident 10 had a moist, harsh, non-productive cough. Crackles were noted in bilateral lungs with diminished air exchange. Oxygen level was 82% on room air, oxygen was applied at 2 liters per nasal cannula, oxygen level increased to 90%. -2/17/25 at 9:42 AM the facility staff received a physician's order for an antibiotic medication for Pneumonia. -2/18/25 at 1:52 PM revealed Resident 10 continued with a moist cough. Lung sounds were diminished in upper lobes with crackles in the lower lobes bilaterally. Observations of Resident 10 revealed the following: - 2/18/24 at 8:50 AM revealed Resident 10 was sitting in a recliner in room, voice crackled, and a loose nonproductive cough was noted. -2/19/25 10:00 AM revealed Resident 10 was in the bathroom, had loose productive cough noted and had coughed up yellow colored phlegm. C. Review of Nursing Progress Notes for Resident 11 revealed the following: -1/30/25 at 10:52 AM revealed Resident 11 had sinus and nasal congestion, both eyes were mattery and puffy under eyes. -1/30/25 at 1:59 PM revealed the facility staff received physicians order for a decongestant and cough medication. 1/31/25 at 10:36 AM revealed Resident 11 continued with nasal congestion and had a non-productive cough. -2/1/25 9:05 AM revealed Resident 11 had a productive cough, head was congested, lung sounds were diminished. -2/4/25 at 9:56 AM, Resident 11 continued with nasal congestion and complained of ears feeling full. Face was puffy with a moist nonproductive cough. Both eyes had drainage. -2/4/25 at 12:31 PM, the resident was seen by physician and received an order for an antibiotic for pneumonia. -2/5/25 at 2:50 PM, Resident 11 continued with a harsh productive cough, lung sounds were diminished bilaterally upper and lower lobes. -2/7/25 at 10:50 AM the resident continued with an occasional moist non-productive cough noted. D. Review of Nursing Progress Notes for Resident 17 revealed the following: -2/8/25 at 10:46 AM, Resident 17 complained of sinus and nasal congestion. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-2/8/25 at 12:09 PM,Physician order received for Benadryl 25 milligrams (mg) every 6 hours as needed for sinus and nasal congestion. -2/9/25 at 10:56 AM, Resident 17 continued with sinus and nasal congestion. -2/10/25 at 1:06 PM, Resident 17 continued to have nasal and sinus congestion. -2/11/25 at 2:05 AM hoarse voice was noted when speaking. An interview with Registered Nurse (RN)-C, infection control nurse, on 2/18/25 at 11:55 AM verified residents 10, 11 and 17 did not have a Covid 19 test or respiratory panel completed when respiratory symptoms started. RN-C further confirmed Resident 10 was not placed in isolation when respiratory symptoms started. 42360 E. Review of Resident 14's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 1/1/25 revealed the resident had moderate cognitive impairment, received substantial assistance with dressing and hygiene, was incontinent of bowel and bladder, and had dementia. Review of Resident 14's Care Plan with a revision date of 10/29/24 revealed the resident had dementia with difficulty making decisions and intermittent confusion. In addition, the resident took medications to treat Congestive Heart Failure and Depression. There was no evidence of treatment for a current or recent respiratory infection. Review of Resident 14's Progress Notes revealed the following: -1/14/25 at 12:31 PM the resident was seen by the physician in the facility and had coarse lung sounds and a loose cough. The physician ordered an antibiotic and anti-inflammatory medication. -1/15/25 at 10:29 AM the resident continued to have coarse lung sounds and a cough -1/16/25 at 6:11 AM the resident continued taking an antibiotic for a respiratory infection and continued to nasal drainage and coughing. -Further review revealed there was no evidence the facility completed COVID testing when the resident presented with signs and symptoms of a potentially infectious respiratory illness. During an interview on 2/18/25 at 3:41 PM the DON revealed the facility was not routinely COVID testing residents who presented with respiratory illness signs and symptoms. The DON would check to see if a COVID-19 test was completed for Resident 14 when respiratory illness symptoms were identified on 1/15/25. During an interview on 2/19/25 at 4:47 PM the DON confirmed the facility did not complete a COVID-19 or any type of respiratory panel testing to identify which respiratory illness Resident 14 had, when the resident presented with respiratory illness symptoms on 1/15/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. Review of Resident 21's MDS dated [DATE] revealed the resident had pneumonia and lung disease, however the resident was offered but declined a pneumonia vaccine. Review of Resident 21's Care Plan with a revision date of 1/2/25 revealed the resident had respiratory disease, shortness of breath and dementia. The resident displayed anxiety and anxiousness when having shortness of breath. Oxygen was used as needed. There was no indication the resident had a recent respiratory infection. Review of Resident 21's Progress Notes revealed the following: -on 1/26/24 at 2:50 PM the resident complained of signs and symptoms of a cold, a loose cough and was given oxygen to help with anxiety and discomfort. -on 1/27/24 at 1:00 AM the resident had a moist cough, labored breathing, and an oxygen level of 83% (90-100% is considered normal). The resident's oxygen levels did not improve with oxygen and thus the resident was transferred to the hospital by ambulance. -Further review revealed there was no evidence the facility completed COVID testing when the resident presented with signs and symptoms of a potentially infectious respiratory illness. During an interview on 2/18/25 at 3:41 PM the DON revealed the facility was not routinely COVID testing residents who presented with respiratory illness signs and symptoms. The DON would check to see if a COVID-19 test was completed for Resident 21 when respiratory illness symptoms were identified on 1/26/24. During an interview on 2/19/25 at 4:47 PM the DON confirmed the facility did not complete a COVID-19 or any type of respiratory panel testing to identify which respiratory illness Resident 21 had, when the resident presented with respiratory illness symptoms on 1/26/24. G. Review of Resident 26's MDS dated [DATE] revealed the resident had dementia, a respiratory condition, diabetes and had taken insulin and an antibiotic in the preceding week. Review of Resident 26's Care Plan with a revision date of 1/15/25 revealed the resident had impaired cognition and required assistance with activities of daily living. In addition, the resident had a history of falling, was diabetic and received insulin daily. There was no evidence the resident had current or recent respiratory illness. Review of Resident 26's Progress Notes revealed the following: -On 12/26/24 at 3:21 PM the resident had congestion and general malaise and an occasional cough. -On 12/28/24 at 5:24 PM the resident continued to complain of head congestion and requested a room tray for dinner. -On 12/29/24 at 9:47 AM the resident congestion was not improving, and the facility called and updated the provider on the resident's symptoms. The provider ordered an anti-inflammatory medication. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 12/30/24 at 5:17 PM the provider visited the resident in the facility and ordered an antibiotic and nebulizer (inhaled breathing) treatments. -Further review revealed there was no evidence the facility completed COVID testing when the resident presented with signs and symptoms of a potentially infectious respiratory illness. During an interview on 2/18/25 at 3:41 PM the DON revealed the facility was not routinely COVID testing residents who presented with respiratory illness signs and symptoms. The DON would check to see if a COVID-19 test was completed for Resident 26 when respiratory illness symptoms were identified on 12/26/24. During an interview on 2/19/25 at 4:47 PM the DON confirmed the facility did not complete a COVID-19 or any type of respiratory panel testing to identify which respiratory illness Resident 26 had, when the resident presented with respiratory illness symptoms on 12/26/24.