STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285305	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookestone Gardens	2615 West 11th Street Kearney, NE 68845

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50253 Based on interviews, observation, and record reviews, the facility failed to follow policy and procedures for constipation management and prevention. This affected 1 of 2 residents sampled (Resident 31). The stated facility census was 53. Record review of the facility Bowel and Bladder Management Standard updated on 04/18/2024 defined constipation as difficulty in passing stools or incomplete or infrequent passage of hard stool. The standard states that the care plan should contain the appropriate interventions based upon the interventions for potential risks. Record Review of the Elimination Protocol dated 6/2024 gave specific nursing instructions to review the elimination records of residents and interventions for bowel management and documentation. -Small bowel movements did not count towards the daily elimination. -Day 2; After 48-hour period without a bowel movement (BM); offer 4 ounces of prune juice or natural laxative of resident's choice. The intervention must be recorded in the column below (on the paper). -Day 3; Day shift without a BM; Give 30 milliliters (ml) of milk of magnesia or Miralax (both are medications to relieve constipation) (or medication ordered by their physician) in the morning on the 6 AM to 2 PM shift. Assess bowel sounds, then palpate and document assessment results. Document findings and medication in the Medication Administration Record (MAR). Record in the intervention column on the daily Elimination Protocol sheet. Communicate interventions/results to the oncoming shift for further action if no BM. -Day 3; Evening/Night shift without a BM; Evening/Night charge nurse to assess bowel sounds, palpate and document assessment results before suppository administration. If No Bowel Sounds for the day, call the physician immediately. Give Dulcolax suppository, as ordered, at a time agreeable to the resident. Document on the MAR. Communicate interventions/results to oncoming shift for further action if no BM. Record in Intervention column of the daily Elimination Protocol sheet. -Day 4; All shifts without a BM; If interventions have not been successful; Contact the physician. Advance to enema as ordered and continue with bowel assessments each shift until resolved. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Minimum Data Set (MDS, part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes to assist in care plans) dated 09/26/2024 revealed that Resident 31 received hospice care, had a BIMS (Brief Interview for Mental Status assessment, which is used to categorize a patient's cognitive impairment) score of 10, meaning moderate cognitive impairment, was continent of bowel, was not on a bowel program, and had diagnoses for Parkinson's disorder, paraplegia, progressive neurological disorder, and difficulty walking. Resident 31 received scheduled and as needed opioid (narcotic) (pain medications). Record review of the Care Plan (a document that outlines a patient's care, including the goals, activities, and who will be involved in care of the resident) revised on 7/12/2024 revealed a potential for alteration in bowel elimination related to narcotic medications, bowels would be managed without complications through the next review date of December 2024, and nursing staff would administer medications per the physician's orders, follow the facility bowel management protocol, and report complications related to bowel elimination. Record review of the Hospice Plan of Care (a document that outlines a patient's care, including the goals, activities, and who will be involved in the resident care) updated on 10/16/2024 revealed that Resident 31 and a family member both verbalized understanding of the risk factors of care that increased the risk of constipation and measures used by Hospice staff to prevent constipation. Interview on 10/28/2024 at 12:20 PM with the family member of Resident 31 revealed that constipation has been an issue. The family member also stated that Resident 31 had gradually become weaker and now received Hospice cares. Interview on 10/28/24 at 1:18 PM with Resident 31 stated I am still having issues with constipation. Resident 31 uses a walker all the time now and no longer walks. Observation on 10/29/2024 at 12:25 when Resident 31 was served a meal there was no prune juice on the food tray. Record review of the Physician Orders printed on 10/29/2024 revealed orders for Milk of Magnesia (400 milligrams (mg)/5 milliliters (ml)) 30 ML daily for constipation, docusate sodium (a medication that works as a stool softener)100 mg capsule 1 capsule twice a day for bowel regulation, bisacodyl suppository (a medication for constipation) 10 mg as needed for constipation, and prune juice 4 ounces (oz) as needed for bowel regulation. Record review of a Bowel Movements (BM) in a 30 day look back period printed on 10/29/2024 for bowel history of Resident 31 revealed the following: -09/30/24; no BM, -10/01/24; no BM, -10/02/24; Resident 31 had a BM, -10/03/24; Resident 31 had a BM, -10/04/24; no BM, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/05/24; no BM, -10/06/24: Resident 31 had four small BMs, -10/07/24; Resident 31 had a BM, -10/08/24; no BM, -10/09/24; Resident 31 had a BM, -10/10/24; Resident 31 had a small BM, -10/11/24; Resident 31 had a BM, -10/12/24; Resident 31 had a BM, -10/13/24; Resident 31 had a BM, -10/14/24; no BM, -10/15/24; no BM, -10/16/24; Resident 31 had a BM, -10/17/24; no BM, -10/18/24; no BM, -10/19/24; Resident 31 had a BM, -10/20/24; no BM, -10/21/24; no BM, -10/22/24; no BM, -10/23/24; Resident 31 had a BM, -10/24/24; no BM, -10/25/24; no BM, -10/26/24; no BM, -10/27/24; no BM, -10/28/24; Resident 31 had a BM, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/29/24 no BM. Record review of the October 2024 MAR/TAR (medication administration record/treatment administration record) for Resident 31 revealed no documented administration of prune juice. The MAR/TAR also revealed Resident 31 received a new order for milk of magnesia 400 milligrams (mg)/5 milliliters (ml) and administered 30 ml daily for constipation with a start date of 9/28/2024. Resident 31 received Dulcolax sodium capsules 100 mg twice daily for constipation. Resident 31 received a bisacodyl suppository 10 mg on October 2, 11, 13, 16, 19, 23, and 27 for constipation. There was no documented suppository given on 10/26/24. Record review of the medical records for Resident 31 did not reveal any physician communication with the physician about constipation. Interview with LPN-F (Licensed Practical Nurse-F) on 10/30/24 at 11:40 AM: Spoke about the Elimination Protocol on day 2, residents get whatever is ordered which is usually prune juice. On day 3 we give the resident milk of magnesia, or the physician ordered medication, if there are still no results. The nurse charts the medication on the MAR/TAR and then follows up throughout the shift. If the resident has had no results, the nursing staff will give this information to the oncoming staff for the next shift. On day four of no BM, staff nurses will give the resident a suppository after we assess the resident bowel sounds, and double check with our nurses' aides to be certain there was not a BM that didn't get charted so we do not give something unnecessarily. The nurse then has to write a nursing progress note. If there are no bowel sounds or if the resident complains of abdominal pain if no BM for several days or if the stuff we are doing simply is not working, we have to call the doctor. We also will reach out when necessary to see if the physician wants to have anything else specifically added to the orders. The nurse will not usually call the doctor unless the resident is having pain or there are no bowel sounds, which is not exactly what the elimination protocol says to do. Interview with the DON (Director of Nursing) on 10/30/2024 at 02:40 PM who confirmed that the bowel and elimination protocols for management and prevention were not followed as written for residents who have constipation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 12-006.09(H)(vi)(3)(d) Based on observation, record review, and interviews, the facility failed to follow the manufacturer's instructions for insulin administration for 1 of 2 residents observed (Resident 24) to prevent the potential for hypoglycemic reaction. The facility census was 53. Findings are: Record review of the Fiasp FlexTouch (insulin aspart injection) (a fast acting insulin) product insert (manufacturer's instructions for use) dated 09/2022 revealed the section titled Dosage and Administration. Item 2.2 Route of Administration Instructions revealed the instructions to inject Fiasp at the start of a meal or within 20 minutes after starting a meal. Record review of the Admission Record for Resident 24 dated 10/29/24 revealed that Resident 24 admitted into the facility on [DATE]. Diagnoses included diabetes. Record review of the Care Plan dated 10/28/24 for Resident 24 revealed that Resident 24 has the potential for abnormal blood sugars related to diabetes. Interventions included to monitor blood sugar and administer insulin as ordered. Report any signs and symptoms of hypoglycemia (low blood sugar): sweating tremor, high heart rate, paleness, nervousness, confusion, slurred speech, lack of coordination to the charge nurse. Record review of the Order Summary Report (a listing of all physician orders for a specific resident) for Resident 24 dated 10/29/24 revealed a physician order for Fiasp insulin injection before meals. Observation on 10/29/24 at 11:51 AM in the room of Resident 24 revealed that Resident 24 sat in a wheelchair. Registered Nurse-H (RN-H) confirmed the blood sugar reading of 258 for Resident 24. RN-H confirmed that the physician order for Fiasp insulin for Resident 24 was to receive 6 units of insulin to be given for a blood sugar reading of 258. RN-H removed a Fiasp Insulin pen from the medication cart. RN-H applied the needle to the pen and turned the dial to 2 units and pushed the plunger to prime the needle. RN-H turned the dial on the insulin pen to the ordered 6 units of insulin. RN-H entered the room of Resident 24 and administered the insulin into the right upper arm of Resident 24. The time was 11:53 AM. RN-H did not offer Resident 24 a snack or juice. RN-H provided no instructions to Resident 24. Resident 24 was assisted to the dining room by an unidentified staff member and placed at a table in the dining room. Observation on 10/29/24 at 12:00 PM in the facility dining room revealed Resident 24 seated in the wheelchair at a dining room table with a cup of coffee and a glass of dark brown liquid. Resident 24 revealed that the glass contained diet coke. Interview on 10/29/24 at 12:07 PM with Dietary Aide-I (DA-I) confirmed that Resident 24 received diet coke and coffee. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/29/24 from 12:00 PM to 12:27 PM in the dining room revealed that Resident 24 received no caloric intake and only had the cup of coffee and glass of diet coke available for consumption. Observation on 10/29/24 at 12:27 PM in the dining room revealed that Dietary Aide-J (DA-J) delivered a plate with a hot dog on a bun to Resident 24. Resident 24 told DA-J it was not what the resident ordered. DA-J carried the plate back to the kitchen. DC-J returned to Resident 24 at 12:30 PM with a menu and clarified what Resident 24 wanted for lunch. Resident 24 remained at the table with only the cup of coffee and glass of diet coke. Resident 24 had consumed approximately 1/4 of the diet coke. Observation on 10/29/24 at 12:39 PM in the dining room revealed that DA-J carried a plate of food to Resident 24. The plate contained a hamburger on a bun, potato salad, and a bowl of mandarin oranges. DA-J sat the plate on the table in front of Resident 24. Resident 24 immediately took a couple of bites of the hamburger. This was 46 minutes after RN-H administered the fast acting insulin to Resident 24. Resident 24 had not received any caloric intake for 46 minutes after the fast acting insulin was administered. Record review of the Treatment Administration Record (TAR, a legal record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) for Resident 24 dated 10/29/24 revealed that RN-H documented the administration of the 6 units of Fiasp insulin for Resident 24 occurred at 11:51 AM (48 minutes before Resident 24 received any caloric intake). Interview on 10/30/24 at 4:12 PM with Registered Nurse-K (RN-K) revealed that the nurse is expected to ensure that a resident receiving fast acting insulin receives nutrition (caloric intake) within 15 minutes of administration. RN-K revealed that RN-K administers fast acting insulin just before the resident goes to the dining room to get nutrition. RN-K revealed that staff should let dietary know that the diabetic is in the dining room. RN-K confirmed that no juice or snack is given from the treatment cart after insulin administration to a resident. Interview on 10/30/24 at 4:38 PM with the facility Director of Nursing (DON) confirmed that residents receiving fast acting insulin are required to receive nutrition with caloric value within 15 minutes of the insulin administration to prevent complications of low blood sugar. The DON confirmed that the coffee and diet Coke provided to Resident 24 did not have caloric value. Interview on 10/31/24 at 9:38 AM with Registered Nurse-H (RN-H) revealed that RN-H ensures a resident receives something with caloric value after insulin administration by telling them to get a cup of juice when they get to the dining room. RN-H revealed that if the resident appeared to need immediate caloric intake the RN-H would get them their meal in the dining room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175NAC 1-005.06 Licensure Reference Number 175NAC 12-006.18 Based on observation, interview, and record review; the facility failed to ensure that oxygen administration supplies were monitored and replaced for 1 of 1 residents observed (Resident 41) to prevent the potential for respiratory infection. The facility census was 53. Findings are: Record review of the facility document titled Facility assessment dated [DATE] revealed that resident care needs include infection prevention and control. Specific care practices include identification and containment of infections and prevention of infections. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 41 dated 10/3/24 revealed that Resident 41 admitted into the facility on [DATE]. The MDS revealed that Resident 41 receives oxygen therapy while a resident in the facility. Record review of the Care Plan dated 10/28/24 for Resident 41 revealed that Resident 41 has altered respiratory function and requires oxygen. The care plan lacked interventions to replace the oxygen administration tubing and nasal cannula (a small, flexible tube that contains two open prongs intended to sit just inside your nostrils to provide supplemental oxygen therapy to people who have lower oxygen levels) for Resident 41. Record review of the Order Summary Report (a listing of all physician orders for a resident) for Resident 41 dated 11/1/24 revealed that it contained a physician's order for oxygen at 2 to 4 liters per minute to be given by nasal cannula. The Order Summary lacked interventions to replace the oxygen tubing and nasal cannula for Resident 41. Record review of the Medication Administration Records (MAR, a legal record of the medications administered to a patient at a facility by a health care professional) and Treatment Administration Records (TAR, a legal record of the administration of scheduled treatments or performance of other scheduled medical tasks for a resident by a health care professional such as a licensed nurse) for Resident 41 for the months of February 2024-September 2024 dated 10/30/24 revealed that Resident 41 received oxygen daily. The MARs and TARs lacked interventions to replace the oxygen tubing and nasal cannula for Resident 41. Observation on 10/28/24 at 12:24 PM in the room of Resident 41 revealed a light blue oxygen concentrator (a medical device that concentrates the oxygen from room air and delivers it to a patient needing supplemental oxygen) with oxygen tubing and a nasal cannula in an undated blue infection control pouch. A humidification bottle with a 10/31/27 manufacturer outdate had no opened date on the bottle. There was no date on the oxygen tubing or the nasal cannula. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/29/24 at 7:39 AM in the room of Resident 41 revealed that Resident 41 was in bed as Registered Nurse-H (RN-H) administered medications to Resident 41. The nasal cannula was in place on Resident 41 and had no date on it. The humidification bottle had no open date documented on it. The oxygen tubing had no date documented on it. The oxygen concentrator was operating and the oxygen flow rate was set at 2 liters per minute. Observation on 10/30/24 at 8:05 AM in the room of Resident 41 with the facility Director of Nursing (DON) revealed that the oxygen tubing was connected to the oxygen concentrator and the tubing had not been dated, the humidification bottle was not dated, and the blue infection control pouch was not dated. Interview on 10/30/24 at 8:05 AM with the facility DON confirmed that the oxygen tubing, cannula, and infection control pouch of Resident 41 were not dated. The DON confirmed that the humidification bottle is not dated with an open date. The DON revealed that oxygen tubing, nasal cannula, and infection control pouches were expected to be changed (replaced) weekly on Thursday nights by the night shift. The DON confirmed that the oxygen tubing and cannula are expected to be changed out weekly. The DON revealed that the weekly changing of the oxygen administration supplies is documented on the monthly cleaning schedule with staff initials to document completion. The DON revealed that the staff are not dating the oxygen supplies when it is changed out. The DON revealed that the DON observed that the oxygen supplies were set out to know that the oxygen supplies were being changed out. Record review of the untitled and undated monthly cleaning log provided by the DON revealed that it contained the instructions for Thursdays: Change out all respiratory bags, tubings including nebulizer masks and mouthpieces- infection control bags (on concentrators, portable tanks- change bags on wheelchairs). The log contained a box to initial completion of changing the respiratory administration supplies on the date it was performed. The monthly cleaning log did not list the residents receiving oxygen. Interview on 10/30/24 at 8:10 AM with the DON confirmed that there is not a cleaning schedule log for individual residents. The cleaning log is for all residents receiving oxygen on the hall and is documented as a whole. The DON revealed that there is one monthly cleaning log for the 400 hall and one monthly cleaning log for the 300 hall. The DON confirmed that there is no individual resident documentation that the oxygen supplies were changed out weekly for each specific resident as required. Interview on 10/30/24 at 4:28 PM with the DON confirmed the facility had no documentation of individual resident oxygen being replaced for any residents. The DON confirmed that the facility had no documentation that the oxygen supplies were replaced weekly as required for Resident 41.