

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  28E302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  Srmc Long Term Care, LLC Dba Pole Creek Estates		STREET ADDRESS, CITY, STATE, ZIP CODE  1855 Greenwood Rd Sidney, NE 69162	

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 0605  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.  (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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09(H) Based on record review, observation, and interview, the facility failed to identify and address potential adverse side effects of psychotropic (drug that affects brain activities associated with mental processes and behavior) medications for 1 (Resident 7) of 5 sampled residents. The facility identified a census of 60. Findings are: A record review of the facility's policy Psychotropic Drug Use with a last revised date of 4/21/2025 revealed the effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis upon physician evaluation routinely and as needed, during the pharmacist's monthly medication regimen review, during Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) quarterly, annually, and with any significant change, and in accordance with nursing assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care. Additionally, the resident's response to the medication(s), including progress towards goals and the presence/absence of adverse side effects, shall be documented in the resident's medical record. A record review of the American Association of Psychiatric Pharmacists What You Need to Know About Tardive Dyskinesia (TD) dated November 2023, defined TD as a movement disorder that causes a range of repetitive movements in the face, neck, arms and legs that are beyond the person's control. Symptoms of TD can include difficulty swallowing, grimacing, jerking movements, lip smacking, eye blinking, eyebrow arching, and neck twisting. TD primarily occurs as an adverse side effect of medications such as antipsychotics, anti-nausea, and Parkinson's disease medications. Additional risk factors identified were being of an older age and having diabetes. The risk for TD can be managed by routine screenings at least every three months for these movements and early detection. A record review of Resident 7's Snapshot revealed Resident 7 was admitted to the facility on [DATE]. Resident 7 had diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior) and Diabetes Mellitus (DM) Type 2 (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production.) A record review of Resident 7's medication list (as of 7/17/2025) revealed the following orders:- Buspirone (an anxiolytic - medication for anxiety) 5 milligrams (mg) with directions to take one tablet three times a day for Generalized Anxiety Disorder (GAD). This medication had a start date of 5/6/2025.- Olanzapine (an antipsychotic) 2.5 mg with directions to take once on Mondays and Thursdays for agitation. This medication had a start date of 12/26/2024. A record review of Resident 7's Care Plan revealed, as of 2/11/2025, Resident 7 was at risk for potential drug related complications associated with the use of psychotropic medications. A goal stating Resident 7 would be or remain free of related complications including hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL (Activities of Daily Living) decline, decline in appetite and abnormal involuntary movements through 09/07/25 had been developed. Interventions were as follows:1) Observe for and report to nurse any drug related signs or symptoms,2) Report to PCP any significant drug related signs or symptoms,3) Administer medications as ordered (see current orders),4) Monitor for side effects/effectiveness of medications such as decreased target symptoms, and5) Monitor for changes that may indicate the need for drug dose increase decrease or discontinuation A record review of Resident 7's Extended Care Pharmacist Monthly Medication Review dated 4/14/2025, revealed Resident 7 was noted to have a shuffling gait and facial grimacing. The note stated this may be associated with the reduction in their olanzapine dose from two 5 mg tablets every other day to two 5 mg tablets on Mondays and Thursdays on 12/25/2024. It was noted that olanzapine is associated with parkinsonism which is related to the dose. TD, which includes involuntary grimacing, is duration-related and can evolve into a full syndrome over days or weeks. The pharmacist recommended that even with the low dose [gender] may be experiencing extrapyramidal side effects of olanzapine and recommended the discontinuation. There was no response from the prescribing physician. A record review of Resident 7's Progress Notes from 5/9/2025-7/14/2025 revealed the following:- There was no evidence of body movements noted between 5/9/2025-6/11/2025.- On 6/12/2025, it was noted staff had reported Resident 7 having intermittent body twitches. Resident 7 was assessed by the nurse and</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>(continued on next page)</p>

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensure Reference Number 175 NAC 12-006.09(C)(ii) Based on record reviews and interviews, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS, a federally mandated assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) within 14 days of determining there had been a significant change (major decline in a resident's status that will usually not resolve) in the condition for 1 (Resident 7) of 1 sample resident. The facility identified a census of 60. Findings are: A record review of the facility's policy Resident Assessment last revised 6/17/2025, revealed the MDS Coordinator would be responsible for ensuring a comprehensive resident assessment was completed within 14 days of the facility determining there had been a significant change in the resident's status in accordance with the Resident Assessment Instruction (RAI) guidelines. A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare &amp; Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) with a last revised date of 10/2024, revealed a SCSA would be appropriate when a decline in two or more of the following areas are present:- Resident's decision-making ability has changed;- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-2 to 9(C)), e. g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;- Any decline in an ADL physical functioning area (e.g., self-care or mobility) (at least 1) where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect normal fluctuations in that individual's functioning;- Resident's incontinence pattern changes or there was placement of an indwelling catheter;- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;- Resident begins to use a restraint of any type when it was not used before; and/or- Emergence of a condition/disease in which a resident is judged to be unstable. A record review of Resident 7's Encounter Psych Progress Note dated 5/28/2025 revealed the Social Services Director (SSD) reported Resident 7 had shown a notable decline in (gender) functional abilities. Resident 7 now required increased assistance with mobility, transfers, and movement while they previously had been independent. Resident 7 had also been displaying increased anxiety and fearfulness with an increase in behaviors, such as hitting staff. A record review of Resident 7's quarterly MDS with an Assessment Reference Date (ARD) of 4/7/2025 revealed the following:- Section D revealed a Patient Health Questionnaire (PHQ-2 to 9, A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder) score of 0, which indicated no symptoms of depression.- Section E revealed no hallucinations or delusions, no physical behaviors, verbal/other behaviors 1-3 days, no rejection of care, or wandering.- Section E revealed Resident 7 had exhibited verbal/other behaviors 1-3 days and no behaviors of hallucination, delusions, physical behaviors, rejection of care, or wandering.- Section GG revealed Resident 7 was ambulatory 10-150 feet with supervision. A record review of Resident 7's annual MDS with an ARD of 6/13/2025 revealed the following:- Section D revealed a PHQ-9 score of 7, which indicated Resident 7 had symptoms of mild depression.- Section E revealed Resident 7's behavioral symptoms had worsened compared to the previous MDS.- Section GG revealed walking 10-150 feet had not attempted due to safety/ability concerns. An interview on 7/17/2025 at 8:45 AM with the SSD confirmed Resident 7 had a significant change in May 2025 as Resident 7 had gone from being ambulatory to wheelchair bound and having an increase in behaviors. An interview on 7/17/2025 at 9:48 AM with the Infection Preventionist (IP) revealed the IP and/or Director of Nursing (DON) are responsible for overseeing, certifying, and signing for the accuracy and completion of the MDS. The IP revealed the facility follows the RAI Manual to determine if a resident has had a significant change in their abilities. Additionally, the IP confirmed a SCSA was indicated but was not completed as indicated by the RAI manual.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.09(H)(v)Based on record review, observation, and interview, the facility failed to provide care, treatment, and ensure services were obtained for a hand contracture (a condition where the fingers bend towards the palm and cannot be straightened due to tightened tissues in the hand) for 1 (Resident 40) of 2 sampled residents. The facility identified a census of 60. Findings are: A record review of [NAME] Healthcare's Contracture Management dated 11/1/2014, revealed limited mobility and the need for supportive therapies should be evaluated for on admission and at least quarterly. Treatment considerations were as follows:- Frequent, simple stretching, noting that even a few degrees of movement can help.- Consider positioning devices for long-term use such as splints. Positioning devices can ensure prolonged contracture management and limit further tone development.- Educate all staff and encourage to provide daily range of motion (ROM) stretching outside of therapy services. A record review of Resident 40's Problem List (as of 7/16/2025) revealed Resident 40 had a diagnosis of Severe Alzheimer's dementia with agitation. A record review of Resident 40's Progress Note dated 3/21/2025 revealed staff had reported Resident 40's 3rd and 4th fingers of their left hand were contracted and painful. Assessment revealed stiffness and pain in the hand. A message was sent to the resident's primary care physician (PCP) for a possible Occupation Therapy (OT) order. A washcloth was implemented to be used until the OT evaluation had been completed. A record review of Resident 40's Nurse Triage Notes dated 3/21/2025 revealed a message had been sent to the resident's PCP but the PCP's nurse had responded to send to the secondary physician due to the PCP being out of the office on Fridays. There was no evidence the secondary provider had been contacted or the primary provider had been followed up with. A record review of Resident 40's Care Plan with a last reviewed date of 6/5/2025 revealed no evidence of a focus area regarding the resident's hand contracture. A record review of Resident 40's Plan of Care Addendum Note dated 4/2/2025 noted Resident 40 had a contracture to their left hand and the facility had attempted to place a rolled washcloth in their hand, but the resident had refused due to the pain and would attempt to hit staff if attempted. There was no evidence of alternative interventions attempted. A record review of Resident 40's Plan of Care Addendum Note dated 6/3/2025 was a copy of the note from 4/2/2025 noting Resident 40 had a contracture to their left hand and the facility had attempted to place a rolled washcloth in their hand, but the resident had refused due to the pain and would attempt to hit staff if attempted. There was no evidence of alternative interventions attempted. A record review of Resident 40's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date (ARD) of 3/31/2025 revealed 0 minutes of physical therapy (PT), OT, ROM exercises, or splint/bracing assistance had been completed in the past 7 days of the ARD. A record review of Resident 40's MDS with an ARD of 6/2/2025 revealed 0 minutes of PT, OT, ROM exercises, or splint/bracing assistance had been completed in the past 7 days of the ARD. A record review of Resident 40's chart revealed no evidence an OT evaluation had been completed. Additionally, there was no evidence of other interventions attempted to prevent worsening of the contracture or monitoring of the contracture for potential complications, such as skin breakdown.An observation on 7/16/2025 at 12:00 PM revealed Resident 40's left hand to be tightly closed.An interview on 7/16/2025 at 1:11 PM with Nurse Aide (NA) - A confirmed Resident 40's left hand was tightly closed and will no longer open. In the past, staff have tried to put a rolled-up washcloth in there, but the resident would get mad and take it out. NA-A was not aware of any other interventions having been attempted. An interview on 7/17/2025 at 7:55 AM with the Director of Nursing (DON) confirmed that although an OT referral had been requested in March 2025, the evaluation had never been completed. Additionally, the DON confirmed no further follow-up, or other interventions were attempted to prevent the worsening of the contracture or potential for complications. An interview on 7/17/2025 at 9:50 AM with the Quality Assurance Registered Nurse revealed the facility did not have a policy regarding contracture management or care.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensure Reference Number 175 NAC 12-006.09(H)(vi) and 175 NAC 12-006.14Based on record review, observation, and interview, the facility failed to provide assistance with eating and administration of medications that was consistent with the needs of an individual with a diagnosis of dementia for (a progressive disorder that primarily affects cognition, memory, and behaviors that includes agitation) 1 (Resident 40) of 4 sampled residents. The facility identified a census of 60. Findings are: A record review of the facility's undated policy, Dementia Care revealed the purpose of the policy was to provide appropriate treatment and services to those with dementia to meet their highest practicable well-being. This goal would be met by developing a care plan for the resident that was individualized to their symptoms and implementing interventions that were effective in enhancing the resident's well-being. A record review of Resident 40's Problem List (as of 7/16/2025) revealed Resident 40 had a diagnosis of severe Alzheimer's dementia with agitation. A record review of Resident 40's Care Plan with a last reviewed date of 6/5/2025 revealed the following:- A problem area for Dementia had been added revealing Resident 40 was having more difficulty being able to express their needs. An intervention of offer simple choices and honor preference and offer assistance/guidance as needed was added. - A problem area for Behavioral Symptoms had been added revealing Resident 40 would express their pain by exhibiting behaviors of raising their fist or yelling at staff. Interventions to assess for aggressive behavior, encourage appropriate behavior, redirect, and identify stressors and take steps to avoid had been added.- A problem area for Medication had been added revealing Resident 40 had a history of spitting out their medication. An intervention to gently encourage the resident to take their medication and monitor/report concerns had been added.- A problem area for Nutrition had been added revealing Resident 40 was at risk for malnutrition and an intervention for staff to help feed/encourage meals as the resident allows had been added. A continuous observation on 7/16/2025 from 12:10 PM through 1:15 PM revealed the following:- At 12:10 PM, staff had sat a plate of food in front of the resident. Resident 40 had their head down and appeared to be asleep. - From 12:10 PM to 12:21 PM, the resident continued to have their head down and appeared to be sleeping. No cueing or assistance was provided.- At 12:21 PM, Resident 40 began to holler out. Resident 40 had taken a sip of their fluids at this time, but no attempts to eat were made. Nurse Aide (NA) - B spoke to the resident seated across from Resident 40, but did not address, cue, or assist Resident 40. NA-B then sat down to assist another resident at a nearby table.- At 12:25 PM, Resident 40 had their head back down and appeared to be back asleep. - At 12:30 PM, NA-A had returned from delivering a meal tray and sat down at the same table as NA-B was assisting. - At 12:31 PM, NA-A stated to NA-B, I guess I should go help [Resident 40]. NA-A then pulled a chair next to Resident 40. NA-A then gently awoke, cued, and assisted Resident 40 with a bite of food. Resident 40 accepted bite without difficulty. - At 12:34 PM, Resident 40 had their head back down and appeared to be asleep. NA-A stated to NA-B, well [Resident 40] is falling asleep on me. NA-A then left Resident 40's table without any further cueing or attempts to assist the resident with their meal.- From 12:36 PM to 12:50 PM, Resident 40 had awoken and was taking sips of their juice, but no attempts were made to eat. No cueing or assistance with eating were provided.- At 12:50 PM, the Nursing Home Administrator (NHA) came over and started a conversation with the resident. Resident was alert and pleasantly conversating back with the NHA. No cueing or assistance was provided during the conversation.- From 12:51 PM to 1:00 PM, no cueing or assistance was provided to the resident for their meal. - At 1:00 PM, Medication Aide (MA) - C brought Resident 40's medications over to administer. Resident 40 refused, MA-C continued to attempt to administer the medication by placing the spoon of medications near the resident's mouth. Resident 40 raised their voice and yelled, get out of here at MA-C. MA-C continued to attempt to administer the medications by placing the spoon of medications near the resident's mouth. Resident 40 continued to refuse and escalate in agitation. - At 1:05 PM, Resident 40 yelled at MA-C threatening to kill them if they did not leave them alone. MA-C again attempted to speak to the resident but was cut off by Resident 40 yelling shut up and get out of here already. MA-C then walked away from the resident. - At 1:15 PM, Resident 40 was taken out of the dining room and assisted back to their room. Less than 10% of their food was observed as consumed. A record review of Resident 40's intake from the 7/16/2025, 1200 Lunch meal, revealed it had been documented Resident 40 refused and 0% of their meal was consumed. An interview on 7/16/2025 at 1:11 PM with NA-A confirmed Resident 40 required total assistance with all Activities of Daily Living (ADLs) including eating. An interview on 7/16/2025 at 1:20 PM with MA-C revealed</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)Licensure Reference Number 175 NAC 12-006.18(D) Based on record reviews, observations, and interviews; the facility failed to ensure staff followed proper glove use practices by changing gloves when contaminated or between tasks in accordance with facility policy and Center for Disease Control (CDC) guidelines during meal service to prevent the potential for cross-contamination. This had the potential to affect all 15 residents who reside within the Memory Care Unit (MCU). The facility identified a census of 60. Findings are: A review of the facility policy titled Hand Hygiene last revised 4/21/2025 revealed staff are required to perform hand hygiene after each resident contact, before and after glove use, and that glove use does not replace hand hygiene. A CDC guideline titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/2024 revealed gloves are to be changed between tasks and after contact with potentially contaminated surfaces or residents. A continuous observation on 7/16/2025 from 11:55 AM through 12:20 PM revealed the following:- Nurse Aide (NA) - A had donned gloves and began to pass out coffee mugs to each resident. After distributing mugs to all residents, NA-A had gone back to a resident and retrieved their cups. NA-A poured coffee and juice into this resident's cups with their gloved hands. NA-A then delivered their drinks back to their table, handling the drinking rims of both cups with their gloved hands. NA-A then grabbed another resident's cups from in front of the resident. NA-A dispensed juice into the resident's cup. Then pushed the lid with a drinking spout back onto the cup, touching the drink spout with their gloves, then delivered it back to the resident.- In continuing to dispense fluids to residents, NA-A had touched numerous surfaces with their contaminated gloves, including the juices, coffee handles, cupboard handles, then touched the rims of the residents' glasses to return them to the residents.- NA-A then obtained two cups from another resident, setting these down on the counter. NA-A then opened a cupboard door, closed the cupboard door, poured the resident's fluids, and then delivered the cups back to the resident, touching the rims of the cups, with their same gloved hands.- NA-A then was called over to a resident. The resident handed NA-A a towel that had been in contact with their body. NA-A sat the towel down on the kitchen counter and returned to preparing resident's fluid. NA-A touched the rims of two cups from another resident with their same gloved hands.- Once all residents had their fluids, NA-A then removed their gloves and completed hand hygiene. NA-A then donned a new pair of gloves and began delivering food trays to residents. NA-A was observed putting both of their gloved hands on their thighs, when speaking to a resident. Following, NA-A removed a food cover from a plate and had handled the plate with their thumb and first finger inside the inner rim of the plate with their gloved hands while delivering it to the resident.- NA-B was observed donning gloves. NA-B then began to pass meal trays to residents. NA-B removed the food covers with their gloved hands and then delivered to the residents. NA-B had used their gloved hand that had removed the food cover to handle the plate while delivering. Their hand had been positioned inside the inner rim of the plate and had touched the resident's food with their same gloved hand.- Medication Aide (MA) - C was observed donning gloves. MA-C then removed the plastic wrap that had been covering the tray of deserts with their gloved hands. MA-C then began to hand out the deserts to the residents. MA-C had touched the inside of the desert bowls with their thumb and first finger. MA-C delivered the deserts to five different residents and had touched the inside of each of the desert bowls with their same gloved hands. An interview on 7/16/2025 at 1:11 PM with NA-A confirmed their understanding that gloves are contaminated after contact with residents or surfaces and acknowledged gloves should have been changed during the observed tasks but had not been aware of the contamination in the moment. An interview on 7/16/2025 at 1:25 PM with the Infection Preventionist (IP) confirmed that contact with residents, surfaces and food coverings would contaminate gloves and confirmed gloves should be changed to prevent cross-contamination after contact.</p>		