STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285297	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone View	850 Laurel Parkway Drive Broken Bow, NE 68822

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50348 Licensure Reference Number 175 NAC 12.006.09D Based on interview and record review; the facility failed to ensure parameters (a range) for 1 (Resident 17) of 5 sampled resident's Amlodipine (a blood pressure medication) were followed, and at least 8 ounces of fluid were given to 1 (Resident 17) of 5 sampled resident's four times a day per the physician's order. The facility census was 52. Findings are: In an interview on 03/20/2024 at 3:45 PM, the facility's Administrator confirmed the facility did not have a following provider orders policy, procedure, or guideline. A record review of Resident 17's Clinical Census dated 03/19/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 17's Medical Diagnosis dated 03/21/2024 revealed the resident had diagnoses of: Essential (Primary) Hypertension (high blood pressure), Unspecified Systolic (Congestive) Heart Failure, Cardiomyopathy, Unspecified (disease of the heart muscle), Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris (plaque build-up in the arteries, Presence of Cardiac Pacemaker (a device use to stimulate the heart), and Dementia In Other Diseases Classified Elsewhere, Moderate With Anxiety (confusion with worry). A record review of Resident 17's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 12/19/2023, revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 0 which indicated the resident was severely cognitively impaired. The resident was dependent on staff for all activities of daily living. A record review of Resident 17's active Care Plan revealed the resident had a Focus area of being at risk for altered cardiovascular (heart and vessels) related to Pacemaker and Cardiomyopathy. The Care Plan identified an intervention of providing medications and labs as per physician's order and monitor the resident's blood pressures and pulse weekly and as needed. A. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 17's Order Summary Report dated 03/21/2024 revealed the resident had an order of: Amlodipine Besylate Tablet 5 milligrams (MG), Give 1 tablet by mouth in the morning for Hypertension. Hold Amlodipine if Systolic (1st number in blood pressure (BP) reading) less than 110 or Diastolic (2nd number in BP reading) less than 50 or if pulse less than 60 beats per minute. A record review of Resident 17's Physician Visit/Communication Form (v6) dated 04/24/2019 revealed a reason for visit/fax of Resident 17 was to start Amlodipine due to the resident's blood pressure being elevated. The provider responded with parameters for the medication of: to hold if the systolic BP less than 110, diastolic BP less than 50, and hold if pulse less than 60. A record review of Resident 17's Medication Administration Record (MAR) dated February 2024 and March 2024 revealed Amlodipine was administered outside of parameters on the following dates: -02/05/2024 was administered with a BP of 104/71, -02/11/2024 was administered with a pulse of 59, -03/03/2024 was administered with a BP of 108/72, -03/05/2024 was administered with a BP of 105/68, -03/13/2024 was administered with a BP of 103/59, -03/14/2024 was administered with a BP of 109/64. In an interview on 03/20/2024 at 7:50 AM, Licensed Practical Nurse (LPN)-B revealed Resident 17's Amlodipine was not to be administered if the systolic BP was less than 110, the diastolic BP was less than 50, or the pulse was less than 60. LPN-B confirmed that the Amlodipine was administer with out-of-range parameters on the above dates and should not have been. In an interview on 03/20/2024 at 7:53 AM, Medication Aide (MA)-F confirmed MA-F administered a dose of Amlodipine on 03/14/2024 to Resident 17 with a Systolic BP reading of 109 and should not have. In an interview on 03/20/2024 at 2:20 PM, the Director of Nursing (DON) confirmed the MA was responsible for documenting the BP on the MAR and should not have administered the Amlodipine if it was not within the parameters the provider specified on the orders. B. A record review of Resident 17's Order Summary Report dated 03/19/2024 revealed the resident had an order of: Give 8 ounces (oz) of fluid QID (four times a day) for increase fluids. A record review of Resident 17's Physician Visit/Communication Form (v6) dated 12/13/2022 revealed an order to increase fluids - 84 oz per day. A record review of Resident 17's Nutritional Risk Assessment V3 dated 12/16/2022 revealed the Registered Dietician documented: 12/13/2024 MD wrote to increase fluids to 84oz per day (2450cc) on [DATE]oz QID for added fluids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 17's MAR Dated January 2024 revealed the only days that 8 oz of fluids were administered 4 times per day were: -01/01/2024 -01/02/2024 -01/03/2024 -01/04/2024 -01/09/2024 -01/12/2024 -01/15/2024 A record review of Resident 17's MAR dated February 2024 revealed the only day the resident was given 8oz of fluids 4 times per day was on 02/04/2024. A record review of Resident 17's MAR dated March 2024 revealed the only day the resident was given 8oz of fluids 4 times per day was on 03/13/2024. In an interview on 03/19/2024 at 2:56 PM, the DON confirmed that the provider did order a specific fluid intake parameter and the facility's RD changed it to 4 times per day on 12/18/2023. In an interview on 03/20/2024 at 7:50 AM, LPN-B confirmed LPN-B reviewed January - March 2024 MARs the resident did not get 8oz of fluid 4 times per day or 84 oz per day and should have.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641 Licensure Reference Number 175 NAC 12.006.09D6(5) Based on observation, interview, and record review, the facility failed to ensure a valid oxygen order was followed for 1 (Resident 30) of 2 sampled residents. The facility census was 52. Findings are: In an interview on 03/20/2024 at 3:45 PM, the facility's Administrator confirmed the facility did not have an oxygen policy, procedure, or guideline. A record review of Resident 30's Clinical Census dated 03/20/2024 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 30's Medical Diagnosis dated 03/20/2024 revealed the resident had diagnoses of Unspecified Bacterial Pneumonia, Obstructive Sleep Apnea (periods of not breathing when sleeping), Acute Combined Systolic (congestive) and Diastolic (Congestive) Heart Failure, Cerebral Infarction, Unspecified (stroke), and Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (confusion without behaviors). A record review of Resident 30's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 12/28/2023 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 14 which indicated the resident was cognitively aware. The resident was dependent on staff for toileting, bathing, lower body dressing, putting on and taking off footwear, partial/moderate assistance for oral hygiene (cleaning), and substantial/maximal assistance for upper body dressing. The MDS revealed Resident 30 was on continuous oxygen when discharged . A record review of Resident 30's Clinical Physician's Orders dated 03/20/2024 revealed the resident had an order for: Oxygen at all times to keep oxygen saturation (percent oxygen in bleed) above 90 percent (%). An observation on 03/18/2024 at 2:59 PM revealed Resident 30 had a nasal cannula (tubing that goes in nose to deliver oxygen) on and oxygen was set at 2 liters per minute (l/m). An observation on 03/20/2024 at 8:20 AM revealed Resident 30 was seated in the dining room with a nasal cannula in the nose but the flowmeter on the oxygen tank was set at 0. In an interview on 03/20/2024 at 8:23 AM, Resident 30 confirmed he was supposed to be on the oxygen all the time since the last hospital visit. Resident 30 confirmed the oxygen was supposed to be set at 2 l/m. An observation on 03/20/2024 at 8:27 AM with the Director of Nursing (DON) revealed Resident 30 was seated in the dining room with a nasal cannula in the nose and oxygen tank flowmeter was set at 0. The DON turn the dial on the oxygen tank flowmeter to a setting of 1 l/m. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/20/2024 at 8:27 AM, the DON confirmed the oxygen was set at 0 and the resident had an order for oxygen as needed and that the DON set the oxygen to 1 l/m and the order did not contain a specific liter flow. The DON confirmed Resident 30 does request the oxygen to be on for comfort. A record review of Resident 30's Patient Discharge Instructions from the hospital dated 01/25/2024 with the DON revealed the provider ordered: Oxygen at 2 l/m at all times. In an interview on 03/20/2024 at 1:01 PM, the DON confirmed Resident 30 should worn the oxygen all the time and it should have been set at 2 l/m per the provider's discharge instructions.

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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** 48271 Liscensure Reference Number 12-006.18C Liscensure Reference Number 12-006.17D The facility failed to ensure proper hand hygiene and gloving was performed during wound care for Resident 29, failed to ensure contaminated laundry was carried in a manner to prevent cross contmination and hand hygiene was performed after transportation, failed to ensure Resident 21's Neb kit was cleaned after each treatment. The facility census was 52. 50348 B. A record review of the facility's undated Medication Aide Procedure Checklist Topical (applied to skin) Medication revealed the facility staff was to apply gloves, apply the topical medication according to the five rights, remove gloves and discard into waste container, then wash and dry hands thoroughly when applying topical medication. A record review of facility's Hand Hygiene (cleaning) policy with a revision date of 09/12/2017 revealed the staff were to use gloves before contact with blood and body fluids, and non-intact skin (skin that was open). The policy revealed the staff was to perform proper hand hygiene to prevent the transmission of infectious agents after contact with inanimate objects (non-living items). A record review Resident 29's Clinical Census dated 03/21/2024 revealed that the facility admitted Resident 29 on 07/26/2022. A record review of Resident 29's Medical Diagnosis dated 03/19/2024 revealed a diagnoses of Systemic Lupus Erythematosus (SLE)(the body's immune system attacks healthy tissue), Unspecified. Essential (Primary) Hypertension (high blood pressure), Hypo-Osmolality (low blood nutrients and electrolytes) and Hyponatremia (low sodium), Hypokalemia (low calcium), Hypothyroid (low throid levels), Peripheral Vascular Disease (low blood flow in extremities), Unspecified, Anorexia (unknow eating disorder), Unspecified Protein-Calorie Malnutrition (reduced nutrition status), and Chilblains (inflamed or swollen patches and blisters on the hands and feet). A record review of Resident 29's Care Plan with an admitted [DATE] revealed Resident 29 was an extensive assist with dressing lower body, one assist to dress upper body, extensive assist of one for bed mobility and bathing, one assist for stand pivot transfer with a gait belt, extensive assist for toilet use, and one assist for personal hygiene. The Care Plan dated 04/13/2022 revealed a focus area of: Impaired immunity related to chronic steroid use; Lupus and long-term steroid use with interventions of zinc barrier cream to buttocks with peri cares (cleaning after bowel elimination), alternating pressure mattress, and encourage repositioning. The Care Plan did not reveal a focus area or interventions for coccyx wound (open area on buttocks). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of Resident 29's Order Summary Report dated 03/19/2024 revealed the resident had an order for: Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to wound on coccyx topically two times a day for chronic skin integrity issue(s). May cover with Mepilex (dressing) border- remove bottom border when applying. Peel back Mepilex and reapply with TRIAD cream application, if the dressing is intact and not wrinkled up. In an observation on 03/20/2024 at 9:15 AM A observation of Licensed Practical Nurse (LPN)-B, charge nurse, completed Triad cream treatment. LPN-B washed hands and donned (put on) a glove to the right hand only. LPN-B used ungloved left hand to peel up the bottom portion of the Mepilex which was located to Resident 29's coccyx area. With the right gloved hand LPN-B placed the Triad cream on Resident 29's open wound, then replaced the bottom portion of the Mepilex that was peeled up. LPN-B then donned glove to the left hand and obtained a peri wipe. LPN-B performed a wipe on the resident's peri area. LPN-B wiped from front to back and placed the wipe in the trash, LPN-B then obtained a clean wipe and wiped the outer portion of resident's bottom and placed wipe in the trash. LPN-B then pulled up Resident 29's pants. LPN-B removed gloves and performed hand hygiene. The observation did not reveal LPN-B donned a glove on the left hand to prior to touching the coccyx to peel up bottom portion of Mepilex or that LPN-B performed hand hygiene prior to donning a glove on the left hand. In an interview on 03/20/2024 at 9:30 AM, LPN-B, charge nurse, confirmed staff was to wear gloves on both hands when performing a wound treatment, and that this time only the right hand was gloved. LPN-B confirmed that LPN-B did not perform hand hygiene or glove prior to working with the Mepilex dressing located on the coccyx area. C. A record review of the undated Infection Prevention Guide to Long-Term Care Interdisciplinary and Support Services guideline provided by the Infection Preventionist (IP) revealed the following were factors that should be monitored to minimize the risk for infection transmission associated with soiled linen and clothing: -Soiled linen should be handled as little as possible and with minimal agitation to prevent microbial contamination of the air and any healthcare personnel or other individuals in the adjacent area. -All soiled linen should be handled as if contaminated and should be bagged and put into laundry carts at the location where it is collected. -Soiled linen should be placed in impervious bags, placed in designated carts, and transported to a holding area for either on site processing or scheduled pick up by the contracted laundry service. -Facilities that provide hampers in resident rooms for soiled clothing must be emptied per schedule; clothing should be bagged prior to removal from the room. -All used linen is considered contaminated as a standard precaution. In an interview on 03/20/2024 at 4:13 PM, the IP confirmed that the facility does not have a policy regarding transport of soiled linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of facility's Hand Hygiene policy with a revision date of 09/12/2017 revealed that the staff was to perform proper hand hygiene to prevent the transmission of infectious agents after contact with inanimate objects. An observation on 03/19/2024 at 10:30 AM revealed Medication Aide (MA)-D came out of Resident 203's room with an unbagged towel and a washcloth in the left hand. The observation did not reveal gloves on the hands of MA-D. MA-D then crossed the hallway to the soiled utility room and MA-D entered the soiled utility and placed the towel and washcloth in the soiled linen bin. MA-D then left the soiled utility room. The observation did not reveal hand hygiene was performed by MA-D after carrying the soiled linens that were placed in the soiled linen bin. MA-D then exited the soiled utility room and shut the door. No hand hygiene or sanitizing was observed for MA-D. MA-D then walked down the hallway and entered resident's room [ROOM NUMBER]. An observation on 03/19/2024 at 10:36 AM revealed MA-D came out of residents' room [ROOM NUMBER]. No gloves were present. MA-D carried a black garbage bag in one hand, and a towel and washcloth without a bag in the other hand. MA-D then crossed the hallway to the soiled utility room. MA-D entered the soiled utility and placed black garbage bag in bin, and the towel/washcloth in the soiled linen bin. MA-D then left the soiled utility room and no hand sanitizing was observed from MA-D after carrying the soiled linens that were placed in the soiled linen bin. MA-D then walked down the hallway not stopping to complete hand hygiene, MA-D walked off the unit. An Observation of Nursing Assistant (NA)-E on 03/20/2024 at 1:25 PM revealed NA-E wheeled Resident 21 from dining room to room [ROOM NUMBER]. NA-E entered room [ROOM NUMBER] with the resident and shut the door. At 1:35 PM NA-E exited room [ROOM NUMBER] holding a black garbage bag in the left hand and a towel and washcloth with a wet appearance in the right hand. No gloves were observed NA-E hands. NA-E then crossed the hallway to the soiled utility room. NA-E opened the door and placed the black bag into a trash bin and placed the linens into a soiled linen bin. NA-E held the soiled utility room door open with foot. NA-E then came out of the soiled utility room and walked down the hallway turning to leave the unit. No hand hygiene or sanitizing observed. In an interview with NA-E on 03/20/2024 1:36 PM confirmed that linens were not in a bag while walking from room [ROOM NUMBER] to the soiled utility and that they were to be placed in a bag, to be transported. NA-E also confirmed that gloves were not worn with the soiled linen transport. An interview with Director of Nursing (DON) on 03/20/2024 at 1:45 PM confirmed that the expectation for carrying dirty linens and laundry to the soiled utility room were that all linens were to be placed in a bag for staff transport. 45641 D. A record review of the facility's Nebulizer Therapy, Small Volume policy dated 11/17/2017 revealed the staff should rinse the nebulizer with sterile water and allow to air dry or discard it after each treatment. A record review of Resident 21's Clinical Census dated 03/20/2024 revealed the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of Resident 21's Medical Diagnosis dated 03/20/2024 revealed the resident had diagnoses of Personal History of Traumatic Brain Injury, Diffuse Traumatic Brain Injury with Loss of Consciousness of Unspecified Duration, and Hemiplegia, Unspecified Affecting Right Dominant Side (loss of movement on right side). A record review of Resident 21's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 06/29/2023 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a residents cognitive abilities) of 10 which indicated the resident was moderately cognitively impaired. The resident was supervision or touching assistance for oral hygiene (cleaning), dependent for bathing, and substantial/maximal assistance with all other activities of daily living except eating. A record review of Resident 21's Care Plan with an admitted [DATE] did not reveal the resident had a Focus area or interventions for nebulizer treatments. An observation on 03/18/2024 at 10:26 AM revealed there was a nebulizer kit and mask draped over the nebulizer on the bedside table. The mask had a coating of facial oils on it and there was a residual (small, left over amount) of medication remaining in the nebulizer cup. An observation on 03/19/2024 at 10:46 AM revealed there was a nebulizer kit and mask in the black infection control bag. The mask had a coating of facial oils on it and there was a residual of medication remaining in the nebulizer cup. An observation on 03/20/2024 at 8:00 AM revealed there was a nebulizer kit and mask in the black infection control bag. The mask had a coating of facial oils on it and there was a residual of medication remaining in the nebulizer cup. A record review of Resident 21's Order Summary Report dated 03/20/2024 revealed an order of Albuterol Sulfate Nebulization Solution (a medication that is inhaled to relax the muscle around the tubes in the lungs and allow them to open) every 6 hours as needed. A record review of Resident 21's Medication Administration Record (MAR) dated March 2024 revealed the resident's Albuterol Sulfate Nebulization solution was administered on: -03/04/2024 at 1:45 AM -03/07/2024 at 2:03 AM and 1:38 PM -03/08/2024 at 3:02 PM -03/10/2024 at 9:17 AM -03/11/2024 at 12:14 AM -03/12/2024 at 12:30 AM -03/16/2024 at 7:47 AM and 16:53 PM (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-03/17/2024 at 1:30 AM and 4:40 PM -03/19/2024 at 7:14 AM An observation on 03/20/2024 at 9:15 AM with Licensed Practical Nurse (LPN)-B revealed there was a nebulizer kit and mask in the black infection control bag. The mask had a coating of facial oils on it and there was a residual of medication remaining in the nebulizer cup. In an interview on 03/20/2024 at 9:15 AM, LPN-B confirmed LPN-B observed Resident 21's Nebulizer mask and nebulizer kit had not been cleaned since the last treatment and should have been. LPN-C confirmed the staff was to clean the nebulizer kit and mask after each treatment.