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	05/01/2024

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

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50105 Licensure Reference Number 175 NAC 12-006.05 (4) Based on interview and record review, the facility failed to provide bathing preferences for 1 (Resident 71) of 2 sampled residents. The facility census was 18. Record review of Resident 71's Admission Record dated 05/01/2024 revealed that Resident 71 admitted to the facility on [DATE]. Record review of Resident 71's Minimum Data Set (MDS -a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 04/22/2024 revealed a Brief Interview for Mental Status (BIMS-a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 10, which indicated the resident was mildly impaired. In an interview on 04/29/24 at 11:23 AM with Resident 71 and spouse revealed they wanted a bath twice weekly and that they have not been receiving that preference. A record review of Resident 71's bathing task report documented in Point Click Care (PCC- electronic medical records system) for a 30 day look back, document dated 04/29/2024, baths offered and provided were documented on 04/22/2024 at 12:46 PM with no further documentation that resident received or refused any additional baths. A record review of Resident 71's Progress Notes dated 4/07/2024 - 04/29/2024 revealed no bathing refusals documented or documentation related to bathing. A record review of the Preference Sheet dated 04/18/2024 printed on 04/29/2024 confirmed that Resident 71 prefers 2 baths a week. A record review of Resident 71's Care Plan (CP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) with an initiated date of 04/22/2024 revealed that under bathing/showering the resident is totally dependent on 2 staff to provide shower twice weekly and as necessary. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/30/2024 at 10:41 AM with the Bath Aide-E (BA-E) revealed that preferences and schedules are made when the resident is admitted . That information is then given to the nurse who enters the information on the bathing preferences sheet that is hanging on a wall in the nurses' station. The BA-E will obtain information from the bathing preferences sheet to complete. BA-E confirmed that Resident 71 only received 1 bath since admission. An interview with the Director of Nursing (DON) on 05/01/2024 at 1:17 PM revealed that when a resident is admitted , preferences are obtained and entered within the personal preference sheet, entered in the CP, and entered on the bathing schedule that is hung on the wall at the nurses' station. If a Resident is unable to make decisions or has the capacity to do so, the resident is provided 2 baths a week until preferences change. Preferences can be changed at any time through communication with the residents daily. The DON reported that when a resident refuses a bath, the resident is re-approached. If the resident continues to refuse, this information is documented in the progress notes and task report. The DON reported that there is no bathing policy available.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Based on record review and interview the facility failed to obtain the advanced directive for the residents wishes in regards to code status [a resident's choice for cardiopulmonary resuscitation (a lifesaving attempt combination of rescue breathing and chest compressions when someone's heart has stopped) or do not resuscitate (DNR) (a type of advance directive in which a person states that health care providers should not perform cardiopulmonary resuscitation (restarting the heart) if his or her heart or breathing stops)] and obtain a signed physician order for DNR for 1 resident (Resident 61) and failed to obtain a signed physician order for DNR for 1 resident (Resident 68). The facility census was 18. Findings are: A. Record review of the facility Advanced Directives form dated [DATE] revealed that the facility will provide all clients (residents) with information regarding their right to formulate an Advance Directive and honor Advanced Directives as executed by the client to the extent allowed under state law. The document contained a section with the instructions One of the following must be checked. The first of the two choices provided is I do not want cardiopulmonary resuscitation (CPR) to be attempted should my heart stop beating. The Do Not Attempt Resuscitation (DNR) form must be completed and signed by your physician. The second of the two choices provided is I do want cardiopulmonary resuscitation (CPR) should my heart stop beating. I understand that I will receive cardiopulmonary resuscitation and life sustain treatment to the extent of the provider's ability. Record review of the Admission Record dated [DATE] for Resident 61 revealed that Resident 61 admitted into the facility on [DATE]. Diagnoses included cardiomegaly (an enlarged heart causing difficulty pumping blood), chronic heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and tachycardia (a rapid heartbeat that may be regular or irregular). Record review of the medical record for Resident 61 revealed it contained no completed Advanced Directives form for Resident 61 to identify the resident's choice for CPR or no CPR in the event the resident's heart stopped beating. Record review of the progress note dated [DATE] at 1:16 AM for Resident 61 revealed that the nurse and nurse aide were doing rounds. At approximately 1:16 AM they arrived at the room of Resident 61 and Resident 61 was noted to not be in the bed nor the recliner in the resident's room. The nurse and nurse aide found Resident 61 lying on the bathroom floor. The nurse aide approached Resident 61 and called out the resident's name and shook the resident's arm to wait for a response. Resident 61 did not respond. The nurse aide then raised Resident 61's head and the resident was noted to be unresponsive and not breathing and was blue in the face. The nurse called 911 at 1:18 AM for ambulance assistance. The nurse identified that records in the facility stated Resident 61 was Do Not Resuscitate (DNR) status. The ambulance arrived on scene at approximately 1:30 AM. The Emergency Medical Technician and the paramedic began performing full code (CPR) due to their policy. The ambulance left the facility with Resident 61 at approximately 2:00 AM heading to the hospital. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Code Protocol dated [DATE] revealed that any client (resident) found unconscious without pulse and/or respirations will have Cardiopulmonary Resuscitation (CPR) initiated immediately unless the client has a valid Do Not Resuscitate (DNR) form on file. Record review of the progress note dated [DATE] at 3:08 AM for Resident 61 revealed that a nurse from the hospital called the facility to report Resident 61 had died . Interview on [DATE] at 8:54 AM with the facility Social Services Director (SSD) confirmed that on admission all residents complete the facility Advanced Directives form and indicate their choice for code status (choice of CPR or DNR). The SSD revealed that the Physician's Do Not Resuscitate (DNR) Order for the Medically Ill form is completed for residents that choose a code status of DNR. The SSD confirmed that the Physician's Do Not Resuscitate (DNR) Order for the Medically Ill form is then faxed to the physician for signature. Interview on [DATE] at 9:50 AM with the facility Assistant Administrator (AA) confirmed that the facility did not have an Advanced Directives form for Resident 61. Interview on [DATE] at 10:32 AM with the facility Director of Nursing (DON) revealed that a Licensed Practical Nurse was working when Resident 61 was found without pulse or respirations. The DON revealed that Resident 61 was a DNR. The DON revealed that the Licensed Practical Nurse called Emergency Medical Services (EMS) for an ambulance. The DON revealed that EMS started CPR on Resident 61 due to the facility not having the form signed by the physician documenting Resident 61 was a DNR. The DON confirmed that the facility did not have a physician signed Physician's Do Not Resuscitate (DNR) Order for the Medically Ill form that EMS needed. 49382 B. Review of an Admission Record revealed the facility admitted Resident 68 on [DATE] with diagnoses that included pneumonia, (which is an infection that inflames the air sacs in your lungs and respiratory failure which is a condition that makes it difficult to breath on your own). Record review of facility supplied document labeled Physician's Do Not Resuscitate (DNR) Order for the Medically Ill revealed the resident did not want to be intubated and did not want to be resuscitated. This document was signed by the resident on [DATE]. This document revealed no physician signature. Record review of Resident 68 Physician Orders dated [DATE] revealed Resident 68 had an active physician order for Do Not Resuscitate (DNR). In an interview conducted on [DATE] at 11:35 PM with the DON, confirmed that there was no physician signature on the Physician's Do Not Resuscitate (DNR) Order for the Medically Ill form. The DON confirmed that the facility had not obtained the physicians signature on Resident 68 form ensuring the physician was aware of the residents wishes for Do Not Resuscitate (DNR).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 49382 Licensure Reference Number 175NAC 12-006.12E5; Licensure Reference Number 175 NAC 12-006.12E1b Based on observation, interview, and record review the facility failed to store medications administered by different routes separately for 1 resident, (Resident 67) of 7 sampled residents; failed to administer eye drops following current professional standards of care for 1 resident, (Resident 63) of 7 sampled residents; and failed to ensure accountability of a controlled substance for 1 resident (Resident 7) of 7 sampled residents. The facility census was 18. Findings are: A. Medication pass observation was conducted on 04/30/2024 from 11:50 AM to 12:21 PM with Medication Aide-C (MA-C), in which the following was observed: MA-C knocked and entered Resident 67 room. MA-C used keys to unlock the cabinet located just inside the doorway to Resident 67's room and retrieved a drawer like container from the cabinet that contained unit dose cards for medications and two taller cardboard boxes. The cardboard boxes were labeled as Fluticansone Propionate which is a medication that is administered by inhaling the medication, and the other box was labeled as Lidocaine and Prilocaine cream which is a medication that is applied topically to the skin. In an interview on 04/30/2024 at 11:55 AM with MA-C, MA-C confirmed that the inhalation medication and topical medication should not be stored in the same drawer/container as the oral medications. MA-C stated that medications should be stored separately by route. Record review of the facility supplied policy titled Medication Storage and not dated revealed oral medication should be separated from substances that are for external use only and pharmaceutical products not intended for oral use. B. Medication pass observation was conducted on 04/30/2024 from 11:50 AM to 12:21 PM with Medication Aide-C (MA-C), in which the following was observed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MA-C knocked and entered Resident 63's room. Resident 63 was sitting in their room in their recliner sitting in an upright position. MA-C then informed the resident that the MA was going to administer the residents scheduled eye drops. MA-C handed Resident 63 a Kleenex and then with gloved hand used their finger to lift up on resident 63's left top eye lid of the residents left eye. MA-C then administered the eye drop by holding the container just above the inner corner of the residents left eye and allowed one drop to come out of the bottle landing on the resident's eyeball. MA-C then used a finger of a gloved hand and pulled up on Resident 63's right top eye lid. MA-C then administered the eye drop by holding the container just above the inner corner of the resident's right eye and allowed one drop to come out of the bottle landing on the resident's eyeball. In an interview on 04/30/2024 at 11:55 AM with MA-C, MA-C confirmed that they should have pulled down on the lower eye lid of Resident 63 and instilled the eye drop to the outer corner of the lower eye lid. MA-C confirmed that MA-C incorrectly pulled up on the upper lid and placed the eye drop on the eyeball at the inner corner of the eye. Record review of the facility supplied policy titled Medication Administration: Ophthalmic Eye Drops revealed to pull down on the lower eye lid gently to form a pouch. Instruct the resident to look up. Instill the eye drop inside the lower lid close to the outer corner of the eye. C. In an observation on 04/30/2024 at 2:17 PM Licensed Practical Nurse-B (LPN-B) was preparing to administer a controlled substance liquid to Resident 7. After drawing up the liquid medication from the bottle LPN-B went to sign out the controlled substance in the narcotic record book. LPN-B stated the amount of medication in the bottle per the resident's narcotic record should be 19.25 milliliters. LPN-B set the bottle of medication on top of the medication cart and observed the level of the medication in the bottle at just above the 16 milliliters measurement line indicating a discrepancy in the narcotic count for this medication. LPN-B confirmed that at 2:00 PM on 04/30/2024 a narcotic count was completed with MA-C. LPN-B confirmed when completing this count, the LPN held the bottle up to the light to better see the level of medication in the bottle and did not place the bottle on a flat surface to assist with accuracy of measurement of the medication. LPN-B confirmed that the narcotic count for this medication was not correct. In an interview on 04/30/2024 with the Director of Nursing (DON), confirmed that the narcotic count for this medication was incorrect. The DON confirmed the amount of medication in the bottle measured just above the 16 milliliters measurement line not 19.25 milliliters and that the narcotic count was verified by LPN-B and MA-C and documented as 19.25 milliliters at 2:00 PM. Record Review of the facility supplied policy titled Controlled Substances revealed Medications are dispensed by the pharmacy in readily accountable containers designed for easy counting of contents. A controlled drug administration record must be prepared when the facility is receiving or documenting receipt of a controlled substance and is used to document medication administration to maintain a perpetual inventory. The inventory will be verified at the end of each shift.

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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. 49382 Licensure Reference Number 175 NAC 12-006.09D3(5) Based on interview and record review; the facility failed to ensure routine bowel movements for 1 (Resident 2), of 2 sampled residents. The facility stated census of 18. Review of a facility policy titled Maintaining Bowel and Bladder Function dated 09/21/2023 revealed the Bowel Care Medication regimen will be implemented for all patients unless otherwise directed by the patient's provider to prevent or manage constipation. Review of a facility document labeled Bowel Care Protocol and dated 04/30/2024 revealed Resident 2 had gone five days without a bowel movement. The document also stated: A. on day three of no bowel movement - Milk of Magnesia 30 milliliters by mouth one time. B. on day four of now bowel movement - Bisacodyl 10 milligram suppository one time. C. if no stool with in four hours of having Dulcolax, re-evaluate to rule out impaction and administer one of the following: Fleets enema on time, or Magnesium Citrate 4 ounces by mouth. If no results, contact the physician to update on client's bowel status. Review of a facility document labeled POC Response History, Bowel Elimination dated 04/30/2024 revealed Resident 2 did not have a recorded bowel movement from 04/06/2024 to 04/10/2024, from 04/17/2024 to 04/20/2024, and from 04/24/2024 to 04/30/2024. The Annual Minimum Data Set (MDS) which is a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, with the Assessment Reference Dated (ARD) of 05/13/2024, revealed Resident 2 had a Brief Interview for Mental Status score of 2 indicating severe cognitive impairment. The resident was documented as to being able to understand others and always be understood. The resident needed set up and clean up assistance with eating and substantial or maximal assistance with bed mobility, transfers, and toilet use. The resident needed supervision or touching assistance to walk with a walker for mobility around the facility. The resident was always incontinent of bladder and occasionally incontinent of bowel. In an interview conducted on 04/30/2024 at 9:16 AM with Registered Nurse-D (RN-D), RN-D stated the facility did have a bowel protocol. RN-D stated night shift created the list for day shift of residents who had not had a bowel movement in three days and the day shift administer to the resident the medication intervention as listed on the Bowel Care Protocol sheet. RN-D confirmed that Resident 2 was listed on this sheet as not having a bowel movement in five days. In an interview conducted on 05/01/2024 with the Director of Nursing (DON), confirmed that Resident 2 had no documented interventions for not having a bowel movement in three or more days for the month of April 2024 in either the medication administration record or the residents progress notes. DON confirmed the facility Bowel Care Protocol was not followed ensuring the resident had a bowel movement or intervention to result in a bowel movement after not having a bowel movement in three days.

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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. 49382 Licensure Reference Number 175 NAC 12.006.09D7b Based on observation, interview, and record review; the facility failed to update and or change interventions to prevent falls for 1 resident (Resident 2), out of 2 sampled residents. The facility census was 18. Findings are: Review of facility policy titled Fall Risk Evaluation and Post fall Procedures not dated revealed under procedure to review and update care plan if a resident falls. Review of facility supplied document labeled Post-Fall Checklist dated 02/12/2023 revealed item four, care plan which is a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident, updated post-fall with new fall in focus statement, new intervention, and goals. A review of an Admission Record revealed the facility admitted Resident 2 on 05/04/2023 with diagnoses of dementia which is the impaired ability to remember, think, or make decisions that interferes with doing everyday activities, with mood disturbance which is noticeable disruptions in someone's emotions, and anxiety which is feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities, type 2 diabetes which is when the body has trouble controlling blood sugar and using it for energy , muscle weakness, and pain. The Annual Minimum Data Set (MDS) which is a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, with the Assessment Reference Dated (ARD) of 05/13/2024, revealed Resident 2 had a Brief Interview for Mental Status score of 2 indicating severe cognitive impairment. The resident was documented as to being able to understand others and always be understood. The resident needed set up and clean up assistance with eating and substantial or maximal assistance with bed mobility, transfers, and toilet use. The resident needed supervision or touching assistance to walk with a walker for mobility around the facility. The resident was always incontinent of bladder and occasionally incontinent of bowel. The resident was documented to have had two or more falls without injury in the last 90 days. Record review of facility supplied document unlabeled for Resident 2 revealed the following: -On 12/11/2023 Resident 2 was indicated to have had a fall. No new or changes in interventions related to the determining cause were found on the resident's care plan. -On 01/27/2024 Resident 2 was found on the floor sitting in front of their bed. The interventions documented as being placed not reflected on the resident's care plan. -On 02/17/2024 Resident 2 was indicated to have had a fall. The interventions documented as being placed were already present on the resident's care plan to have been being used to prevent falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 02/26/2024 Resident 2 was indicated to have had a fall. The interventions documented as being placed were already present on the resident's care plan to have been being used to prevent falls. In an observation on 04/29/2024 at 1:36 PM Resident 2 was observed to be lying in their bed on their right side facing the wall. Both residents' feet were observed to be hanging over the edge of the bed and the residents' buttocks was observed to be inches away from the edge of the bed. The bed was observed to be approximately two feet from the floor. In an observation on 04/30/2024 at 9:50 AM Resident 2 was observed to be lying in their bed on the left side facing the room with both feet and knees hanging over the edge of the bed. The resident's right arm was observed to be draped/hanging over the positioning bar located at the head of the resident's bed. The trunk of the resident's body was observed to be at the edge of the bed. In an interview with Medication Aide-C (MA-C), MA-C stated interventions to help prevent Resident 2 from falling were frequent checks while the resident was in their room, for the residents bed to be at the height therapy indicated safe for resident to transfer, and if staff observed the resident close to the edge of the bed staff would assist the resident to position better towards the center of the bed. In an interview on 04/30/2024 at 11:15 AM with Registered Nurse-D (RN-D), RN-D revealed fall prevention interventions were communicated to staff through report and updated on the care plan after each fall or incident. Stated would have to check Resident 2 care plan for specific fall prevention interventions. In an interview on 05/01/2024 with the MDS Coordinator (MDSC) which is a facility nurse that utilizes a mandatory comprehensive assessment tool for care planning and reviews and updated resident care plans as needed, at 10:41 am, MDSC stated that new interventions are placed on the care plan after each fall/incident. Stated these interventions are reviewed weekly at the weekly risk meetings and updated or changed if needed at that time. In an interview on 05/01/2024 with the Director of Nursing (DON) the DON confirmed Resident 2 had falls on 12/11/2023, 01/27/2024, 02/17/2024, and 02/26/2024 and no new or change in fall prevention interventions were present on the resident's care plan reflecting actions taken to prevent further incidents.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licsensure Reference Number 175 NAC 12-006.09D Based on record review, observation and interviews, the facility failed to ensure that medications used together will not lead to adverse consequences, and that all medications had adequate indications for use with an appropriate diagnosis code. This affected 1 (Resident 3) of 5 sampled residents. Census was 18. Findings are: A. The National Capital of Poison Control posted an article entitled Trazodone: Side Effects, Interactions, and Overdose on their website accessed and read May 2024. Taking trazodone with other medications that increase serotonin levels, such as dextromethorphan, tricyclic antidepressants, tryptophan or 5-HTP, and buspirone, can cause a potentially life-threatening condition called serotonin syndrome (serotonin syndrome is a potentially life-threatening drug reaction. It causes the body to have too much serotonin, a chemical produced by some nerve cells.). Trazodone commonly causes drowsiness, which may be increased when taken with other sedating medications. People with underlying heart disease, or those who take medications that affect heart rhythm, are at increased risk of developing irregular heartbeats when taking trazodone. https://www.poison.org/articles/trazodone#:~:text=Trazodone%20Interactions, condition%20called%20%E2%80%9Cserotonin%20syndrome%E2%80%9D. The National Institute of Health reveals Buspirone is primarily used to treat generalized anxiety disorder (GAD). It is an FDA-approved medicine for managing anxiety disorders or the short-term relief of anxiety symptoms. Off-labeled buspirone is used for the augmentation of unipolar depression. [NAME] TK, Tripp J. Buspirone. [Updated 2023 [DATE]]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK531477/ The National Institute of Health reveals Trazodone is a medication used in the management and treatment of major depressive disorder. It is in the serotonin-antagonist-and-reuptake-inhibitor class of medications. Shin JJ, Saadabadi A. Trazodone. [Updated 2022 [DATE]]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK470560/ RXLIST.com reveals that the side effects of trazodone include weight loss, tiredness, and sleep. https://www.rxlist.com/trazodone/generic-drug.htm Drugs.com reveals that Buspar may cause drowsiness. www.drugs.com/buspar (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 3's Order summary dated 4/29/2024 reveals orders for the following two medications: -Trazadone Tablet (Tab) 50 miligrams (mg) 1 Tab by mouth every bedtime. (Related diagnosis: Dementia in other disease classified elsewhere with mood disturbance) started on 9/5/2023 -Buspirone Tab 5mg 1 Tab by mouth every bedtime. (Anxiety) started on 9/23/2023 Record review of Resident 3's electronic medical record (EMR) shows that resident was admitted first to the memory care unit on September 5, 2023, and transferred to the long term care unit September 28, 2023. Resident 3 is a Hospice resident with a terminal diagnosis. Record review of Resident 3's electronic medical record (EMR) dated September 2023 to present date revealed Resident 3's chart is reviewed monthly for needed gradual dose reductions (GDR) but found no evidence that these two drugs (trazadone and buspirone) were reviewed for reduction or discontinuation. Record review of Resident 3's Order Summary for Trazadone was started on 10/09/2023 state the Trazadone is for dementia in other diseases classified elsewhere with mood disturbances. Resident does have related diagnoses for insomnia, restlessness and agitation. However Resident 3 does not have a diagnosis for major depressive disorder found in the diagnosis list found in the order summary. Record Review of the Current Minimum Data Set (a tool used for resident assessment are care screening) (MDS) dated [DATE] does not indicate a diagnosis of major depressive disorder. Observation on 4/29/2024 at 9:09 AM in Resident 3's room Resident 3 was lying in bed sleeping. Water is on the bedside table. Interview on 4/29/2024 at 11:00 AM with Registered Nurse-D (RN-D) revealed Resident 3 doesn't always speak to strangers. The resident does sleep a lot more than when first arrived. Truly depends on the day as we take it one day at a time with the resident to see how Resident 3 will act and react when approached and at meal times. Interview on 4/29/2024 at 11:45 AM with Resident 3's spouse reveals Resident 3 is more or less stopped eating. Continues to drink water in large amounts but does need help now lifting the glass to mouth to drink. Resident 3 drinks large amounts of water when the spouse is there to assist with the water glass. Resident 3 was placed on a pleasure diet (a diet which allows a resident to eat anything they want to eat in any amount desired). Resident 3 sleeps frequently and has no interest in activities, can no longer walk or stand per self, and needs assistance for almost everything. Resident 3 has gotten weaker and has a difficult time holding a water glass. Resident 3 sleeps often in the bed or the wheelchair. Because of weight loss, the clothes Resident 3 entered the facility with no longer fit. The spouse of Resident 3 has purchased new clothing for Resident 3 to wear. Observation on 4/29/2024 at 12:30 PM. Resident 3 is sitting in wheelchair at the dining table. Resident 3 has occasional assistance while eating but refusing most of the meal. Record Review of meal intake from 4/29/2024 at 1:10 pm reveals the resident ate only 25-50% of the noon meal. (continued on next page)

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	05/01/2024

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 4/29/2024 at 3:35 PM. Resident 3 is sitting in front of the television in room with television on. When asked if there is anything needed, Resident 3 states I just need a lot of water. Just make sure there is a lot of water. Observation on 4/30/2024 at 2:40 PM. Resident 3 is sleeping in his wheelchair which is tipped back as Resident 3 sits in room in front of the tv. Observation on 5/1/2024 at 2:30 PM. Spouse is in the room and Resident 3 is sleeping.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licensure Reference Number 175 NAC 12-006.11A1 Based on record review, observation and interviews; the facility failed to use recipes during meal preparation of all foods to ensure the nutritional adequacy of dishes served. This affected all residents that ate food prepared by the facility kitchen. Current census was 18. Findings are: Observation on 04/30/24 at 9:21 AM in the facility's main kitchen. Observed the Cook-A (C-A) preparing a substituted soup of the day; Ham and Beans. There was no recipe visible. This will be an alternative to scheduled soup of the day. Information was sent out to the satellite areas so that all residents were aware of the change. Interview on 04/30/24 at 9:25 AM with the Certified Dietary Manager (DM). When asked about the recipe C-A was using, DM states the ham and beans were substituted for the [NAME] Wedding Soup that they were to have today. DM confirms that recipes are generated from their Dining Manager (DiningRD) computer program to which the facility is subscribed (this program creates food menus and recipes for the facility and residents to assure nutritionally complete menus). When changes are made to any of the recipes, those changes are then sent to the remote Registered Dietician (RD) who then prepares a recipe and sends this back to the facility as an approved recipe. The facility uses a remote Registered dietician that is available daily. A Registered dietician only visits the facility every 6 months, but the DM has a weekly remote calls with an RD (by phone or zoom calls). Observation on 04/30/24 at 9:30 AM in the facility's main kitchen. A recipe for the Italian Wedding soup was observed but there was no recipe for the Ham and Beans. The [NAME] Wedding soup recipe was removed for review but there was not a recipe for the ham and beans available to review at the time of the observations in the kitchen. C-A retrieved a large fully cooked ham from the walk in refrigerator and cut the ham in half. C-A diced up over 1/2 of the ham for the soup and added the cut up pieces to the soup stock pot on the stove, as well as two large serving spoons of a soup base. The weight of the diced ham was not weighed nor was the amount of diced ham measured. Interview on 04/30/24 at 9:40 AM with the C-A who stated once enough ham for the soup had been diced, the rest of the ham was diced for the salad bar. C-A confirmed there were cut up carrots, celery, onions, garlic salt, and salt simmering together with the ham. When asked about whether a recipe for the ham and bean soup had been used, C-A said, it's just memorized and stored in my head because I have made it so many different times. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 04/30/24 at 9:45 AM with DM. The DM stated that there would be a recipe for the bean soup shortly as it had to be sent off to the RD to ok the recipe. DM stated throughout the kitchen visit that the facility is continually evolving as they get new residents in each department of the facility. It feels that they are more like a PIONEERING facility because the census changes so often as more residents are admitted that the kitchen staff is constantly having to adjust so much every week. C-A was a chef that has come to the side of institutional cooking and everyone continues to learn. C-A is going through DM training now too and should be certified by May or June. Record Review with a copyright date of 2024 of the recipe for the Ham and Bean soup served on 4/29 indicates that Great Northern beans were substituted for the Navy beans and an additional 4 cups of carrots were added to the recipe. Carrots were not a part of the recipe. There is a variation of the soup that states that ham base may be substituted for the water. The recipe had not been updated to include the addition of the carrots to the soup. Interview on 04/29/24 at 1:30 PM with DM confirms C-A did not follow a printed recipe.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50253 Licensure Reference Number 175 NAC 12-006.11E Based on record review, observation and interviews; the facility failed to ensure that foods were maintained at the required temperatures to prevent food borne illnesses on the steam table during meal service and failed to remove and destroy foods that were in the refrigerator longer than 7 days. This had the ability to affect all 18 residents who ate food served by the facility kitchen. Current census was 18. Findings are: A. The Nebraska Food Code of 2017 states that foods must be heated to a temperature of 165 degrees Fahrenheit prior to serving and can then be held for hot holding at a temperature of 135 degrees Fahrenheit until served for up to two hours. (Nebraska Food Guide 2017) Observation on 04/29/24 at 11:50 AM in the satellite kitchen of the Long Term Care (LTC) area: Food products were transferred from the main kitchen area to the satellite kitchen in the LTC area. Once the food products were loaded onto the steam table, all foods were temped. Temperature of the turkey ham and cheese sandwich alternative had a temperature of 135 degrees Fahrenheit (F). Record Review of the Recipe copyrighted 2024 for the Grilled Turkey Ham and Cheese Sandwich states in paragraph 3. of the instructions that sandwiches are to maintain a temperature of 135 degrees or above. Interview on 04/29/24 at 12:20 PM with the Certified Dietary Manager (DM) in the satellite kitchen of LTC: While taking the temperature of the foods at the end of the meal distribution, DM stated. Let's get the elephant out of the room. The temperature of the sandwiches are difficult to maintain and although we did keep them covered with plastic wrap, staff seem to have a difficult time keeping the sandwiches at the appropriate temperatures. The DM then took the temperature of the sandwiches. The DM stated there needs to be more education around keeping the temperatures of foods at their proper levels for the duration of the food service distribution during meal times. Observation on 04/29/24 at 12:20 PM in the satellite kitchen of the LTC area: Temperature of the turkey, ham, and cheese sandwiches that remained on the steam table were now 131 Degrees F, under the required 135 degrees F at which they were to be maintained. Interview on 05/01/24 at 09:30 AM with DM confirms facility follows the leftover guidelines for food safety. DM has been able to do some teaching with the staff in the kitchen about maintaining temperatures and food storage both yesterday and this morning. B. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Nebraska Food Guide of 2017 states that foods that remain in the original container and refrigerated under the conditions of less than 41 degrees Fahrenheit may be kept for up to a period of 7 days prior to removing and destroying any leftovers. (Nebraska Food Guide, 2017) Observation on 04/29/24 at 8:25 AM Upon initial observation in the walk-in refrigerator in the main kitchen, the following items were found: Sausage cooked and labeled on 4/5 remain in the refrigerator. Mashed potatoes labeled on 4/10 remain in the refrigerator. Apples labeled 4/10 remain in the refrigerator. Interview on 04/30/24 at 9:15 AM with DM; Confirms and agrees that the Cook-A (C-A) must have done the daily walk through as the sausage, potatoes and apples are no longer in the walk-in refrigerator. The walk in areas have not been cleaned or swept but will give staff further directions on keeping these areas clean. Record review of the Facility Food and Nutrition policy and procedure manual dated January 2023 discloses the purpose of the policy and procedure to be: to provide a guideline for handling leftovers. Paragraph 5. states Leftovers are to be refrigerated (40 degrees F or below) for no longer than 3 days. Interview on 05/01/24 at 9:30 AM with DM confirms facility follows the left over guidelines for food safety. DM has been able to do some teaching with the staff in the kitchen about maintaining temperatures and food storage both yesterday and this morning.