STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285291	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone Acres	4715 38th Street Columbus, NE 68601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D(l)(i)(3) Based on observations, record review, and interviews; the facility failed to implement, to revise and/or develop new interventions to prevent further falls for 2 (Residents 14 and 41) of 4 sampled residents. The facility census was 75. Findings are: A. Review of the facility Fall Prevention/Management Standard with a revised date of 1/2024 revealed the following guidelines: -residents were to be reviewed during the pre-admission/admission process to identify and determine risk for falls. -when a resident was identified at risk for falls, the care plan was to reflect the potential for injury/safety risk. Approaches/interventions were to be implemented and maintained related to identified areas of risk. All team members were to be knowledgeable of the resident's fall interventions. -falls were to be investigate as they occurred, and the staff were to collect factual evidence related to the fall event using the Root Cause Analysis process. The Root Cause Analysis is a process to find out what happened, why it happened and to determine what can be done to prevent it from happening again. -when the evaluation was completed, and the Charge Nurse had gathered enough information for a detailed report, they were to complete a Fall Scene Investigation Report. Appropriate interventions were to be implemented to prevent future falls based on information from the Fall Scene Investigation. The care plan was to be reviewed and revised with the dated interventions added. B. Review of Resident 41's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 8/9/24 revealed the following was assessed regarding the resident: -admitted [DATE] with diagnoses of dementia, hemiplegia (muscle weakness or paralysis on one side of the body) and depression. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was totally dependent on staff for assistance with bed mobility, transfers, dressing and toileting. -occasionally incontinent of urine. -had a history of falls with 2 falls without injury and 2 falls with injury (except major) since the previous assessment. Review of the resident's current Care Plan dated 5/17/24 revealed the resident had a history of falls and remained at risk related to confusion, dementia, and awareness of safety needs. The following interventions were identified: -5/17/24 anticipate and meet resident needs. -5/26/24 gripper socks when in bed. -6/3/24 assist the resident to the bathroom after all meals, stay with the resident and then transfer to bed, the recliner, or the recliner in the wife's room. -6/5/24 toilet the resident after the morning shift change. -6/6/24 get the resident up first for the day. -6/6/24 give the resident verbal reminders not to transfer or to ambulate without assistance. -6/8/24 encourage the resident to sit in the commons area before meals for visual assurance of safety. -6/9/24 keep the resident's walker and wheelchair next to the resident for safety. -6/10/24 frequent checks of the resident around mealtimes and staff to attend the resident when the resident leaves the dining table. -6/15/24 toilet the resident first on midnight rounds. -6/30/24 call light pendant to be worn on the outside of the resident's shirt. -6/30/24 check on the resident frequently. -7/4/24 resident to be brought to the commons area for visual safety assessment in the afternoon. -7/5/24 Dycem non-skid pad underneath cushions in chairs. -7/10/24 physically assist the resident the resident from the dining room to the resident's room, toilet and offer to transfer to the bed or the recliner. -7/13/24 both shoes to be worn during transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/17/24 non-skid floor strips on floor of bathroom. -8/15/24 toilet after the 2:00 PM shift change. Review of Fall Scene Investigation Reports for Resident 41 revealed the following: -6/3/24 at 2:10 PM the resident had a fall in the resident's room when attempting to self-transfer into the bathroom. New interventions identified were use of a pendant call light and to toilet the resident after meals. -6/4/24 at 11:30 PM the resident was found on the floor between the bed and the nightstand, and the resident indicated a need to use the bathroom. The resident was barefoot, and a new intervention was developed to make sure the resident wore gripper socks in bed and to provide more frequent toileting. -6/5/24 at 6:10 AM the resident fell when attempting to self-transfer to the bathroom. The resident was last toileted at 5:00 AM. A new intervention was developed to have the resident be the first gotten ready for the day. -6/8/24 at 11:00 AM the resident had attempted to self-transfer from the recliner to the wheelchair and fell . New intervention indicated for the staff to take the resident to the commons area prior to meals for visual assurance of safety. -6/10/24 at 6:05 PM the resident had a fall in their room when attempting to self-transfer into the bathroom. The resident had independently left the dining room after the evening meal. The report indicated the resident was last toileted at 10:35 AM (8 1/2 hours earlier). New interventions were listed for frequent checks, 1:1 with the resident if doing report or a shift change, to toilet immediately after leaving the dining room and staff to stay with the resident if wanting to leave the table in the dining room after meals. -6/13/24 at 8:45 AM the resident was found sitting on the floor of the bathroom in front of the toilet. Staff failed to document the last time the resident was toileted. The night shift had gotten the resident up and dressed, then laid the resident back in bed. The day shift got the resident up at about 6:45 AM and the resident was taken to breakfast at 7:45 AM. The resident then left the table at around 8:30 AM. The staff implemented a new intervention to position the resident by the window in the main dining room to make it easier for the staff to identify when exiting the dining room independently. -6/13/24 at 2:30 PM the resident had attempted to self-transfer to the wheelchair to get to the bathroom. The resident had been given a laxative that morning and had no results. New interventions included; walk-to-dine for all meals, to place in a regular dining room chair, increase the resident's laxative to twice a day and encourage increased fluid intake. -6/15/24 at 12:20 AM the resident attempted to self-transfer out of bed and into the wheelchair to use the bathroom. A new intervention was identified to toilet the resident first on midnight rounds. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/19/24 at 6:30 PM the resident was in the wheelchair and had just finished eating in the dining room. The resident left the dining room independently and fell when attempting to self-transfer into bed. The staff were to ensure the resident was assisted to the bathroom immediately after meals and to offer to reposition the resident in bed or the recliner after toileting. -6/30/24 at 4:00 PM the resident fell when attempting to self-transfer into the bathroom for toileting. The resident's call light pendant was in place but was underneath of the resident's shirt. A new intervention was indicated to place the pendant on the outside of the resident's shirt. -7/4/24 at 4:30 PM the resident had a fall when attempting to self-transfer into the wheelchair to get to the bathroom. New interventions were developed for a medication review and a 3-day Bowel and Bladder assessment. -7/5/24 at 10:15 AM the resident attempted to self-transfer from the recliner to the wheelchair to use the bathroom. A gel cushion was in the seat of the recliner and had gotten tucked into the back of the chair making the front of the recliner seat [NAME]. Staff placed a Dycem non-slip pad between the gel cushion and the recliner seat to prevent the cushion from sliding. -7/10/24 at 8:30 AM the resident was found on the floor of the resident's room after self-transferring out of the recliner. The facility implemented a new intervention for staff to keep the resident in the dining room/living room until staff was able to take to the bathroom and then safely transfer into the bed/recliner. No further interventions were developed. -7/13/24 at 6:40 PM the resident fell when attempting to self-transfer from the wheelchair and into the resident's bed. Staff were to toilet the resident after meals and then place the resident into bed. No further interventions were identified. -7/17/24 at 7:45 AM the resident fell when attempting to self-transfer into the bathroom. Staff failed to document when the resident was last toileted. The resident was eating the breakfast meal in the resident's room. A new intervention for non-slip strips to be placed on the bathroom floor was identified. -7/26/24 at 7:25 PM the resident fell when attempting to self-transfer from the recliner to the wheelchair. Resident was more confused and seemed more worried than usual. The staff initiated 15-minute checks on the resident. -8/15/24 at 3:30 PM the resident had a fall in the resident's room when attempting to self-transfer and indicated a need to use the bathroom. A new intervention was indicated for staff to toilet the resident at shift change. Observations of Resident 41 revealed the following: -8/27/24 at 12:09 PM the resident was in the wheelchair with bilateral foot pedals in place and staff provided total assist with mobility from the resident's room to the dining room. The resident had not been seated in the common's area to increase visual supervision prior to the meal and staff failed to walk the resident to the dining room and to transfer the resident into a regular chair once in the dining room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/27/24 at 1:41 PM the resident was provided total assist with mobility out of the dining room and to the resident's room. Staff made no attempt to ambulate with the resident back to the resident's room. -8/28/24 at 7:17 AM staff assisted the resident out of the recliner and into the wheelchair. Staff failed to toilet the resident prior to going to the dining room, made no attempt to walk the resident or to position the resident into a regular chair once in the dining room. -8/28/24 at 12:47 PM the staff provided the resident total assist with wheelchair mobility out of the dining room to the resident's room. The resident was not seated in a regular chair and the staff did not provide an opportunity for the resident to participate in the walk-n-dine program. An interview with the Director of Nursing on 8/27/24 at 2:42 PM confirmed the following: -the Charge Nurses were responsible for identifying causal factors and then developing a new intervention or revising current interventions with each resident fall. -Resident 41 was at high risk for ongoing falls and was very difficult to keep from falling. -the resident was to be toileted before and after meals or every 2 hours especially at night. -with the resident's fall on 6/8/24 at 11:00 AM the resident was attempting to self-transfer out of the recliner and into the wheelchair. A new intervention was indicated to take the resident out to the commons area prior to meals for visual assurance of safety. -with the resident's fall on 6/10/24 at 6:05 PM the resident left the dining room unattended and attempted to self-transfer into the bathroom. The Fall Scene Investigation Report indicated the last time staff toileted the resident was at 10:30 AM despite an intervention dated 6/4/24 for frequent toileting. -with the resident's fall on 6/13/24 at 2:30 PM the resident attempted to self-transfer into the bathroom. New interventions were identified for walking the resident to/from the dining room for all meals and to transfer into a regular chair in the dining room. -with the fall on 6/19/24 at 6:30 PM the resident left the dining room in the wheelchair and self-propelled to the resident's room then attempted to self-transfer into bed. Staff had failed to walk the resident to the dining room, to place the resident in a regular chair, to walk the resident back to their room and to toilet the resident immediately after the meal. -with the resident's fall on 7/4/24 at 4:30 PM the resident had attempted to self-transfer into the wheelchair. New interventions were identified for a medication review and a 3-day Bowel and Bladder assessment. The medication review was completed 7/11/24 with no changes and no patterns or changes with identified with the Bowel and Bladder assessment to prevent further falls. -with the fall on 7/13/24 at 6:40 PM the resident had left the dining room in the wheelchair independently and self-transferred out of the wheelchair trying to put self in the bed. The resident was not walked to/from the dining room and had not been placed in a regular chair in the dining room. In addition, the resident was not immediately toileted after the evening meal. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-with the fall on 7/10/24 at 8:30 AM the resident independently left the dining room in the wheelchair and fell when attempting to self-transfer in the resident's room. The resident was not walked to/from the dining room and had not been placed in a regular chair in the dining room. In addition, the resident was not immediately toileted after the breakfast meal. During an interview on 8/28/24 at 7:34 AM, Nurse Aide (NA)-A confirmed the resident was to be toileted every 2 hours, and/or before and after all meals. NA-A indicated the staff did not place the resident in the commons area before or after meals but would normally take the resident back to their room. NA-A was unaware the resident was on a walk-to-dine program or that the resident was to be transferred out of the wheelchair and into a regular chair when in the dining room for meals. 45739 C. Review of Resident 14's MDS dated [DATE] revealed the resident was cognitively impaired, had diagnoses of heart disease, arthritis, and dementia, was dependent with toileting, dressing, transfers and personal hygiene, and had two or more falls without injury. Review of Resident 14's Care Plan last revised 7/24/24 revealed the following: -the resident had dementia, -required assistance with bed mobility, dressing, transfers, and personal hygiene, and -fall interventions included: place items frequently used within reach, keep the wheelchair next to the bed, traction strips on the floor in the bathroom, toilet before and after meals, take the resident back to the resident room to assist to bathroom as needed and help transfer into bed after meals, initiate routine bowel movement, take from the dining room to the bathroom immediately after lunch; and offer to lay down after lunch after being toileted. Review of the facility forms Fall Scene Investigation Reports regarding Resident 14 revealed the following: -6/25/24 at 3:50 AM the resident was observed on the floor. The resident stated they were trying to go to the restroom and had gone 2 days without a bowel movement. The intervention implemented was to toilet the resident after breakfast daily and to stay with the resident to promote a daily bowel movement. No new intervention had been implemented, and -7/26/24 at 1:00 PM the resident was observed on the floor. The resident stated they were trying to get into bed. The intervention implemented was to assist to bed after breakfast and lunch. No new intervention was implemented. Interview on 8/29/24 at 1:35 PM with the DON and the Administrator confirmed new interventions were not implemented for Resident 14 for falls on 6/25/24 and 7/26/24.

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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. 29638 Licensure Reference Number 175 NAC 12-006.09D Based on record review and interview; the facility failed to have a diagnosis for the use of an antipsychotic (a drug or substance that affects how the brain works) medication and to attempt a gradual dose reduction (GDR) and/or have a documented contraindication for use of the antipsychotic medication for 1 (Resident 50) of 5 sampled residents. The facility census was 75. Findings are: A. Review of the Psychoactive Medication and Medication Regimen Review Management Standard dated 6/2024 revealed the following: -residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication was beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. -psychotropic medications included antipsychotics, antidepressants, anti-anxiety, and hypnotics. -attending physicians assumed leadership in medication management by developing, monitoring, and modifying regimens in collaboration with residents, families/responsible parties, other professionals, and the interdisciplinary team. -the indication for use of psychotropic medications were documented in the medical record. -residents and their families were educated on the benefits and risks of psychotropic medications as well as alternate treatments available. -residents who used psychotropic medications received gradual dose reductions, unless clinically contraindicated, to discontinue those medications. -the Physician in collaboration with the Consultant Pharmacist re-evaluated the use of medication and considered whether the medication could be reduced or discontinued. B. Review of Resident 50's Minimum Data Set (MDS- federally mandated comprehensive assessment used to develop resident Care Plans) dated 8/15/24 revealed the resident had diagnoses of Alzheimer's disease, dementia, anxiety, and depression. The resident had no behaviors, and the resident took an antipsychotic and an antianxiety medication. Review of Resident 50's Physician's Orders revealed an order for the antianxiety medication Lorazepam cream 1 milligram (mg)/milliliter (ml) 0.5 ml to be applied topically twice a day for anxiety and restlessness dated 8/4/23. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 50's Monthly Medication Review (MMR) dated 1/18/24 revealed the Consultant Pharmacist had made a recommendation to attempt a GDR for the resident's Lorazepam or to provide a clinical rationale as to why the GDR should not be attempted. The resident's Physician returned the recommendation on 2/28/24 with a response to continue the medication as needed. Further review revealed no clinical rational was provided regarding why a GDR could not be attempted for the resident's Lorazepam. Review of Resident 50's Physician Orders revealed an order dated 9/21/23 for the antipsychotic medication Seroquel 25 mg to be administered twice a day for a diagnosis of dementia. Review of an MMR dated 11/22/23 revealed the Consultant Pharmacist had sent a note to the resident's physician asking for a diagnosis for the resident's Seroquel and requesting a trial GDR for the medication or a documented rationale versus benefit as to why a GDR should not be attempted. Review of the physician's response dated 12/6/23 revealed a new diagnosis of agitation/dementia and to continue use of the medication with no GDR due to a potential risk of injury to self or others. Further review revealed no documentation regarding a clinical rationale for continued use of the Seroquel. Review of an MMR dated 5/16/24 revealed the Consultant Pharmacist again asked the resident's physician for an appropriate diagnosis for use of the Seroquel and requested a trial GDR for the medication or a documented clinical rationale as to why no GDR was to be attempted. The physician responded on 5/20/24 to continue use of the medication for the resident's safety. During an interview on 8/28/24 at 3:02 PM, the Director of Nursing confirmed the facility had no evidence the facility had attempted a GDR of Resident 50's Lorazepam and Seroquel and had no evidence of a documented contraindication by the provider.