STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285139	A. BUILDING _____ B. WING _____	**04/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER ESTATES OF PIERCE, LLC	**P O BOX 189, 515 EAST MAIN STREET PIERCE, NE 68767**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D1c Based on interview and record review, the facility failed to provide bathing assistance for 1 (Resident 1) of 3 sampled residents who were dependent with bathing. The facility census was 43. Findings are: Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 1/29/20 revealed [DIAGNOSES REDACTED]. The MDS further indicated the resident required extensive assistance with bed mobility, transfers, toileting and bathing. Review of Resident 1's current Care Plan with revision date 2/3/20 revealed the resident had an activities of daily living, self-care deficit with an activity intolerance. The resident had an order for [REDACTED]. Documentation indicated showers were provided March 3, 4, 6, 10, 12, 16, 18, 24, 26, and 30 and April 1, 6, 8, 10, 12, 14 and 16, 2020 (a total of 17 out of 24 showers that were to have been provided). During an interview with Resident 1 on 4/20/20 at 9:00 AM, the resident indicated a shower was not provided for the resident every other day as ordered by the resident's physician. The resident further indicated no showers were received over the weekends as not enough staff were available. Interview with the Director of Nursing (DON) on 4/20/20 at 10:00 AM confirmed Resident 1 did not receive a shower every other day throughout the months of March 2020 and April 2020 as ordered by the resident's physician.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D2b Based on record review and interview; the facility failed to provide the necessary care and monitoring of a pressure ulcer for 1 (Resident 1) of 2 sampled residents to promote healing. The facility census was 43. Findings are: Review of Resident 1's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 1/29/20 revealed [DIAGNOSES REDACTED]. The MDS further indicated the resident required extensive assistance with bed mobility, transfers and toileting; and the resident had one Stage 2 (partial thickness skin loss that presents as an abrasion, blister or shallow crater) pressure ulcer; 1 venous ulcer (ulcer due to inadequate blood supply to an affected area); and 1 [MEDICAL CONDITION]. Review of the current Care Plan with revision date 2/3/20 revealed Resident 1 was at risk for the development of pressure ulcers related to immobility, obesity and incontinence. In addition, the resident was identified as non-compliant with lying down throughout the day and repositioning off the resident's buttocks. Nursing interventions included the following: -roho cushion (pressure reducing device) to seat of wheelchair; -air mattress to bed; -wound clinic as needed; -monitor and treat area to right buttock as ordered; and -[MEDICATION NAME] topical (medication used to kill bacteria, fungi or viruses to prevent potential infections) shower every other day. Review of a Pressure Injury Weekly assessment dated [DATE] at 1:32 PM revealed an Unstageable (full thickness tissue loss in which the base of the ulcer is covered by dead tissue which may be brown, black or tan in color) pressure ulcer to the resident's right buttock which was facility acquired. The area measured 1.2 centimeters (cm) by 1.2 cm with a depth of 1.5 cm. The ulcer had a moderate amount of serous drainage (thin, watery, clear drainage). Review of documentation from the Wound Clinic dated 3/2/20 revealed an order for [REDACTED]. Review of a Pressure Injury Weekly assessment dated [DATE] at 3:17 PM revealed the ulcer to the resident's right buttock was defined as Stage 3 (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss) which measured 2 cm by 2.3 cm with a depth of 0.2 cm. The wound now had a large amount of serosanguinous (thin watery drainage which often has pink to red color) drainage and had a foul odor. Review of a Pressure Injury Weekly assessment dated [DATE] at 5:38 PM revealed the pressure ulcer to the resident's right buttock now measured 0.7 cm by 1.2 cm with a depth of 1.2 cm and was classified as Unstageable. The wound had a moderate amount of drainage and no odor was noted. Review of a Physician Visit Record from the Wound Clinic dated 3/18/20 revealed a new order for [MEDICATION NAME] (antibiotic used to treat bacterial infections) 100 milligrams (mg) twice a day for 10 days. Review of a Pressure Injury Weekly assessment dated [DATE] at 4:07 PM revealed the resident's right buttock pressure ulcer measured 1 cm by 1.9 cm with a depth of 0.5 cm. A large amount of serous drainage was identified with no odor. Review of a Physician Visit Record from the Wound Clinic dated 3/25/20 revealed an order for [REDACTED]. The pressure ulcer was now classified as a Stage 2 and was described as having no odor and no drainage. Review of a Pressure Injury Weekly assessment dated [DATE] at 3:05 PM revealed the resident's right buttock pressure ulcer measured 0.5 cm by 1 cm with a depth of 0.2 cm and continued to be classified as a Stage 2. The ulcer now had a large amount of drainage which had an odor at times. Review of a Pressure Injury Weekly assessment dated [DATE] at 5:44 PM revealed the ulcer to the resident's right buttock measured 0.4 cm by 1 cm with a depth of 0.1 cm and was classified as a Stage 3. The wound now had a large amount of drainage which was identified as having a foul odor. Review of a Physician Visit Record from the Wound Clinic dated 4/15/20 revealed the resident had indicated the right buttock pressure ulcer was more painful. The wound had increased in size and had an increase in drainage. The pressure ulcer was debrided by the clinic and now measured 1 cm by 1.2 cm with a depth of 8.5 cm after the debridement. New orders were received for a bone scan, a [DEVICE] (device that creates negative low atmospheric pressure at a constant rate. It is used on open wounds to remove fluid secretion and enhance granulation tissue and wound healing) and a referral to a plastic surgeon. Review of a Pressure Injury Weekly assessment dated [DATE] at 4:50 PM revealed the resident's right buttock pressure ulcer measured 1 cm by 1.2 cm with a depth of 8.5 cm. The ulcer had a large amount of drainage that had a strong foul odor. The skin surrounding the ulcer was red and appeared macerated (softening and breaking down of skin resulting from prolonged exposure to moisture). Review of a Point of Care Audit Report which identified the dates Resident 1 received the [MEDICATION NAME] shower to promote healing of the resident's right buttock pressure ulcer from 3/1/20 through 4/16/20 revealed the resident received a shower on 3/3/20, 3/4/20, 3/6/20, 3/10/20 (4 days later), 3/12/20, 3/16/20 3/18/20, 3/24/20 (4 days later), 3/26/20, 3/30/20 (4 days later), 4/1/20, 4/6/20 (5 days later), 4/8/20, 4/10/20, 4/12/20, 4/14/20 and on 4/16/20. During an interview on 4/20/20 at 9:00 AM, Resident 1 indicated the resident was not receiving a shower every other day as ordered by the resident's physician. During interview on 4/20/20 at 10:00 AM, the Director of Nursing confirmed the following regarding Resident 1: -Unstageable pressure ulcer to the resident's right buttock which was facility acquired; -staff should have continued to identify the ulcer as Unstageable with weekly documentation; -the resident was not receiving a [MEDICATION NAME] shower every other day as ordered to promote healing of pressure ulcer; -was seen weekly by the Wound Clinic for treatment of [REDACTED]. buttock pressure ulcer completed on 4/6/20 at 3:05 PM revealed the resident's ulcer had an increase in drainage with a foul odor noted at times; -weekly documentation of the right buttock pressure ulcer dated 4/13/20 at 5:44 PM revealed the ulcer continued to have a large amount of drainage with a foul odor; and -the resident's physician was not notified of the deterioration of the resident's right buttock pressure ulcer until 4/15/20 when the ulcer had increased in

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.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) size, had a large amount of strong, foul odor and the skin surrounding the ulcer was red and had a macerated appearance.
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 record review and interview, the facility failed to assure a safe environment for 1 (Resident 1) of 3 sampled residents. Staff failed to follow the process and procedure for reporting a malfunction of the lift from the facility transportation van, which led to Resident 1's fall with injury. The facility census was 43. Review of a facility Incident/Accident Report dated 3/9/20 at 4:40 PM revealed the facility had received a phone call from Transportation Aide (TA)-F who indicated while assisting Resident 1 out of the van, the lift had malfunctioned. The resident's wheelchair had been positioned on the lift platform and the brakes to the chair were locked. While attempting to lower the resident and the wheelchair out of the van, the lift gave out falling to the ground. The resident was taken to the emergency room for evaluation and sustained abrasions to the top of right foot on the first and second toes, to the top of the left foot on the first and second toes and bruising to the right shoulder blade area. In addition, the resident complained of increased stiffness and pain related to the incident. Interview with TA-F on 4/20/20 at 2:00 PM, confirmed Resident 1 had a fall when the van lift malfunctioned on 3/9/20. When the resident's wheelchair was positioned on the lift platform, the platform initially did not lower and then it gave out and the platform fell straight down to the ground instead of lowering slowly. When the lift platform hit the ground, the resident's wheelchair tipped over. The resident then rolled out of the wheelchair, striking the resident's head on the ground. TA-G indicated this was not the first time the lift platform had failed. In the past, when the Deploy Platform push-button switch was pressed, the lift platform did not respond. TA-G stated the staff had to then manually lower the lift platform. TA-G identified reporting this failure to the facility Administrator and the Maintenance Supervisor. TA-G verified this was done verbally and that no written documentation or work order was completed. During an interview on 4/20/20 at 2:15 PM, the Housekeeping (HK) Supervisor verified driving residents to physician appointments when needed. The HK Supervisor also indicated concerns in the past with the van lift. The lift platform of the transportation van did not always deploy when activated and staff would have to lower the lift platform manually. The HK Supervisor also reported notification of this failure to the Maintenance Supervisor and the Administrator. However, no written documentation or work order was completed by the HK Supervisor. Interview with the Maintenance Supervisor on 4/20/20 at 2:30 PM revealed the following: -staff were to complete a written work order regarding any equipment maintenance or failure; -unaware prior to Resident 1's fall on 3/9/20 at 4:40 PM that the platform lift of the transportation van was not functioning properly; and -a routine safety inspection was completed on the transportation van on 2/19/20 with no issues identified. Review of the work order logs from 11/1/19 through 4/20/20 revealed no notification of any concerns regarding the transportation van or with the lift platform used to lower residents out of the back of the van. Interview with the facility Administrator on 4/20/20 at 2:45 PM confirmed facility staff were expected to document on a work order form and then give the notification to the Administrator or the Maintenance Supervisor if a piece of resident care equipment was not working properly so that it could be repaired.