STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285307	A. Building B. Wing	12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabitha at Prairie Commons	3490 Ewoldt Street Grand Island, NE 68803

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-006.09(H)(i)(3) Based on observation, record review, and interview, the facility failed to answer call lights timely for 1 (Resident 1), of 8 sampled residents and failed to ensure residents received routine bathing for 1 (Resident 1), of 8 sampled residents. The facility census was 32. Findings are: Review of the facility supplied Resident Handbook revealed documentation that residents would be assisted with a bath or shower each week or more often if necessary and assistance from the nursing staff may be obtained by pushing the button on the call light or pendent. Review of the resident demographic record revealed Resident 1 was admitted to the facility on [DATE] with diagnoses of: multiple sclerosis (which is disease that affects central nervous system causing muscle weakness and vision changes), malnutrition (which is the lack of proper nutrition), type 2 diabetes (which is when the body does not produce enough or properly use insulin resulting in elevated blood sugar levels), neurogenic bladder (which is a condition that causes a loss of bladder control due to damage to the nervous system), and enterocolitis due to clostridium difficile (which is an infection in the longest part of the large intestine resulting in diarrhea often uncontrollable). The comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 12/09/2024 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 13 indicating the resident was cognitively intact. The MDS was coded to reflect it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The resident had range of motion limitations to both upper and lower extremities and used a wheelchair for mobility in and outside of the facility. Staff provided set up or clean up assistance with eating and the resident was dependent on staff assistance for bed mobility, bathing, and transfers. The resident was frequently incontinent of bowel and bladder and dependent on staff assistance for toilet use and personal hygiene. Review of Resident 1's Care Plan dated 12/23/2024 revealed a focus of the resident having a self-care performance deficit with interventions listed of 1 or 2 staff assistance for bathing or showering and transfers with a full body lift. A focus of the resident having diabetes melilitus and interventions of medication as ordered by doctor. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. In an observation completed on 12/23/2024 at 11:39 AM Resident 1 was visualized to be sitting in their wheelchair beside their bed in their room. The residents call light indicator located to the left of the head of the bed had a green light glowing on it. When asked the resident stated that light being on indicated they had their call light activated to get assistance. In an interview completed on 12/23/2024 at 11:40 AM with Resident 1, Resident 1 stated they often must wait long periods of time to have their call light answered. The resident stated has waited over a half an hour to have their call light answered in the past. In an observation completed on 12/23/2024 at 11:55 AM Resident 1 was visualized to be sitting in their wheelchair beside their bed in their room. The green light indicating the call light had been activated was visible in the box to the left of the head of the resident's bed. In an interview completed on 12/23/2024 at 11:55 AM Resident 1 stated staff had not answered their call light yet and continued to await staff assistance. In an observation completed on 12/23/2024 at 12:02 PM Resident 1 was visualized to be sitting in their wheelchair beside their bed in their room. The resident's position was unchanged from the prior two observations. In an interview completed on 12/23/2024 at 12:02 PM with Resident 1, Resident 1 stated no staff had entered the room or come to answer the call light. The resident stated continued to wait of assistance from staff. In an interview completed on 12/23/2024 at 12:02 PM with Licensed Practical Nurse G (LPN-G), LPN-G stated the only way to turn off a call light was to enter the room and manually turn the call light off. In an interview completed on 12/23/2024 at 12:30 PM with Resident 1, Resident 1 stated staff answered their call light just after noon and assisted them to the bathroom as requested. In a Record Review of the facility supplied document titled Ascom and dated 12/23/2024 revealed Resident 1 had a call light lasting 23 minutes on 12/23/2024 from 11:39 AM till 12:01 PM. In a interview on 12/23/2024 at 2:23 PM with the facility Assistant Director of Nursing (DON), the DON confirmed that the facility did not have a call light time standard for being answered. The DON confirmed that 23 minutes was outside of their expectation for answering call lights in a timely manner and the call light should have been answered sooner. B. In an interview completed on 12/23/2024 at 11:40 AM with Resident 1, Resident 1 stated on admission they had stated that they would prefer to have a bath or shower twice a week. The resident stated that they had gone over a week with out a bath or a shower multiple times since admission to the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility supplied document titled POC (Point of Care) Response History-Bathing revealed from 11/23/2024-12/23/2024 Resident 1 had a bath or shower documented on 12/12/2024 and 12/18/2024. In an interview completed on 12/23/2024 at 4:00 PM with the Director of Nursing (DON), the DON confirmed that the facility standard is for residents to receive choice of bathing at least weekly. The DON confirmed that Resident 1 had no documentation of bathing occurring from 11/23/2024 through 12/11/2024 indicating the resident did not receive weekly bathing as indicated in the facility Resident Handbook.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175NAC 12-006.10D Based on observation, record review, and interview, the facility failed to follow provider orders for medication administration for 1 (Resident 1) of 2 sampled residents, and failed to ensure proper labeling and priming of an insulin pen for 1 resident (Resident 1) of 1 sampled resident. The facility census was 32. Findings are: A. Review of the resident demographic record revealed Resident 1 was admitted to the facility on [DATE] with diagnoses of: hypertensive heart disease (which is high blood pressure), type 2 diabetes (which is when the body does not produce enough or properly use insulin resulting in elevated blood sugar levels), and atrial fibrillation (which is a type of irregular heartbeat). The comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 12/09/2024 revealed Resident 1 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 13 indicating the resident was cognitively intact. The MDS revealed that the resident had range of motion limitations to both upper and lower extremities and used a wheelchair for mobility in and outside of the facility. Staff provided set up or clean up assistance with eating and the resident was dependent on staff assistance for bed mobility, bathing, and transfers. The resident was frequently incontinent of bowel and bladder and dependent on staff assistance for toilet use and personal hygiene. The MDS was coded to reflect the resident received insulin injections 7 days during the look back period. Review of Resident 1's Care Plan dated 12/23/2024 revealed a focus of the resident having diabetes and unstable blood sugar levels with an intervention for diabetic medication as ordered by the physician. Review of the facility supplied Resident Handbook revealed documentation that residents would receive medications as ordered by their physicians. Review of Davis's Drug Guide dated 12/23/2024 revealed for the medication Digoxin, which is a medication used to strengthen and regulate the heart rate, to monitor apical pulse for 1 full minute before administering the medication and to hold the dose and notify the health care professional if the pulse rate is less then 60 bets per minute in an adult. Review of Resident 1's physician orders on 12/23/2024 at 11:25 AM revealed Resident 1 had an order for Digoxin 0.125 milligrams with directions to give half of a tablet one time a day with lunch and to hold the medication if apical heart rate was less than 60 beats per minute dated 11/21/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation completed on 12/23/2024 at 11:12 AM Medication Aide-B (MA-B) prepared medications for Resident 1. MA-B placed the medication into a clear plastic cup the took the medication to Resident 1. MA-B placed an electronic pulse oximeter on the residents left index finger and stated to the resident they needed a pulse prior to the resident taking the medication. MA-B told the resident their pulse was 59 beats per minute then handed the clear medication cup to the resident and a small cup containing water. The resident placed the medication into their mouth and swallowed the medication using the water provided by MA-B. MA-B then returned to the medication cart and documented the resident's pulse and medication administration in the residents electronic medication record. In an interview completed on 12/23/2024 at 11:25 AM with MA-B, MA-B denied knowledge of why a pulse was obtained prior to the administration of the Digoxin medication. MA-B revealed [gender] was not aware of any directions to not give the medication or to notify the nurse due to the pulse rate being obtained prior to administration of the medication. In an interview completed on 12/23/2024 at 11:30 AM with Licensed Practical Nurse-G (LPN-G), LPN-G confirmed that an apical pulse was not obtained on Resident 1 prior to administering the Digoxin medication. The LPN confirmed directions in the order for the medication to have an apical pulse obtained prior to administering the medication and to hold the medication and notify the provider for a pulse less then 60 beets per minute. The LPN confirmed that MA-B did not hold the medication for a pulse less then 60 and that the nurse did not notify the provider of a pulse less then 60 as directed by the providers orders. B. Record review of a document labeled Humalog KwikPen dated 07/2023 revealed: -Do not use the pen for more then 28 days after first use of the pen. -Not priming the pen before each injection will result in to much or to little insulin. -To prime the pen turn the dose knob select 2 units, gently tap the pen to collect air bubbles at the top, push the dose knob until it stops and count to 5 slowly. Record review of a facility supplied policy titled Insulin Pen Administration and dated 08/2016 revealed: -Prime pen before each injection by dialing two units on the pen and press the button to shoot insulin into the air. In an observation completed on 12/23/2021 at 11:30 AM LPN-G obtained an insulin pen from the medication cart. The insulin pen was labeled with the manufacturer label only. There was no resident identification, pharmacy label, expiration or open date on the insulin pen. The LPN then obtained another insulin pen from the medication cart. This pen was labeled with a pharmacy label including Resident 1's name. A white label was also on the insulin pen with typed writing Discard Date. There was no date written in this area. No legible date of opening or discarding was present on the pen. LPN-G obtained a needle cap and screwed the cap onto the end of the insulin pen. The LPN turned the dose dial at the end of the insulin pen and then depressed the plunger. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LPN-G on 12/23/2024 at 11:35 LPN-G confirmed that neither of the two insulin pens were labeled correctly. The LPN confirmed that the insulin pens should be discarded, and new pens obtained prior to administering insulin to the resident. The LPN stated they do not turn the dial to a certain number of units when priming the insulin pen. The LPN stated that they just turn the dial some and depress the plunger and continue to do this until insulin comes out meaning the pen is primed. In an interview on 12/23/2024 at 4:30 PM with the Director of Nursing (DON), confirmed that the insulin pens are to be labeled properly with the resident information pharmacy label and open or discard date present before using the pen. The DON confirmed all required labeling information was not present on the 2 insulin pens. The DON confirmed the LPN did not follow manufacturer recommendation or facility policy for priming of the insulin pen.