STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285273	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainview Manor	101 W Harper Ave Plainview, NE 68769

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 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 45739 Licensure Reference Number 175 NAC 12-006.04A3b Based on record review and interview, the facility failed to ensure residents were free from potential abuse regarding a failure to verify there were no negative findings in the state nurse aide registry for 2 (Dietary Aides F & K) of 5 employee records reviewed. The facility census was 34. Findings are: A. Review of the undated Resident Abuse & Neglect Policy revealed: 1) all employees would have license verifications completed via the state board of licensure/registry and 2) the facility would not employ anyone that had a history of documented resident abuse or subsequently found guilty of any abuse. Record review on 8/7/24 at 08:15 AM of Dietary Aide (DA)-F's employee record revealed DA-F was hired on 2/13/24. There was no evidence of documentation facility staff had checked the state nurse aide registry for adverse findings prior to DA-F working in the facility. Record review on 8/7/24 at 08:15 Am of DA-K's employee record revealed DA-K was hired on 2/15/24. There was no evidence of documentation facility staff had checked the state nurse aide registry for adverse findings prior to DA-K working in the facility. An interview with the Business Office Manager (BOM) on 8/7/24 at 08:35 AM confirmed there was no evidence of documentation the state nurse aide registry was checked for employees DA-F and DA-K prior to them working in the facility. In addition, the BOM confirmed both employees had been working since they were hired in February 2024.

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 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** 45739 Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to report an incident related to elopement for Resident 15. The sample size was 2 and the facility census was 34. Findings are: Review of the facility policy Elopement Emergency, undated revealed the following: -once a resident leaves facility grounds it was considered an elopement, -upon return to the facility, the resident would be assessed for injuries, -the resident's provider would be notified, -the charge nurse would document all events that transpired prior to the elopement through the residents return assessment including how the elopement occurred, if the alarm sounded, and the time the Director of Nursing (DON), Administrator, and Provider were notified, -Adult Protective Services (APS) would be notified within 24 hours (unless injury and medical treatment needed must be within 2 hours), -the Administrator, DON, and Social Service Director (SSD) would complete an investigation within 5 working days, -if a resident was not wearing a wander guard one would be placed, -residents that were at risk of elopement or had a wander guard device would be left unattended outside of the facility, and -nursing would monitor and document the resident for 48 hours after the elopement. Review of Resident 15's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 7/25/23 revealed the following: -the resident was admitted on [DATE], -had severe cognitive impairment, -had diagnoses of high blood pressure, arthritis, and dementia, -behaviors included hallucinations, delusions, and daily wandering, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-required moderate assistance with toileting and dressing and supervision with transfers and ambulation, and -a wander guard alarm was not in use. Review of the facility form Wandering Risk Scale dated 7/29/23 revealed the resident was found to be at high risk for wandering. Review of the facility form Morse Fall Scale dated 7/29/23 revealed the resident was found to be at high risk for falling. Review of the resident's Progress Notes an entry dated 8/15/23 at 3:58 PM revealed the resident was found outside of the building by themself, the resident went back inside easily with staff assistance, and a wander guard was placed. Further review revealed no documentation that the DON, Administrator, Provider or that APS had been notified. Review of the resident's Care Plan last revised on 10/24/23 revealed on 8/18/23 the resident wandered outside by themself, and a wander guard was placed on the resident's wrist was handwritten in. Interview on 8/7/24 at 3:30 PM with the Administrator confirmed the elopement was not reported to the State Agency.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC ,d+[DATE].09 Based on record review and interview; the facility failed to ensure Transportation Personal maintained current Cardiopulmonary Resuscitation (CPR-emergency procedures performed if a person stops breathing or their heart stops) credentials. This had the potential to affect 2 Residents 34 and 25) of 23 total sampled residents. The facility census was 34. Findings are: A. Review of the facility policy Emergency Procedure-Cardiopulmonary Resuscitation with a revision date of , d+[DATE] revealed a policy statement which indicated personnel were to have completed training on the initiation of CPR for victims of sudden cardiac arrest (the sudden loss of all heart activity due to an irregular heart rhythm). The policy further indicated if a resident was found unresponsive and was not breathing, a certified staff member should initiate CPR unless it was known that a Do Not Resuscitate (DNR- (physician order which instructs staff not to perform CPR if a resident would stop breathing or if their heart would stop beating) order was in place. If the resident's DNR status was unclear, CPR was to be initiated until the resident's status was determined. Training was to be provided/required biannually by a certified instructor and staff were to provide the facility with current CPR card with completion. B. Review of Resident 34's Nursing Progress Note dated [DATE] at 11:30 AM revealed the resident was transferred to the facility per the facility van with the Social Service Director (SSD)-M driving. Review of the resident's Advanced Medical Directives (a written document that tells your health care provider who should speak for you and what medical decisions they should make for you) dated [DATE] revealed the resident wanted CPR for a witnessed arrest of heart or respirations. C. Review of Resident 25's Nursing Progress Notes dated [DATE] at 11:00 AM revealed the resident was transported by SSD-M to the facility from the hospital in the facility van. Review of Resident 25's Advanced Medical Directives dated [DATE] revealed the resident had requested CPR for witnessed arrest of the heart or respirations. D. Review of a current roster of staff who were listed as course participants in the CPR training dated [DATE] revealed no evidence SSD-M was listed as having received CPR certification. E. Interview on [DATE] at 10:37 AM with the Director of Nursing (DON) indicated a CPR certified staff member should always be available for any residents who indicated they wanted to receive CPR with a witnessed cardiac arrest and/or who had stopped breathing. F. Interview with SSD-M on [DATE] at 11:12 AM confirmed SSD-M was not CPR certified when SSD-M transported Residents 34 and 25 in the facility van.

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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. 42360 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview, the facility failed to have a diagnosis in place to support the use of an antipsychotic (medication that affects behavior, mood, thoughts, perception, and is used to manage psychotic disorders) medication for Resident 25. The sample size was 5 and the facility census was 34. Findings are: Review of the undated facility policy Restraints-Physical or Chemical revealed the following: - Residents had the right to be free from any chemical of physical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. -An example of a chemical restraints included but was not limited to, psychoactive (mind or consciousness altering) medications or any other medication class ordered for the purpose of discipline or convenience and not required to treat medical symptoms. Review of the undated facility policy Psychotropic Medication Review and Gradual Dose Reduction revealed the following: -All antipsychotic medications were reviewed upon admission and quarterly to reduce unnecessary drugs and adverse drug reactions. Review of Resident 25's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 6/10/24 revealed the following: -The resident had diagnoses of dementia -The resident had taken Antipsychotic medication daily, Review of Resident 25's Care Plan with a revision date of 6/10/24 revealed the following: -The resident had a diagnosis of dementia without behavioral, psychotic, or mood disturbance. -The resident had severe cognitive impairment and displayed inattention and disorganized thinking. -The resident was taking antipsychotic medication, and staff were to monitor for adverse reactions. Review of Resident 25's Medication Administration Record dated August 2024 revealed the resident was taking the antipsychotic medication Quetiapine Fumurate 25 milligrams daily at bedtime. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/24 at 3:35 PM the Director of Nursing confirmed the facility did not have a diagnosis in place for the use of the antipsychotic medication for Resident 25.