STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285130	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEATRICE HEALTH AND REHABILITATION	**1800 IRVING STREET BEATRICE, NE 68310**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Licensure Reference Number 175 NAC 12-006.05(6) Based on observations, record review and interviews; the facility failed to ensure that staff were calling residents by preferred names, for 4 residents, (Residents 12, 47, 30 and 38). The facility census was 60. Findings are: A. An observation on 08/19/20 from 12:18 PM-1:00 PM revealed that MA (Medication Aide) J called 3 different residents, (Residents 47, 30 and 38) sweetheart while eating in the North Dining Room. Record review of care plans for Residents 47, 30 and 38 revealed no documented preference to be called sweetheart. An interview on 8/27/20 @ 11:00AM with DON (Director of Nursing) confirmed that calling residents sweetheart could be a dignity issues if a resident hasn't identified that as a preference. An observation on 8/19/20 at 3:09 PM revealed NA (Nursing Assistant) - A answered call light and asked Resident 12 What can I do for you honey? Resident 12 responded oh I don't remember pushing it NA-A replied ok honey can I get you any apricots? Resident said no NA-A replied ok honey and left the room. An interview on 08/27/20 at 11:16 AM with DON (Director of Nursing) confirmed calling residents by name honey is not acceptable and is a dignity issue. Record review of Resident 12's Care Plan dated 6/9/20 revealed no documentation of Resident 12 to be addressed by name honey.
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** Licensure Reference Number 175 NAC 12-006.05(4) Based on observations, record review and interviews; the facility failed to honor Resident 52's preference for bedtime and failed to offer to complete personal hygiene tasks related to shaving of legs for Resident 12. This affected 2 of 15 sampled residents. The facility census was 60. Findings are: A. An interview on 8/19/20 at 9:15 AM with Resident 52 stated that doesn't have any choices when I have to go to bed. Resident 52 stated the other night was put to bed at 7:45 PM. Resident 52 also stated that can't sleep through the night when goes to bed that early and preference is to go to bed after 11:00 PM, after Sports Center. Record review of annual MDS dated [DATE] states resident preference for choosing own bedtime, somewhat important. Record review of Care Plan dated 07/29/2018 under ADL's (Activities of Daily Living) states: I prefer to go to bed late in the night and get up around early in the morning. I don't like to spend much time in my bed. Review of ADL documentation look back report of bed mobility, described as how person move to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture, reveals the following times documented for the days of 8/12/20-18:33, 8/15/20-19:05, 8/19/20-19:39, 8/23/20-18:20 and 8/25/20-19:11. An interview on 8/27/20 @ 11:05am with DON revealed couldn't tell for sure if the ADL documentation means Resident 52 was put to bed at those times but it is not our policy to put people to bed that early. An interview on 08/19/20 at 2:46 PM with Resident 12 revealed (gender) would like to have (gender) legs shaved. Resident 12 states (gender) has asked the bath aid many times but; they are too busy to shave (gender) legs. An observation on 8/19/20 at 2:46 PM revealed Resident 12 has multiple 2-3 inch hairs on both legs. Record review of Resident 12's bathing task charting dated 7/23/20 - 8/20/20 revealed Resident 12 has received 2 baths each week on Monday's and Thursday's; Shaving of legs was not mentioned. Record review of Resident 12's MDS (The Minimum Data Set) (is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems) dated 6/8/20 revealed Resident 12 is totally dependent during bathing and requires 1 person assistance. An interview on 8/27/20 at 11:14 AM with DON (Director of Nursing) confirmed Resident 12 has the choice to have (gender) legs shaved if desired and staff need to accommodate this choice.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Licensure Reference Number 175 NAC 12- 006.16 G (2) Based on record reviews, interviews and observations the facility failed to ensure residents could file an anonymous grievance and written grievance forms were available to all residents without asking for them. This had the potential to affect all residents in the facility. The facility census was 60. Findings are: An interview on 8/24/20 at 10:40 AM with Residents 52, 56, and 42 revealed they do not know where grievance forms are at and no box is available to place grievance or complaints. . An observation on 8/25/20 at 8:06 AM revealed no grievance forms were available for residents to pick up. An interview on 8/25/20 at 8:06 AM with LPN (Licensed Practical Nurse) C revealed grievance forms are at each nurse's station. LPN-C was not able to find form at this time. Record review of policy Titled Resident Rights dated 11/28/17 revealed under prevention all personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. Providing residents and representatives, information on how and to whom they many report concerns, incidents and grievances without the fear of retribution and providing feedback regarding the concerns that have been expressed. An interview on 8/25/20 at 8:15 AM with Administrator confirmed no grievance forms were available for residents; unless they asked staff for them. Also a secured location to placed completed grievance forms is not available.
F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05 (8) Based on observations, Record reviews and interviews the facility failed to ensure a blue wedge was not used as a restraint device for Resident 12. This affected 1 resident of 15 residents sampled. The facility census was 60. Findings are: An interview on 08/19/20 at 2:50 PM with Resident 12 revealed (gender) is unsure why there is blue matt on floor and has a blue wedge to the outside of bed and other side of bed is up against wall and window. 1. An Observation on 8/19/29 at 2:50 PM a blue matt was on the floor, and a wedge was placed on Resident

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285130	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEATRICE HEALTH AND REHABILITATION	1800 IRVING STREET BEATRICE, NE 68310

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 12's left side. Resident 12 only able to move (gender) upper body not below waist due to [DIAGNOSES REDACTED]. Record review of Resident 12's Care Plan dated 6/9/20 revealed the following Safety Date Initiated: 03/08/2018 Will not sustain serious injury Through the review date. Date Initiated: 03/08/2018 1-2 assist for transfers depending on MS symptoms - often attempts to self-transfer When MS symptoms are mild. Park W/C adjacent to bed for resident's safety. Date Initiated: 03/10/2018 3/27/18 nonskid strips applied to floor in front of bed and sign placed by bed to Remind her to call for assist. Date Initiated: 03/27/2018 4/3/18 when resident is in bed, blue matt is put next to bed on floor with W/C on top of Mat next to bed. Date Initiated: 04/03/2018 5/16/20 Concave mattress to define the edges of the bed. Date Initiated: 05/16/2020 Resident has a history of climbing down to bedside cushioned mat due to being unable to transfer self. Record review of Resident 12's MDS (The Minimum Data Set) (is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems) dated 6/5/20 revealed under Section G- Functional Assistance ADLS(Activities of Daily Living) revealed Resident 12 requires extensive assistance with bed mobility, transfers, toileting, dressing, with the help of 2 people. Resident 12 does not walk, resident 12 uses a wheelchair for locomotion in room and off unit and 1 person assistance of 1. An interview on 8/25/20 at 9:13 AM with CMA (Certified Medication Aide) D - revealed Resident 12 is always a 2 assist with gait belt. Blue wedge and mat are used to prevent resident from rolling out of bed. CMA-D stated Resident 12 can only move upper body due to MS diagnosis. Record review of Resident 12's Progress Notes dated 02/19/20-8/27/20 revealed no documentation about when or why blue wedge was applied. Record review of Resident 12's safety Device Evaluation Dated 6/5/20 revealed under section 2 indicate below, All measure you have tried before implementing recommended device. This section is blank. Wedge Cushion was a possible option. Section 3 Device recommended- Handrails on bed. Section 4. a is device considered a restraint for this resident- no. 4 b. Explain why or why not: Helps resident with bed mobility and repositioning. Benefits for device- increase sense of safety/ security per resident request, potentially prevents resident from rolling out of bed, enhances bed mobility. An interview on 8/27/20 at 11:09 AM with DON (Director of nursing) confirmed resident has a blue wedge cushion to bed and is unsure why resident has the wedge in place. An interview on 8/27/20 at 11:22 AM with DON confirmed no documentation of why wedge was used was available. DON stated wedge was used for repositioning of Resident 12 to reposition resident off of pressure area.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Licensure Reference Number 175 NAC 12-006.4A3d Based on record review and interview, the facility failed to report a significant injury for 1 resident, (Resident 500) and an elopement for 1 resident (Resident 54) as required by regulations. This affected 2 residents of 15 residents sampled. The facility census was 60. Findings are: Record review of Resident 500's Progress Notes dated 2/29/20 revealed Resident 500 had a 10 cm x 5 cm area of open skin to right calf. Area was bleeding. Resident 500 was unaware of injury. An ambulance was called and Resident 500 was sent to ER for treatment. Record review of Resident 500's Progress Note dated 3/1/20 revealed Resident 500 returned to facility via ambulance. Right calf was wrapped with gauze. Orders are to leave wrap inplace unless it starts to bleed. Deep sutures(stitches) were placed. Sutures will dissolve on there own. Keep leg covered. Record review of date of incident for Resident 500 revealed no report was completed and sent to state agency. An interview on 8/31/20 at 11:50 PM with DON (Director of Nursing) revealed a state report had not been submitted by facility for the incident on 3/29/20 for Resident 500. A record review of the elopement report for Resident 54 revealed elopement occurred on Saturday 2/1/20 and was called in to APS that day. The record review revealed the facilility did not send in the written investigation until 2/7/20. 08/26/20 09:30 AM, an interview with the facility Director of Nursing and the Assistant Director of Nursing confirmed that the written investigation for Resident 54's elopement occurred on 2/1/20 did not get sent to APS until 2/7/20 which is outside of the 5 day requirement.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05 Based on interviews and record reviews, the facility failed to notify the resident or responsible party in writing of reason for transfer to the hospital for 2 residents (Residents 42 and 212) of 15 residents sampled. The facility census was 60. The findings are: The record review revealed Resident 212 was sent to the hospital on [DATE] due to nausea and vomiting. 08//24/20 08:25 AM an interview with the DON confirmed notice of transfer was done via phone call to Resident 212's spouse and was not completed in writing. An interview on 8/19/20 at 11:00AM with Resident 42 revealed resident recently yesterday or the day before had [MEDICAL CONDITION] and went to the hospital. Resident 42 stated I didn't want to go but, the staff said I looked pale and not well So I went. Resident 42 revealed [MEDICAL CONDITION] occur frequently. Record review of progress notes dated 8/18/17/2020 at 7:31 PM revealed the following Resident 42 was observed in low stimuli dining room on the floor @ approx . 4:00PM and observed res. in some [MEDICAL CONDITION] activity. Observed chair that res. was sitting in a distance away from table where res. was sitting. When res. was able to come out of [MEDICAL CONDITION] activity, res. was exhibiting increased lethargy and was disoriented. Res. was only able to say her husband's name. Observed res. cool, pale and diaphoretic. Res. stated had pain in back, neck and had a headache. Res. was not able to sit up even with assistance. Placed a pillow under res. head for comfort due to not being able to sit up with assistance. Res. then was observed in another [MEDICAL CONDITION] activity, this nurse then called 911 due to res. condition. VS assessed 168/82-83-16-97.2-97%. After calling 911 res. had another [MEDICAL CONDITION]. Res. remained increasingly lethargic when Beatrice Ambulance arrived. Res. left facility with squad at approx 4:19 PM. Update Hospital. Attempted to notify husband at 4:25 PM, 5:17 PM and was able to update husband at 6:00PM. Physician 4:30 PM. Received a phone call from Hospital at 7:35 PM stating that resident was ready to come back. An interview on 8/25/20 at 4:00PM with DON(Director of Nursing) confirmed written documentation for notification of Resident 42 hospitalization was not completed. The facility notifies resident's family via phone.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09B1(2) Based on record reviews and interviews, the facility failed to complete a significant change MDS (Minimum Data Set, a standardized assessment tool that measures health status in nursing home residents) when a decline in level of care occurred for 1 resident (Resident 29) of 15 sampled residents. The facility census was 60. The findings are: A record review of the Annual MDS dated [DATE] revealed Resident 29 was a 1 person assist with transfers and ambulation. The record review revealed that the quarterly MDS dated [DATE] indicated Resident 29 was a 2 person assist with be transfers and ambulation. A record review of the current Comprehensive Care Plan (CCP, a document that defines the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being) for Resident 29 started on 8/10/20 indicated that Resident 29 was independent with transfers and ambulation. 08/20/20 01:01 PM an interview with NA-E, revealed Resident 29 is no longer able to transfer independently. 08/20/20 02:45 PM an interview with the Director of Nursing confirmed that a significant change of condition MDS was not completed when Resident 29 had a decline in transfer and ambulation ability.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to complete a level II PASRR (an assessment used to help ensure that individuals are not inappropriately placed in nursing homes for long term care) after identification of a new mental health diagnosis. This affected 1 residents (Residents 55) of 15 sampled. The facility census was 60. Findings are:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285130	A. BUILDING _____ B. WING _____	**08/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEATRICE HEALTH AND REHABILITATION	**1800 IRVING STREET BEATRICE, NE 68310**

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 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Record review of Resident 55's MDS (The Minimum Data Set) (is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems) dated 8/5/20 revealed under section I - Active [DIAGNOSES REDACTED]. Under section Neurological Resident 55 has the following [DIAGNOSES REDACTED]. Record review of Resident 55's MDS dated [DATE] revealed under section I - Active [DIAGNOSES REDACTED]. Under section Neurological Resident 55 has the following [DIAGNOSES REDACTED]. Record review of Resident 55's PASRR (Preadmission Screening and Resident Review) (is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. . Offered all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings) dated 3/19/13 revealed a PASRR level 1 form was completed Resident 55 box 1 asks the following question Does the individual have any of the following serious mental illness (SMI) ? NO was check marked. Box 2 does the individual have any of the following mental disorders? NO was checked. Question 19. Does the individual have a [DIAGNOSES REDACTED].? NO. An interview on 8/24/20 at 3:22PM with DON (Director of Nursing) confirmed a level 2 PASRR was not done on Resident 55 after new mental health conditions were diagnosed .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C Based on record reviews and interviews, the facility failed to revise the Comprehensive Care Plan (CCP, a document that defines the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being) related to fall interventions and transfer ability for Resident 29, fluid restrictions for Resident 212 and Self-administration of oxygen administration for Resident 212, the use of blue wedge for positioning and Range of motion for Resident 12. Resident sample size was 15. The facility census was 60. The findings are: A) A record review of the Comprehensive Care Plan for Resident 29 revealed interventions in place that are no longer appropriate, such as educated resident to not carry purse on walker tray which was no longer used by Resident 29. The record review revealed that Resident 29 is no longer independent in room and is now a 2 assist with transfers which was not indicated on the care plan. 08/25/20 10:50 AM during an interview with the Director of Nursing, after review of the fall interventions for Resident 29, it was confirmed that some interventions no longer met Resident 29's needs for the current level of care. B) 08/19/20 03:43 PM an observation revealed Resident 212's oxygen concentrator was not turned on. 08/24/20 10:40 AM an interview with the Director of Nursing revealed that Resident 212 transfers oxygen over independently and does not allow staff to do so. A record review of the current Comprehensive Care Plan revealed no indication that Resident 212 transfers oxygen from portable machine to concentrator independently. An interview on 08/19/20 at 02:50 PM with Resident 12 states (gender) is unsure why there's a blue wedge cushion to the right side of bed on mattress. An Observation on 8/19/29 at 2:50PM a blue matt was on the floor, and a wedge was placed on Resident 12's right side. Record review of Resident 12's Care Plan dated 6/9/20 revealed the following no indication for blue wedge cushion to Resident 12's bed. Record review of Resident 12's Progress Notes dated 02/19/20-8/27/20 revealed no documentation about when or why blue wedge cushion was applied. An interview on 8/27/20 at 11:09AM with DON (Director of nursing) confirmed resident has a blue wedge cushion to bed and is unsure why resident has the wedge in place. An interview on 8/27/20 at 11:22AM with DON confirmed no documentation of why wedge was used was available. DON also confirmed wedge cushion would be removed and care plan not updated to reflect need or removal of wedge cushion.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09 Based on observation, record review and interview, the facility failed to follow the physician orders [REDACTED]. The facility failed to notify the physician related to Systolic Blood Pressure greater than 160 for Resident 59. This affected 2 residents of 15 sampled. The facility census was 60 The findings are: A record review for Resident 212 revealed an order dated 7/30/20 to notify the physician of blood sugars below 70 or above 350. A record review of the Treatment Administration Records for Resident 212 revealed blood sugars outside of ordered parameters six times in July 2020 and one time in August 2020. 08/24/20 01:05 PM an interview with the Director of Nursing (DON) confirmed physician notification did not exist for blood sugars below the parameter on 7/7/20, 7/9/20, 7/13/20, 7/14/20 and 8/15/20. 08/24/20 02:42 PM an interview with the DON confirmed Resident 212 transfers oxygen from concentrator to portable and back. The interview with the DON confirmed Resident 212 did not have an evaluation nor order to self-administer oxygen. 08/26/20 09:30 AM an interview with the facility DON confirmed no progress notes had been written related to Resident 59's elevated blood pressure from 8/25/20. The DON confirmed that no follow up assessment was documented regarding Resident 59's elevated blood pressure.
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.** Licensure Reference Number 175 NAC 12-006.09D7 Based on interviews, record reviews and observations; the facility failed to ensure interventions were implemented to prevent falls for 1 resident, Resident 20 and failed to ensure that 1 resident, Resident 26 was not smoking on facility property. The facility census was 60. Findings are: A. An observation on 08/24/20 at 01:40 PM revealed that Resident 26 was outside in wheelchair on facility property, East sidewalk leading to East Emergency Exit, smoking. An observation and interview on 08/24/20 at 01:50 PM with DON (Director of Nursing) and ADM (Administrator) revealed that Resident 26 was outside smoking on facility property and confirmed that smoking policy says they will not smoke on the facility property. Review of facility Smoking policy revised 09/2007 reveals that facility is a non smoking facility. Residents who wish to smoke are not permitted to smoke on facility property. An observation on 8/19/20 at 12:00PM revealed Resident 20 sitting in dining room for lunch; Resident 20 had large purple/black area to right side of face and down neck. Also a large hematomata about right eye that protruded out a few inches was visible. An interview on 8/20/20 at 9:00AM with Resident 20 revealed Resident 20 was very sleep and hard to arouse; Resident 20 stated that she could not keep her eyes open and that she was very tired. Record review of Resident 20's Progress Notes dated 8/11/2020 at 09:00AM revealed staff was called to resident's room et resident was observed lying on stomach in front of toilet with head against BR door, arms up to head and legs straight behind her. Resident has self-transferred to toilet. ROM performed was within normal limits. Resident 20 complained of (gender) head being sore it was observed that (Resident 20) had a hematoma on right forehead above eyebrow. Ice was applied. Resident 20 was helped up to wheelchair with 3 peoples assistance and then to front waiting area to chair. Neuro checks initiated per facility protocol. Physician was notified and Resident 20's daughter was notified. Resident was wearing appropriate clothing and had shoes on. The floor was dry. Non-slip strips applied to floor in front of toilet. Record review of Resident 20's Progress notes Resident 20 has had multiple falls on these days: 6/24/20 at 6:17 PM 7/10/20 at 11:45 PM 7/14/20 at 1:00 PM 7/20/20 at 6:23 AM 7/24/20 at 8:04 AM 8/11/20 at 9:00 AM Record review of Resident 20's Progress notes and incident reports revealed that 4 out of 6 falls resident was attempting to get to bathroom. Record Review of Resident 20's Care plan dated 6/16/20 revealed a new intervention: Toileting Plan: Offer toileting at 0100, 0500, 0800, 1100, 1300, 1600, 1900, and 2000 and PRN Date Initiated: 07/17/2020. Record of Resident 20's Task charting Titled Toileting Plan Offer toileting at 0100, 0500, 0800, 1100, 1300, 1600,1900, and 2000 and PRN. Revealed staff was charting 3 times per day that toileting was being offered but not that at the specific times assigned was a staff member asking resident if needed to use the restroom. An interview on 8/27/20 at 11:06 AM with DON (Director of Nursing) confirmed staff are not documenting offering toileting at 0100,0500,0800,1100,1300,1600,1900 and 2000 and PRN as per care plan interventions listed.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285130	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEATRICE HEALTH AND REHABILITATION	1800 IRVING STREET BEATRICE, NE 68310

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **in locked compartments, separately locked, compartments for controlled drugs.** Licensure Reference Number 175 NAC 12.006.12E1 Based on observations, interviews and record reviews; the facility failed to ensure refrigerator temperatures were maintained for proper storage of medications. The facility census was 60. Findings are: A) 08/25/20 09:00 AM an observation of the medication storage refrigerator revealed a temperature of 56 degrees F. The observation revealed the refrigerator to hold insulin pens, TB serum and suppositories. 08/25/20 10:55 AM an observation of the medication storage refrigerator revealed a temperature of 50 degrees F. 08/26/20 12:34 PM an observation revealed a new refrigerator was placed in the medication storage room. The temperature noted was 54 degrees F. 08/26/20 02:00 PM an interview with RN-F, revealed the thermometer in the new refrigerator to be broken as evidenced by a visible gap in the mercury. An interview with the facility Administrator revealed the contents had been moved to another refrigerator and 2 new thermometers were being obtained by the maintenance staff.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Licensure Reference Number 175 NAC 12- 006.17 Based on observations, interviews and record reviews the facility failed to ensure catheter care was completed and a catheter bag was not stored on the floor to prevent cross contamination for Resident 12, Staff failed to complete hand hygiene after touching outside of face mask, and Staff failed to wear surgical mask in Laundry area. This had the potential to affect all resident in the facility. The facility census was 60. Findings are: A and B An observation on 8/24/20 at 9:30 AM revealed NA(Nursing Assistant) E and CMA(Certified Medication Aide) - I Knocked on Resident 12's door asked permission to enter room, Resident responded and said ok NA-E proceeded to raise Resident 12's Bed and removed blue floor mat and blue wedge. CMA-I washed hands with soap and water for 20 seconds, NA-E then washed hands for 20 seconds. Both applied gloves. CMA-I then Told resident going to pull down pants to see catheter and preform catheter care and perineal care. When pants were pulled down resident brief came off as well; CMA -I then stated I guess we will replace this a well Brief was removed by pulling from the front of pants between legs. CMA-I spread resident legs apart and used a disposable wiped to clean near the catheter tube downward one time, new wipe, wiped down each side of the groin. Another new wipe was used to wiped the catheter tubed and was wiped toward the tubes insertion point. Resident 12 stated it hurt and asked staff to stop. CMA-I then used one more wiped to the catheter tube going away from the insertion point. Resident 12 mentioned again that wiping the area genital/ catheter area hurt. CMA-I stated all done; new brief was applied by having resident turn side to side and pulled pants up. Resident was covered with a blanket during catheter care. CMA-I and NA-E preformed hand hygiene with soap and water for 20 seconds and dried with paper towels. After CMA- I and NA-E were finished repositioning resident and call light - I noticed the catheter bag was on the floor. An interview on 8/24/20 at 9:35 AM with CMA - I confirmed some of the steps completed during catheter care were done out of order. When reviving catheter care cleaning inner meatus and catheter insertion point the going to groin; CMA- I confirmed (gender) did wiped down the middle, both sides of groin and then back to catheter tube and meatus area. An interview on 8/24/20 at 9:40 AM with NA-E confirmed the catheter bag was on the floor and needs to be hung on the bed. Record review of Catheter Care, Indwelling policy and procedure dated 12/2019 revealed that during procedure step 8) Using disposable wipes, clean Cather insertion in a downward motion, (front to back) Use each disposable wipes for one cleansing motion. An interview on 8/26/20 at 10:48 AM with DON (Director of Nursing) Confirmed when completing catheter care the wipes should be going from front to back and dirty to clean; also that catheter bag should not be placed on the floor. This incidents have the potential for cross contamination. C. An observation on 08/25/20 at 10:15 AM in the laundry area revealed 2 staff members LS (Laundry Staff) G and H were not wearing masks. An interview on 8/25/20 at 10:15 AM with LS- G and LS- H revealed they do not wear masks when in laundry room area as they are not close together and no residents are in laundry area. Record review of Personal Protective Equipment-Universal Masking not dated revealed all staff will apply a standard ear-loop face mask upon entering the building and for the entire time they are in the building. An interview on 8/25/20 at 10:32 AM with DON (Director of Nursing) confirmed staff need to wear surgical masks at all times when in the facility; unless staff is eating or drinking in designated area. D. An observation on 8/20/20 at 2:50 PM revealed NA L talking to Resident 52 in the hallway. NA L was wearing a surgical mask and took hand and placed on outside of surgical mask and pulled mask down and spoke to Resident 52. NA L then put hand to outside of mask and pulled the mask back up onto face. NA L did not perform hand hygiene before or after touching hand to face mask. An interview on 8/25/20 at 10:28 AM with DON confirmed hand hygiene should have been performed after touching hand to mask.
F 0943 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Licensure Reference Number 175 NAC 12-006.04B1 Based on record review and interview, the facility failed to ensure initial orientation was completed for 5 Nurse Aides of 5 Nurse Aides reviewed. The facility census was 60. Findings are: Record review revealed no documentation of initial orientation for NA's (Nurse Aides) A, L, M, N and O who were hired within the last 4 months. Record review of facility Residents Rights Policy revised 11/28/2017 revealed facility will engage in training and orienting its new and existing nursing staff on topics which relate to the delivery of care in the post-acute setting. Topics of such training will include, but not be limited to:a. Prohibiting and preventing all forms of abuse, neglect, exploitation, and misappropriation of resident property;b. Identifying what constitues abuse, neglect, exploitation, and misappropriation of resident properly; c. Recognizing signs of abuse, neglect, exploitation, and misappropriation of resident properly, such as physical, or psychosocial indicators; d. Reporting abuse, neglect, exploitation, and misappropriation of resident properly, including injuries of unknown sources, and to whom and when staff and others must reort their knowledge related to any alleged violation without fear of reprisal; e. Reporting reasonable suspicion of a crime against a reisdent in accordance with Section 1150B of the Social Security Act; f. Procedures for reporting incidents, generally;g. Dementia management/Care of Cognitively Impairedh. Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect and how to respond. These symptoms, include, but are not limited to, the following: i. Aggressive and/or catastrophic reactions of residents; ii. Wandering or elopement-type behaviors; iii. Resistance to care; iv. Outbursts or yelling out; and v. Difficulty in adjusting to new routines or staff. An interview on 8/26/20 at 12:10 PM with Administrator confirmed there are no orientation checklists for NA's A, L, M, N and O.