STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285306	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemingford Care Center	605 Donald Avenue Hemingford, NE 69348

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.04C3a(6) Based on record review and interviews, the facility failed to notify the resident's representative of a resident's change in condition for 1 (Resident 1) of 4 sampled residents. The facility census was 27. The Findings Are: A record review of facility policy Change in a Resident's Condition or Status with a last revised date of February 2021, revealed in #2 A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions., in #4 Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status., and in #8 The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A record review of Resident 1's admission record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of acute and chronic respiratory failure with hypoxia. The admission record also revealed the resident's child had been designated as: Responsible Party, Power of Attorney (POA)-Care, and Emergency Contact #1. A record review of Resident 1's undated Care Plan revealed the resident had a focus area related to fluid balance with an intervention for the staff to monitor, document, and report any signs/symptoms of dehydration. One of the signs listed was recent/sudden weight loss. Resident 1 also had a focus area related to their nutritional status with an intervention to monitor, record, and report signs/symptoms of malnutrition. One of the signs listed was significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. A record review of Resident 1's weights documented in Point Click Care (PCC), an electronic health record system, revealed a weight of 189 pounds on 2/19/24. The resident also had a weight of 180 pounds on 3/14/24, a weight of 175 pounds on 3/18/24, and a weight of 175 pounds on 3/21/24. All of these weights were documented as being obtained on the bath scale. This was a 7.4% weight loss in one month. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of all of Resident 1's Progress Notes from 2/1/24 through 3/24/24 revealed there was no documentation Resident 1 had experienced a significant weight loss or that the resident's POA had been notified of the resident's significant weight lost. An interview on 3/27/24 at 10:33 AM with Licensed Practical Nurse (LPN)-A revealed that [gender] did not recall noticing that Resident 1 had a weight change between when they documented the resident's weight of 190 pounds on 3/11/24 and documented the resident's weight of 175 pounds in PCC on 3/21/24. An interview on 3/27/24 at 10:40 AM with the DON confirmed that a significant weight loss, per MDS standards, was something the DON would consider to be a change in condition for a resident and that this was something the DON would expect staff to report to a resident's Power of Attorney (POA) or representative. The DON stated that if a change in resident condition was identified, the DON would expect the Charge Nurse (CN) to notify the DON so they could monitor the resident, notify the primary care provider, notify the resident's POA or guardian, and to document in PCC. The DON confirmed they had not been made aware that Resident 1 had a 7.4% weight loss over the last month and as such, was not aware of whether the resident's POA or PCP had been notified.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49766 Licensure Reference Number 175 NAC 12-006.09D1c Based on record review, observations, and interviews, the facility failed to assist a dependent resident with toileting. This affected Resident 2. The facility identified a census of 27. The findings are: A record review of Resident 2's Admission Record indicated the facility admitted Resident 2 on 5/4/2023 with diagnoses of: left side hemiplegia, paraplegia, epilepsy, Spina Bifida, and muscle weakness. A record review of Resident 2's Minimum Data Set (MDS a standardized assessment tool that measures health status in nursing home residents), dated 2/22/2024 revealed Resident 2 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The MDS also revealed the resident had impairment of upper and lower extremities and required total assistance for all Activities of Daily Living (ADLs.) A record review of Resident 2's undated Care Plan revealed Resident 2 required two-person total assistance for toileting. An observation on 3/26/2024 at 11:57 AM revealed Resident 2 had reported to Licensed Practical Nurse (LPN)-A that the Nurse Aides (NA) had come into (gender) room and had shut off the call light without assisting Resident 2 to the bathroom. LPN-A responded to the resident that [gender] would go and get assistance for Resident 2. A continuous observation on 3/26/2024 from 11:57 AM to 12:25 PM revealed LPN-A had not asked for assistance for Resident 2 for toileting nor had any staff entered Resident 2's room. An interview on 3/26/2024 at 2:22 PM with Resident 2 revealed no staff had assisted Resident 2 with toileting and was common for the staff to shut off the call light without assisting Resident 2. An interview on 3/27/2024 at 10:32 AM with NA-B revealed Resident 2 is dependent for all cares. An interview on 3/27/2024 at 10:35 with the Director of Nursing (DON) revealed the DON's expectation for providing ADL care includes following the residents care plan, answering call lights in a timely manner, and providing cares as soon as requested such as going to the bathroom or repositioning. A record review of a facility policy Activities of Daily Living (ADLs), Supporting with a last revised date of March 2018 revealed appropriate care and services will be provided to dependent residents in accordance with the care plan including toileting. The policy also revealed if residents resist care, staff will not assume the resident is refusing or declining care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09D8b Based on record reviews and interviews, the facility failed to identify a significant weight loss for 1 (Resident 1) of 4 sampled residents. The facility census was 27. The findings are: A record review of facility policy Weight Assessment and Intervention with last revised date of September 2008, revealed in the Weight Assessment section, #3 Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. Verbal notification must be confirmed in writing. and #6 The threshold for significant unplanned and undesired weight loss will be based on the following criteria: a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months-7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe. A record review of facility policy Change in a Resident's Condition or Status with a last revised date of February 2021, revealed in #2 A 'significant change' of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions., in #4 Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status., and in #8 The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. A record review of Resident 1's admission record revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of acute and chronic respiratory failure with hypoxia. A record review of Resident 1's Transfer/Discharge report revealed the resident was discharged on [DATE] at 8:27 PM to Acute Care-Regional [NAME] Medical Center for Altered Mental Status. A record review of Resident 1's weights documented in Point Click Care (PCC an electronic health record system), revealed a weight of 189 pounds on 2/19/24. The resident also had a weight of 180 pounds on 3/14/24, a weight of 175 pounds on 3/18/24, and a weight of 175 pounds on 3/21/24. All of these weights were documented as being obtained on the bath scale. This was a 7.4% weight loss in one month. A record review of Resident 1's undated Care Plan revealed the resident had a focus area related to fluid balance with an intervention for the staff to monitor, document, and report any signs/symptoms of dehydration. One of the signs listed was recent/sudden weight loss. The resident also had a focus area related to their nutritional status with an intervention to monitor, record, and report signs/symptoms of malnutrition. One of the signs listed was significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/27/24 at 10:27 AM with Nurse Aide (NA)-C revealed the NA's responsibility regarding resident weights was to obtain the weights as ordered and give the weights to the nurse on duty. The NA stated the nurses documented the resident weights PCC. A record review conducted on 3/27/24 of Resident 1's task section in PCC, nutritional intakes revealed there were no fluid or meal intakes documented in the prior 30 days. An interview on 3/27/24 at 12:10 PM with Licensed Practical Nurse (LPN)-A revealed the staff write each resident's intakes on a paper document that is located in the dining room, then the aides document the intakes in PCC. The LPN confirmed that there was no documentation in PCC regarding Resident 1's fluid or meal intake for the prior 30 days. An interview on 3/27/24 at 12:12 PM with Cook-E revealed the facility only retained the paper intake documents for a year. A record review of Resident 1's meal and fluid intakes recorded on the facility's Meal Intakes documents from 3/1/24 through 3/24/24 revealed that the resident refused or there was no documentation of intake for breakfast 8 times, for lunch 17 times, and for supper 20 times. Of the 16 days the resident ate breakfast, they consumed 50% or less 5 times and each of these occurrences were after 3/13/24. Of the 7 days the resident ate lunch, 6 of the days were before 3/11/24. A record review of Resident 1's assessments revealed there was a Nutritional Assessment completed on 11/30/23 by the dietitian and that no additional nutritional assessments had been documented since that date. A record review of Resident 1's Progress Note dated 2/15/2024 at 11:02 AM by Registered Dietitian (RD)-F revealed a late entry note of Watching for decreased appetite. Resident had been eating less recently. Resident on a new pain medication that may be altering appetite. Monitoring appetite and intake closely to prevent weight loss. Resident was eating in the dining room and was independent in dining skills but benefits from cueing and encouragement at meals. A record review of Resident 1's Progress Note dated 3/23/2024 at 1:56 PM by LPN-D revealed the resident had refused their lunch and would not come out of their room. When the LPN asked the resident what was wrong the resident stated, my back door hurts. The LPN also documented that the provider was aware. A record review of all of Resident 1's Progress Notes from 2/1/24 through 3/24/24 revealed there were no other progress notes documented that indicated the resident had been refusing meals or that the resident was experiencing a weight loss. A record review of a scanned document in Resident 1's Electronic Health Record (EHR) revealed the resident was seen by their Primary Care Provider (PCP) on 3/15/24 for a 60-day recertification visit. The PCP documented in the History of Present Illness, HPI section that the resident reported they had been feeling shaky and nauseous since 3/14/24 and nothing was tasting good and that the resident reported not having much of an appetite. There was no further documentation regarding the resident's lack of appetite or nausea. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 1's Weekly Skin assessment dated [DATE] by LPN-D revealed there was no documentation indicating that the resident had any edema (fluid retention that results in swelling of the extremities). A record review of Resident 1's Weekly Skin assessment dated [DATE] by LPN-D revealed there was no documentation indicating that the resident had any edema (fluid retention that results in swelling of the extremities) or that the nurse had noticed a change in the resident's weight status. A record review of the Assessments section of Resident 1's EHR revealed there were no additional skin assessments documented during the month of March 2024. An interview on 3/27/24 at 10:33 AM with LPN-A revealed that the resident weights were documented by the nurse on duty in PCC. The LPN stated they were unsure if there was a facility process for reviewing resident weights but stated that if a resident's weight was up or down by three or more pounds, PCC would flag the weight. When this happened, the LPN stated they would report the weight change to the Director of Nursing (DON). If the resident had a weight loss, the LPN stated they usually initiated faxing the resident's primary care provider (PCP) with the weight change information and made a request for a supplement. The LPN stated they did not recall noticing that Resident 1 had a weight change when they entered the resident's weight in PCC on 3/21/24. The LPN stated this resident's EHR used to show the resident's previous weight when they would document a new weight, but this resident's EHR did not show that anymore. An interview on 3/27/24 at 10:40 AM with the DON confirmed that a significant weight loss, per the Minimum Data Set (MDS) standards, was something the DON would consider to be a change in condition for a resident and that this was something the DON would expect staff to report to a resident's Power of Attorney (POA) or representative. The DON stated that if a change in resident condition was identified, the DON would expect the Charge Nurse (CN) to notify the DON, notify the primary care provider, notify the resident's POA or guardian, and to document in PCC. The DON confirmed that they had not been made aware that Resident 1 had a 7.4% weight loss over the last month and as such, was not aware of whether the resident's POA or PCP had been notified. The DON also stated they had not seen a physical change nor had a physical change been reported by staff that would have indicated the staff were aware of a change in the resident's weight. The DON revealed the resident's recent complaints had been primarily related to their hemorrhoidal pain and that the facility had been addressing this. The DON stated PCC had a warning that triggered when a resident had a weight entered that was significant per MDS standards; 5% in one month, 7.5% in 3 months, or 10% in 6 months, but the DON stated they did not recall seeing a warning for Resident 1 and did not recall the charge nurses notifying them of the resident having a weight loss. The DON confirmed that Resident 1's weight section of PCC did not have any information in the warnings section but that the Profile section of the resident's EHR did have the resident's most recent weight in red with a warning symbol next to it. The DON revealed they conducted a review of all residents' weights at least twice a week, ensuring weights had been entered and looking for weight warnings and changes. The DON stated that when a weight change was identified, the facility first obtained a re-weigh to verify the weight was accurate. Once the weight change was confirmed, the facility would contact the PCP and POA, then look into why the resident was losing weight, such as whether there was an illness, or the resident was not liking what was being served on the menu. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/27/24 at 12:13 PM with NA-B revealed Resident 1 was independent with eating and that over the prior 2 weeks the resident had been refusing to go to dining room, so the staff was delivering meal trays to the resident's room. The NA revealed that over time, the resident had been requesting only a dessert in the evenings and that the resident had only consumed a dessert in the evening for the last week. The NA stated that the nurses had been giving the resident a shake at times since the resident was not eating as much as they used to. An interview on 3/27/24 at 12:35 PM with LPN-A confirmed the LPN worked the 6 AM to 6 PM shift and was in the facility for the supper meal on the days they worked. The LPN revealed that about six months ago, Resident 1 thought they were getting too heavy and had started to occasionally decline their evening meal at that time and would only eat dessert in an attempt to lose weight, but that the resident did not lose weight with this practice. The LPN confirmed that they had recently, on occasion, given the resident a house supplement that was high in calories and nutrients. The LPN also stated that if they identified a resident that was routinely not eating well, the nurses would request order for a supplement, such as Ensure or Boost, from the resident's PCP. An interview on 3/27/24 at 1:09 PM with LPN-A revealed that when Resident 1 would refuse a meal, the staff would offer an alternative item such as soup, a sandwich, or items from the facility's snack cart. The resident had recently been frequently requesting Jello and had also requested a popsicle one day. The LPN confirmed the facility staff did provide Jello and the popsicle when requested. The LPN stated that usually when the resident refused their meal, the resident would say it was because they were just not hungry. The LPN revealed that on Sunday, 3/24/24, the resident had been complaining of not feeling well and had appeared lethargic (a state of weariness that involves diminished energy, mental capacity, and motivation) throughout the day. When asked, the resident reported they did not feel well due to their ongoing hemorrhoid pain. The LPN had asked the resident that day if they wanted to go to the emergency room (ER) to be evaluated and the resident had initially declined to go, but later the resident's family convinced the resident to go to the ER, so the nurse obtained an order from the PCP and sent the resident. After the resident was evaluated in the ER, the ER staff contacted the LPN at the facility and informed the LPN that the resident had diverticulitis and dehydration and that the resident was going to be sent to Regional [NAME] Medical Center. The LPN stated they did not know how the resident could have been dehydrated as the resident had drunk three pitchers of water in their room that day prior to going to the ER. The LPN revealed that in regard to the house supplement, the supplement was made in the facility kitchen and that the nurses used their nursing judgement for deciding when and how much to give a resident. The LPN stated that when they had a resident that didn't want to eat or when the LPN was worried about potential weight loss for a resident and the resident had already been offered and refused alternative foods, then the LPN would provide the house supplement. The LPN confirmed that the facility staff often did not document when a resident refused their meal, what alternative foods/drinks had been offered and accepted or refused, or when they were giving the residents the house supplement when there was no order in place.

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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. 49766 Licensure Reference Number 175 NAC 12-006.10D Based on observations, interviews, and record review, the facility failed to prepare and administer the correct dosage for 2 (Resident 8 and Resident 12) of 11 sampled residents. The medication error rate was 7.69%. The facility identified a census of 27. The findings are: An observation on 3/26/2024 at 12:18 PM revealed Licensed Practical Nurse (LPN) - A prepare an unmeasured amount of Resident 8's Dicolfenac Gel 1%. An interview on 3/26/2024 at 12:20 PM with LPN-A revealed [gender] was not knowledgeable of how to measure Diclofenac Gel 1%. A record review of Resident 8's order revealed Diclofenac Gel 1% with a direction to apply 2 grams to both knees. A continuous observation on 3/26/2024 at 12:23 PM revealed LPN-A had administered 17 grams or a converted measurement of 1.1497 tablespoons of Miralax to Resident 12. An interview on 3/27/2024 at 10:43 AM with LPN-A revealed [gender] follows the orders to know the correct amount to administer and had acknowledged the dosage varies for each resident. A record review of Resident 12's Miralax order revealed directions to administer 2 tablespoons mixed in 8 ounces of water. A record review of facility policy Administering Medications with a last revised date of April 2019 revealed the individual administering medications is to verify the right medication, right dosage, right time, and right method before administration. The policy also revealed each nurses' station has current medication reference guides available.