STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285149	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE CREST HEALTH CENTER	2824 NORTH 66TH AVENUE OMAHA, NE 68104

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 0576 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on interviews, the facility failed to ensure residents were able to receive mail on Saturdays. This has the potential to affect all residents. The census was 132. Findings are: On 09/08/20 at 11:28 AM, Resident 51, the acting Resident Council President, was interviewed. Resident 51 stated mail was not delivered to the residents on Saturdays. Mail was only delivered Monday through Friday, even though it was available for delivery on Saturdays. On 09/09/20 at 8:24 AM, Medical Records-I was interviewed. Medical Records-I stated the facility did not have a receptionist on Saturdays, so no one was at the front desk to receive the mail. On 09/09/20 at 8:27 AM, Receptionist-H was interviewed. Receptionist-H stated the facility requested the local post office hold mail delivery on Saturdays when the facility cut the Saturday receptionist position. Receptionist-H stated, we did not want the mail just sitting here all weekend, so the residents do not get mail delivered on Saturdays. On 09/09/20 at 8:30 AM, Admissions Director-E was interviewed. Admissions Director-E stated it was in the resident handbook mail was delivered Monday through Friday, but it was not verbally explained upon admission. On 09/09/20 at 8:37 AM, Nursing Home Administrator-J was interviewed. NHA-J was unable to explain why the decision was made to stop mail delivery on Saturdays.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.05(3) Based on record review and interview; the facility staff failed to provide information on Advanced Directives for 2 (Resident 38 and 114) of 7 residents reviewed. The facility staff identified a census of 132. Findings are: A. On 9-3-2020 at 10:30 AM an interview was conducted with Resident 38. During the interview Resident 38 reported being interested in formation regarding Advance Directives. When asked if any of the facility staff had provided information for Advance Directives, Resident 38 stated no. Record review of Resident 38's medical record revealed there was not information related to Advance Directives. On 9-02-2020 at 3:05 PM an interview was conducted with Admissions Coordinator (AC) D. During the interview AC D reported no information is given out for Advanced Directives and confirmed Resident 38 did not have information to wanting an Advance Directive or not. On 9-02-2020 at 3:20 PM an interview was conducted with AC E. During the interview AC E reported AC E does not follow up or give out information related to Advance Directives. B. Resident 114 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had no memory impairment. The resident needed extensive assistance for activities of daily living and supervision for ambulating with a walker. The resident's medical record indicated the resident had a full code status in the event of respiratory and/or [MEDICAL CONDITION]. There was no Advance Directive in the medical record. On 09/09/20 at 11:27 AM, Resident 114 was interviewed. The resident indicated he/she had heard of an Advance Directive, but no one at the facility had offered an opportunity to fill one out or educate the resident about what was involved in filling out the document. Resident 114 felt it was an important document to have in the medical record .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D Based on record review and interview; the facility staff failed to follow up on gradual dose reduction for the use of an antipsychotic medication for 1 (Resident 111) of 5 sampled residents. The facility staff identified a census of 132. Findings are: Record review of an Order Summary Report of active orders dated 9-03-2020 revealed Resident 111's practitioner ordered medications that included [MEDICATION NAME] (an antipsychotic medication) 50 milligrams (mg) daily at bed time. Record review of a Drug Regimen Review sheet dated 7-30-2020 completed by the facility Consultant Pharmacist (CP) revealed the CP recommended asking Resident 111's practitioner for a does reduction of the [MEDICATION NAME] medication. Review of Resident 111's medical record revealed there was no evidence the facility staff had followed up on the CP recommendation. On 9-08-2020 at 12:15 PM an interview was conducted with Licensed Practical Nurse (LPN) H. During the interview LPN H confirmed the recommendation for a dose reduction for resident 111 was not completed.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on observations, record reviews and interviews; the facility staff failed to ensure a medication error rate of less than 5%. Observations of 32 medications for 3 (Resident 113, 44 and 119) of 4 residents revealed 5 errors resulting in an error rate of 15.63%. The facility staff identified a census of 132. Findings Are: A. Record review of Resident 113's Order Summary Report (OSR) of active orders as of 9-03-2020 revealed Resident 113's practitioner ordered medications that included Potassium [MEDICATION NAME] (supplement medication) 10 mcg to be given with meals and [MEDICATION NAME] (steroid medication) 5 milligrams (mg) to be given daily. Observation on 9-03-2020 at 7:30 AM revealed Certified Medication Assistant (CMA) A prepared the medication to be administered including the Potassium and the [MEDICATION NAME]. Further observations revealed the label on the medication Potassium [MEDICATION NAME] and [MEDICATION NAME] instructed the medication be given with food. CMA A with the prepared medication, entered Resident 113's room and administered the medications without food. On 9-03-2020 at 8:02 AM an interview was conducted with CMA A. During the interview CMA A confirmed the Potassium and the [MEDICATION NAME] were not given with food and should have been. B. Record review of Resident 44's OSR of active orders as of 9-08-2020 revealed Resident 44's practitioner

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) ordered medications that included Carvedilol (medication to assist with blood pressure control) 12.5 mg's to be taken 2 times a day with food. Observation on 9-08-2020 at 7:10 AM revealed Registered Nurse (RN) B prepared Resident 44's medication that included the Carvedilol without providing food. On 9-08-2020 at 7:25 AM an interview was conducted with RN B. During the interview RN B confirmed the Carvedilol should have been given with food. C. Record review of Resident 119's OSR with active orders as of 9-08-2020 revealed Resident 119's practitioner ordered medications that included [MEDICATION NAME] (an anticonvulsant medication)250 mg to be given 2 times a day and [MEDICATION NAME] (an anticonvulsant medication) 200 mg to be given 2 times a day with meals. Observation on 9-08-2020 at 8:04 AM revealed CMA C began to prepare Resident 119's medication. CMA C was not able to locate the [MEDICATION NAME] medication. CMA C proceeded to prepare the rest of the medications for that time including the [MEDICATION NAME]. CMA C them administered the medication prior to meal time. On 9-08-2020 at 8:10 AM an interview was conducted with CMA C. During the interview CMA C confirmed the [MEDICATION NAME] was not available to be given and the [MEDICATION NAME] was not given with a meal.
F 0840 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to have a contract with an outside [MEDICAL TREATMENT] clinic providing [MEDICAL TREATMENT] treatments to a resident. This affected 1 of 1 sampled resident (Resident 101) reviewed for [MEDICAL TREATMENT]. There were 5 residents receiving [MEDICAL TREATMENT] services outside the facility. The census was 132. Finding are: Resident 101 [DIAGNOSES REDACTED]. Due to end stage [MEDICAL CONDITION], Resident 101 was started on [MEDICAL TREATMENT] in 2018. On 09/02/20, the facility's contract binder was reviewed for [MEDICAL TREATMENT] contracts. Resident 101 had been receiving [MEDICAL TREATMENT] services at Resident 1's [MEDICAL TREATMENT] center of choice since 2018. A contract for this [MEDICAL TREATMENT] clinic was not located within the contract binder. On 09/02/20 at 2:27 PM, the Nursing Home Administrator (NHA-J) was interviewed. NHA-J was not aware a contract for Resident 1's [MEDICAL TREATMENT] center of choice location was not in the contract binder. On 09/02/20 at 2:30 PM, the Director of Nursing (DON-K) was interviewed. DON-K was not aware a contract for the Resident 1's [MEDICAL TREATMENT] center of choice was not in the contract binder. During a follow up interview with NHA-J on 09/09/20 at 8:50 AM, NHA-J stated a contract with Resident 1's [MEDICAL TREATMENT] center of choice was unable to be located and a new contract would need to be reviewed by the corporate office