STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview, the facility failed to ensure that investigations of potential abuse or neglect were submitted to the state agency within 5 working days as required for 2 residents (Residents 6 and 2) of 3 residents reviewed. The facility census was 21. Findings are: A. Record review of the facility policy titled Abuse, Neglect, and Exploitation dated 2/1/24 revealed that it is the facility policy to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation occur. Record review of the facility policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation dated 2/1/24 revealed it is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. The Facility Administrator or designee will report sufficient information to describe the result of the investigation and any corrective actions taken within 5 working days of the incident. Record review of the Admission Record dated 7/8/24 for Resident 6 revealed that Resident 6 admitted into the facility on [DATE]. Record review of the Care Plan dated 7/8/24 for Resident 6 revealed that Resident 6 is at risk for falls. The care plan revealed that Resident 6 had falls in the facility on 10/8/23, 10/14/23, and 4/24/24. Record review of the progress note for Resident 6 dated 4/24/24 at 8:07 AM revealed that Resident was laying on the floor of the resident's room just outside of the bathroom doorway. When staff began to assist Resident 6, Resident 6 stated ooow with facial grimacing noted. Resident 6 complained of pain in the left mid-thigh and right hip and buttock. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the progress note for Resident 6 dated 4/24/24 at 9:15 AM revealed that an ambulance was requested. Resident 6 was transferred to the emergency room . Record review of the progress note for Resident 6 dated 4/24/24 at 12:15 PM revealed that the report from the hospital revealed that Resident 6 had a fracture of the cervical spine C1 (one of 7 stacked spinal bones that start at the top of the shoulders and continue up to support the skull). Record review of the email dated 5/1/24 at 3:43 PM from the Facility Administrator (FA) to the state agency revealed that it was the investigation report for Resident 6 (This was the 6th business day after Resident 6's fall with injury on 4/24/24). Interview on 7/10/24 at 11:05 AM with the FA confirmed that the email dated 5/1/24 at 3:43 PM was the investigation report submitted to the state agency for Resident 6's fall with injury on 4/24/24. The FA confirmed that the facility had not counted the day of occurrence as day 1 when calculating the 5 days. The FA confirmed the facility had not submitted the investigation to the state agency within 5 business days. B. Record review of the Admission Record dated 7/9/24 for Resident 2 revealed that Resident 2 admitted into the facility on [DATE]. Record review of the progress note for Resident 2 dated 5/14/24 at 11:54 AM revealed that Resident 2 requested that their Social Security check be deposited into their resident trust account and that the resident's bank account be closed. Resident 2 revealed they no longer wanted their child to have access to their finances. The facility notified the Social Security Office of the change requested by Resident 2. The facility contacted the bank to have the money in the bank account of Resident 2 mailed to Resident 2 in the facility. Record review of the progress note for Resident 2 dated 5/24/24 at 3:06 PM revealed that the child of Resident 2 called and requested that the facility send transfer information for Resident 2 to another long-term care facility. The facility faxed the information to the other facility as requested. Record review of the progress note for Resident 2 dated 5/25/24 at 12:19 AM revealed Resident 2 was having difficulty falling asleep. Resident 2 revealed that the resident was still upset about what went on earlier in the day. Record review of the progress note for Resident 2 dated 5/30/24 at 11:34 AM revealed that the child of Resident 2 contacted the facility to send referral information to another long-term care facility. This is the second facility the child requested information be sent to. Resident 2 feels their child wants the resident moved to another facility in order to regain access to Resident 2's bank account. Record review of the progress note for Resident 2 dated 6/4/24 at 2:44 PM revealed that Resident 2 is feeling somewhat indifferent to their child misappropriating the resident's finances. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility misappropriation investigation dated 6/3/24 revealed that Adult Protective Services (APS) was notified on 5/24/24 at 11:37 AM to notify them of the misappropriation of Resident 2's finances. Record review of the email dated 6/3/24 at 5:00 PM from the Facility Administrator (FA) to the state agency revealed that it was the investigation report for Resident 2 (This was the 7th business day after the misappropriation of Resident 2's finances was reported to APS on 5/24/24). Interview on 7/10/24 at 11:05 AM with the FA confirmed that the email dated 6/3/24 at 5:00 PM was the investigation report submitted to the state agency for Resident 2's misappropriation of finances for the 5/24/24 report to APS. The FA confirmed that the facility had not submitted the investigation to the state agency within 5 business days for Resident 2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(H) Based on observation, record review, and interview the facility failed to ensure that residents receiving antipsychotic medications (a psychotropic medication that affects behavior, mood, thoughts, or perception and is used to manage psychotic disorders) were monitored for adverse reactions for 2 of 5 residents reviewed (Residents 6 and 5) and failed to ensure that PRN (as needed) psychotropic medications had a documented rationale and determined duration for use for 1 of 5 residents reviewed (Resident 5). The facility census was 21. Findings are: A. Record review of the facility policy titled Use of Psychotropic Drugs dated 1/13/23 revealed that residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Residents who receive psychotropic medications at regular intervals shall be evaluated on an ongoing basis for the effects of the psychotropic medications on their physical, mental, and psychosocial well-being during Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) review (quarterly, annually, significant change) and in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care. Record review of the MDS assessment dated [DATE] for Resident 6 revealed that Resident 6 admitted into the facility on [DATE]. The MDS revealed that Resident 6 is [AGE] years old. The MDS revealed that Resident 6 had a diagnosis of Dementia, Anxiety, and a diagnosis of Psychotic Disorder other than schizophrenia (a severe mental disorder that causes abnormal thinking and perceptions). The MDS revealed that Resident 6 took an antipsychotic medication during the MDS assessment lookback period. Record review of the Order Summary dated 7/9/24 for Resident 6 revealed that Resident 6 had a physician's order to take Seroquel 25 milligrams (an antipsychotic medication) daily. Record review of the Medication Administration Record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) dated December 2023 revealed that Resident 6 received Seroquel 25 milligrams daily every day in December 2023 (12/1/23-12/31/23). Record review of the MAR dated January 2024 revealed that Resident 6 received Seroquel 25 milligrams daily every day in January 2024 (1/1/24-1/31/24). Record review of the MAR dated February 2024 revealed that Resident 6 received Seroquel 25 milligrams daily on 27 of 29 days in February 2024 (2/1/24-2/27/24). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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	Record review of the MAR dated March 2024 revealed that Resident 6 received no Seroquel 25 milligrams daily during March 2024 (3/1/24-3/31/24). Record review of the MAR dated April 2024 revealed that Resident 6 received Seroquel 25 milligrams daily on 7 of 30 days in April 2024 (4/27/24-4/30/24). Record review of the MAR dated May 2024 revealed that Resident 6 received Seroquel 25 milligrams daily every day in May 2024 (5/1/24-5/31/24). Record review of the MAR dated June 2024 revealed that Resident 6 received Seroquel 25 milligrams daily every day in June 2024 (6/1/24-6/30/24). Record review of the MAR dated July 2024 for the dates of 7/1/24-7/9/24 revealed that Resident 6 received Seroquel 25 milligrams daily every day as of 7/9/24 (7/1/24-7/9/24). Record review of the Nursing 2018 Drug Handbook revealed that Seroquel is in the therapeutic class of antipsychotics (Seroquel is an antipsychotic medication). Seroquel has a Black Box Warning specifying that Seroquel is not indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from cardiovascular disease or infection. Adverse reactions include extrapyramidal reaction (involuntary movements that you cannot control caused by antipsychotic medications). Monitor patient for tardive dyskinesia (an extrapyramidal reaction where your face, body or both make sudden, irregular movements which you cannot control. It can develop as a side effect of medication, most commonly antipsychotic drugs). Observation on 7/9/24 at 7:30 AM in the facility dining room revealed that Resident 6 sat at a table. An unidentified Dietary staff delivered the breakfast meal to Resident 6. Resident 6 slowly picked up a weighted fork with the right hand. Resident 6's right arm did not bend beyond approximately 20 degrees per visual measurement and appeared stiff. Resident 6 began to feed themselves. Resident 6 struggled to lift the fork to their mouth. Observation on 7/10/24 at 8:05 AM in the facility dining room revealed that Resident 6 sat at a dining room table. A plate of food was on the table in front of the resident. Nurse Aide-C (NA-C) sat to the left of Resident 6 and used the silverware to feed Resident 6. Record review of the Care Plan dated 7/8/24 for Resident 6 revealed that Resident 6 uses psychotropic medications (Seroquel) related to hallucinations. Interventions included monitor/document/report any adverse reactions of psychotropic medications: unsteady gait (a person's manner of walking), tardive dyskinesia, EPS (Extrapyramidal Symptoms) (shuffling gait, rigid muscles, shaking). Record review of the medical record for Resident 6 revealed that one Abnormal Involuntary Movement Assessment (AIMS) (an assessment used to assess for abnormal irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips) was completed for Resident 6 on 12/1/23. The medical record revealed no other completed assessments to monitor Resident 6 for adverse extrapyramidal reactions. Record review of the AIMS assessment dated [DATE] for Resident 6 revealed that there was no rigidity of either the right or left arm of Resident 6. The resident was scored as 0.0 meaning no observed abnormal movements or impact of movements on the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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	Interview on 7/10/24 at 12:17 PM with the facility Infection Preventionist (IP) confirmed that Resident 6 takes an antipsychotic medication that requires monitoring for extrapyramidal symptoms. The IP confirmed that the expectation is for an Abnormal Involuntary Movement (AIMS) assessment to be performed quarterly for residents taking antipsychotic medications. The IP confirmed that quarterly AIMS assessments were not completed for Resident 6 as required. 50105 B. Record review of Resident 5's Minimum Data Set (MDS-a federally mandated comprehensive assessment used to develop the resident care plan) dated 05/01/2024 revealed the following: -diagnosis of unspecified dementia, hallucinations, unspecified severity with psychotic disturbance, abnormal weight loss, anxiety disorder unspecified, (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and the presence of cardiac pacemaker -Cognitive score of 1/15, indicating severe cognitive impairment. -behaviors were not indicated in the MDS -the resident received the following high risk drug class medications: antianxiety, antidepressants, antipsychotics, anticoagulants, and diuretics. Record review of Resident 5's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) with a revision date of 06/05/2024 revealed the following: -the resident uses an antidepressant medication -the resident uses an antianxiety medication -the resident uses a psychotropic medication -the resident has behaviors related to dementia evidenced by ineffective coping skills, poor impulse control, hallucinating, and anxiety -the resident has impaired cognitive and communication functions related to dementia, and anxiety, evidenced by hallucinating thoughts -monitor/document/report as needed any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, extrapyramidal symptoms (EPS). Record review of Resident 5's order summary report of physician orders revealed the following psychotropic (any medication that affects behavior, mood, thoughts, or perception) medications: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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	-Zoloft (antianxiety) 50 milligram (mg) one time daily for the treatment of anxiety, with a start date of 08/11/2022 -Buspirone (antianxiety) 5 mg one time daily for the treatment of anxiety, with a start date of 8/11/2022 -Lorazepam (antianxiety) 0.5 mg every 6 hours PRN for anxiety or agitation with a start date of 07/28/2022. Record review of Resident 5's order summary report of physician orders revealed the following ordered antipsychotic (a psychotropic medication used to manage psychotic disorders) medications: -Haloperidol (antipsychotic) 0.5 milliliters (mL) every 6 hours PRN for agitation with a start date of 11/12/2023 and a discontinuation date of 06/19/2024 Record review of Resident 5's order summary report of physician orders revealed the following orders: -admission to hospice services with a start date of 11/06/2023 and a discontinuation date of 04/24/2024 Record review of Resident #5's medical record revealed no assessments for abnormal involuntary movement scale (AIMS) for the medication Haloperidol. The medical record revealed no assessments completed for the duration of the active PRN medication ordered. Interview with IP on 07/09/2024 at 2:20 PM revealed no AIMS assessment or other assessments were completed for the ordered and duration of use for the as needed antipsychotic medication Haloperidol. C. Record review of facility policy titled Use of Psychotropic Drugs with a revised date of 01/12/2024 reveals: Policy: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnoses and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Policy Explanation and Compliance Guidelines: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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	8. PRN orders for psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN medication order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. b. PRN orders for antipsychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication. 10. The resident's response to the medications(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. 11. Use of psychotropic medications in specific circumstances: a. Acute or emergency situations (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety or resident or others): ii. Use of the psychotropic medication shall be consistent with #8 above, regarding PRN orders. Record review of Resident 5's Minimum Data Set (MDS-a federally mandated comprehensive assessment used to develop the resident care plan) dated 05/01/2024 revealed the following: -diagnosis of unspecified dementia, hallucinations, unspecified severity with psychotic disturbance, abnormal weight loss, anxiety disorder unspecified, (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and the presence of cardiac pacemaker -cognitive score of 1/15, indicating severe cognitive impairment. -behaviors were not indicated in the MDS -the resident received the following high risk drug class medications: antianxiety, antidepressants, antipsychotics, anticoagulants, and diuretics. Record review of Resident 5's Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) with a revision date of 06/05/2024 revealed the following: -the resident uses an antidepressant medication -the resident uses an antianxiety medication -the resident uses a psychotropic medication (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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	-the resident has behaviors related to dementia evidenced by ineffective coping skills, poor impulse control, hallucinating, and anxiety -the resident has impaired cognitive and communication functions related to dementia, and anxiety, evidenced by hallucinating thoughts Record review of Resident 5's order summary report of physician orders revealed the following psychotropic (any medication that affects behavior, mood, thoughts, or perception) medications: -Zoloft (antianxiety) 50 milligram (mg) one time daily for the treatment of anxiety, with a start date of 08/11/2022 -Buspirone (antianxiety) 5 mg one time daily for the treatment of anxiety, with a start date of 08/11/2022 -Lorazepam (antianxiety) 0.5 mg every 6 hours as needed for anxiety or agitation with a start date of 07/28/2022. Record review of Resident 5's order summary report of physician orders revealed the following ordered antipsychotic (a psychotropic medication used to manage psychotic disorders) medications: -Haloperidol (antipsychotic) 0.5 milliliters (mL) every 6 hours as needed for agitation with a start date of 11/12/2023 and a discontinuation date of 06/19/2024 Record review of psychotropic and antipsychotic medications ordered as needed did not contain a documented rationale and did not contain a determined duration of use date. Interview with the DON on 07/09/2024 at 11:29 PM revealed there was no physician documented rationale or determined duration of use for the as needed ordered antianxiety medication Lorazepam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to ensure a medication error rate of less than 5% with an observed medication error rate of 7.14% (28 medication administrations with 2 errors). The facility census was 21. Findings are: A. Record review of the facility policy titled Insulin Pen dated 2/1/24 revealed that it is the policy of the facility to use insulin pens in order to improve the accuracy of insulin dosing. The section titled Policy Explanation and Compliance Guidelines revealed that insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. The section titled Procedure revealed the step to attach the pen needle. The procedure steps continued to prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. The procedure steps continued to set the insulin dose: Turn the dose selector to the ordered dose. A click will be heard for each unit dialed. Check dose a second time. Record review of the Admission Record dated 7/9/24 for Resident 2 revealed that Resident 2 admitted into the facility on [DATE]. Resident 2 had diagnosis of Diabetes Mellitus (a chronic disease characterized by elevated levels of blood sugar, which leads over time to serious damage to the heart, blood vessels, eyes, kidneys, and nerves). Record review of the Medication Administration Record (MAR) dated 7/9/24 for Resident 2 revealed that Resident 2 had an order to receive 28 units of Novolog insulin (a mealtime insulin injected under the skin made to help control blood sugar spikes in adults with diabetes) three times daily at 7:30 AM, 11:00 AM, and 5:00 PM. Observation on 7/09/24 at 11:32 AM at the medication cart revealed that Licensed Practical Nurse-A (LPN-A) reviewed the insulin order for Resident 2. LPN-A confirmed that Resident 2 has an order for Novolog insulin (a rapid-acting Insulin to help control blood sugar spikes in adults with diabetes) 28 units subcutaneously (under the skin) three times a day before each meal. LPN-A removed the Novolog insulin pen from inside the medication cart. LPN-A removed the cap from the insulin pen and wiped the top of the pen with an alcohol prep pad. LPN-A dialed the pen dose to 28 units. LPN-A applied a needle to the top of the insulin pen. (LPN-A did not dial the pen to 2 units and prime the needle prior to dialing the ordered dose of 28 units). LPN-A entered the room of Resident 2 with the insulin pen. LPN-A asked Resident 2 which arm they would like the insulin administered in. LPN-A wiped the upper right arm of Resident 2 with an alcohol prep pad. LPN-A placed the insulin pen against the skin of Resident 2's right upper arm and administered the insulin. LPN-A removed the needle from the insulin pen and discarded it into the sharp's container in the resident's room. LPN-A returned to the medication cart and documented the insulin administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/10/24 at 2:52 PM with the facility Director of Nursing (DON) confirmed that staff are expected to prime the insulin pen prior to dialing the ordered insulin dose on the insulin pen to ensure the resident received the correct dose of insulin per the physician's order. The DON confirmed that not priming the insulin pen was a medication error. B. Observation on 7/10/24 at 11:49 AM at the medication cart outside the room of Resident 2 revealed that Licensed Practical Nurse-B (LPN-B) reviewed the insulin order for Resident 2. LPN-B confirmed that Resident 2 has an order for Novolog insulin (a rapid-acting Insulin to help control blood sugar spikes in adults with diabetes) 28 units subcutaneously three times a day before each meal. LPN-B carried the insulin pen and supplies into the room of Resident 2. LPN-B picked up the Novolog insulin pen and removed the cap from the insulin pen. LPN-B opened a needle and attached the needle to the insulin pen. LPN-B dialed the pen dose to 28 units. (LPN-B did not dial the pen to 2 units and prime the needle prior to dialing the ordered dose of 28 units). LPN-B wiped the upper right arm of Resident 2 with an alcohol prep pad. LPN-B placed the insulin pen against the skin of Resident 2's right upper arm and administered the insulin. LPN-B removed the needle from the insulin pen and discarded the needle into the sharp's container in the resident bathroom. LPN-B returned to the medication cart. Interview on 7/10/24 at 2:52 PM with the DON confirmed that staff are expected to prime the insulin pen prior to dialing the ordered insulin dose on the insulin pen to ensure the resident received the correct dose of insulin per the physician's order. The DON confirmed that not priming the insulin pen was a medication error.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to prevent significant medication errors (a medication error which causes the resident discomfort or jeopardizes his or her health and safety) for 1 of 4 residents observed (Resident 2). The facility census was 21. Findings are: A. Record review of the facility policy titled Insulin Pen dated 2/1/24 revealed that it is the policy of the facility to use insulin pens in order to improve the accuracy of insulin dosing. The section titled Policy Explanation and Compliance Guidelines revealed that insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. The section titled Procedure revealed the step to attach the pen needle. The procedure steps continued to prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. The procedure steps continued to set the insulin dose: Turn the dose selector to the ordered dose. A click will be heard for each unit dialed. Check dose a second time. Record review of the Admission Record dated 7/9/24 for Resident 2 revealed that Resident 2 admitted into the facility on [DATE]. Resident 2 had a diagnosis of Diabetes Mellitus (a chronic disease characterized by elevated levels of blood sugar, which leads over time to serious damage to the heart, blood vessels, eyes, kidneys, and nerves). Record review of the Medication Administration Record (MAR) dated 7/9/24 for Resident 2 revealed that Resident 2 had an order to receive 28 units of Novolog insulin (a mealtime insulin injected under the skin made to help control blood sugar spikes in adults with diabetes) three times daily at 7:30 AM, 11:00 AM, and 5:00 PM. Observation on 7/09/24 at 11:32 AM at the medication cart revealed that Licensed Practical Nurse-A (LPN-A) reviewed the insulin order for Resident 2. LPN-A confirmed that Resident 2 has an order for Novolog insulin (a rapid-acting Insulin to help control blood sugar spikes in adults with diabetes) 28 units subcutaneously (under the skin) three times a day before each meal. LPN-A removed the Novolog insulin pen from inside the medication cart. LPN-A removed the cap from the insulin pen and wiped the top of the pen with an alcohol prep pad. LPN-A dialed the pen dose to 28 units. LPN-A applied a needle to the top of the insulin pen. (LPN-A did not dial the pen to 2 units and prime the needle prior to dialing the ordered dose of 28 units). LPN-A entered the room of Resident 2 with the insulin pen. LPN-A asked Resident 2 which arm they would like the insulin administered in. LPN-A wiped the upper right arm of Resident 2 with an alcohol prep pad. LPN-A placed the insulin pen against the skin of Resident 2's right upper arm and administered the insulin. LPN-A removed the needle from the insulin pen and discarded it into the sharp's container in the resident's room. LPN-A returned to the medication cart and documented the insulin administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaver City Manor	905 Floyd Street Beaver City, NE 68926

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 7/10/24 at 2:52 PM with the facility Director of Nursing (DON) confirmed that staff are expected to prime the insulin pen prior to dialing the ordered insulin dose on the insulin pen to ensure the resident received the correct dose of insulin per the physician's order. The DON confirmed that not priming the insulin pen was a significant medication error. B. Observation on 7/10/24 at 11:49 AM at the medication cart outside the room of Resident 2 revealed that Licensed Practical Nurse-B (LPN-B) reviewed the insulin order for Resident 2. LPN-B confirmed that Resident 2 has an order for Novolog insulin (a rapid-acting Insulin to help control blood sugar spikes in adults with diabetes) 28 units subcutaneously three times a day before each meal. LPN-B carried the insulin pen and supplies into the room of Resident 2. LPN-B picked up the Novolog insulin pen and removed the cap from the insulin pen. LPN-B opened a needle and attached the needle to the insulin pen. LPN-B dialed the pen dose to 28 units. (LPN-B did not dial the pen to 2 units and prime the needle prior to dialing the ordered dose of 28 units). LPN-B wiped the upper right arm of Resident 2 with an alcohol prep pad. LPN-B placed the insulin pen against the skin of Resident 2's right upper arm and administered the insulin. LPN-B removed the needle from the insulin pen and discarded the needle into the sharp's container in the resident bathroom. LPN-B returned to the medication cart. Interview on 7/10/24 at 2:52 PM with the DON confirmed that staff are expected to prime the insulin pen prior to dialing the ordered insulin dose on the insulin pen to ensure the resident received the correct dose of insulin per the physician's order. The DON confirmed that not priming the insulin pen was a significant medication error.