STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285242	A. BUILDING _____ B. WING _____	09/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKESTONE VILLAGE	4330 SOUTH 144TH STREET OMAHA, NE 68137

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175NAC 12-006.10A1 Based on record review, observation and interview, the facility failed to assess the cognitive and physical ability of one resident (Resident 76) prior to allowing the self-administration of medication. The sample size was 24. The facility census was 120. Findings are: 09/14/20 10:32 AM An observation revealed Resident 76 had [MEDICATION NAME] mouth spray (a medication used to relieve dry mouth) at bedside. 09/15/20 11:20 AM An interview with Resident 76 revealed Resident 76 used the [MEDICATION NAME] twice daily. A record review for Resident 76 completed on 09/15/20 revealed no self-administration of medication assessment in the resident's record. The record review of the physician's orders [REDACTED]. A record review of the Medication Self-Administration Screen for Resident 76 had been completed on 09/16/20. 09/16/20 03:20 PM An interview with ADON-B confirmed the Medication Self-Administration Screen for Resident 76 did not exist prior to today.
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 review and interview, the facility failed to obtain a Level II 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) after a new mental disorder [DIAGNOSES REDACTED]. The sample size was 24. The facility census was 120. Findings are: A Record review revealed Resident 19 did have a level I PASRR upon admission to the facility on [DATE]. The record review of the level I PASRR dated 01/04/2012 did not indicate any mental or intellectual disorders for Resident 19. A record review of a Department of Psychiatry Progress Note dated 06/13/2017 for Resident 19 revealed no [DIAGNOSES REDACTED].
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175NAC 12-006.09C Based on record review and interview, the facility failed to ensure a comprehensive care plan had been developed for 1 (Resident 1) of 5 sampled residents Resident 1, for a psychoactive medication and exhibited frequent behaviors. There were 78 residents receiving psychoactive medications. The facility census was 120 residents. Findings are: Resident 1 had [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment, dated 08/28/20, documented the resident's Brief Interview for Mental Status score was 99, which indicated severe cognitive impairment. The assessment documented the resident had exhibited no behaviors during the seven days prior to the assessment date and had received an antidepressant medication on seven of seven days prior to the assessment date. A physician's orders [REDACTED]. (The order was discontinued on 09/14/20.) A physician's orders [REDACTED]. The Medication Administration Record, [REDACTED]. The electronic clinical record contained, Out of Character Response notes, which indicated the resident had frequent behaviors of yelling, screaming, hollering and calling out. Progress notes of the behaviors were written on the following dates: 07/06/20 at 8:00 PM, 07/11/20 at 5:30 AM, 07/11/20 at 5:44 AM, 07/12/20 at 10:00 PM, 07/14/20 at 4:15 PM, 07/19/20 at 1:17 PM, 07/19/20 at 8:34 PM, 07/31/20 at 05:46 AM, 08/05/20 at 3:00 PM, 08/10/20 at 4:57 PM, 08/31/20 at 7:46 PM, 08/30/20 at 8:32 PM, 09/03/20 at 3:37 PM, 09/04/20 at 9:00 PM, and 09/04/20 at 2:09 AM. The care plan revised 09/14/20, documented the resident's problems included the use of psychoactive medications related to depression, behavioral and psychotic symptoms due to dementia. The care plan did not address the resident's behaviors of crying/tearful, yelling at others, agitation/anxiousness, and/or paranoia/delusions which were documented on the Behavior/Intervention Monthly Flow Record for 09/2020. Non-pharmacological interventions for the behaviors were not addressed in the care plan. On 09/16/20 at 12:59 PM the Director of Nursing (DON) was asked if a behavior which required the administration of a as needed anxiolytic medication should be care planned, DON stated, If there are multiple occurrences, it should be care planned. On 09/16/20 at 1:40 PM, Registered Nurse (RN)-B was asked if the resident's behaviors of frequent yelling and crying out should be care planned, RN-B stated, Yes.
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 175NAC 12-006.09D1c Based on observation, record review, and interview, the facility failed to provide nail care for 1 (Resident 98) of 1 sampled resident reviewed that required assistance with activities of daily living (ADLs). This had the potential to affect all 120 residents currently in the facility that required assistance or were dependent on staff with activities of daily living. The facility census was 120. Findings are: Resident 98 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status of 11, which indicated moderate cognitive impairment. The MDS documented the resident required limited assistance with ADLs, and extensive assistance with bathing. The care plan, dated 08/12/20, documented the resident's problems included ADL self-care deficit related to activity intolerance. The care plan documented the resident was dependent upon staff for bathing, and hair care/nail care was to be provided with bathing. It documented a licensed professional was to provide nail care because of Resident 98's [DIAGNOSES REDACTED]. had been assessed and/or trimmed since admission. A summary of a pressure ulcer record, dated 09/02/20, documented: Resident asked nurse to trim toe nail. upon inspection of toe noted to have toe nail growing over tip of toe. area is dark purple intact skin. toe nail trimmed and filed as resident tolerated. On 09/16/20 at 9:00 AM, an observation, with the assistance of Registered Nurse (RN)-C, an area, approximately 1 centimeters (cm) x 1 cm was observed on the tip of the Resident 98's left great toe. RN-C confirmed the area was a ruptured blood blister which was the result of the toenail curving into the Resident 98's skin and was facility acquired. On 09/17/20 at 9:25 AM, RN-A was interviewed. When asked how long Resident 98's left great toenail was when the wound to the left great toe was discovered, RN=A stated the nail curled over the tip of Resident 98's s toe and was putting pressure on the end of the toe. RN-A used fingernail clippers to trim the nail and filed it. When asked if a licensed nurse was responsible to trim the nails because the resident was a diabetic, RN-A stated, Yes. When asked if the long, curled toenail should have been discovered prior to 21 days after admission and prior to the development of a wound, RN- A stated, Yes.
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**

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **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** Based on record review and interview, the facility failed to ensure an as needed antianxiety medication was administered only with an indication for use and after non-pharmacological interventions had been attempted for 1 (Resident 1) of 5 sampled residents reviewed for unnecessary medications. The facility identified 23 residents were receiving antianxiety medications. The census was 120. Findings are: The facility, Medication Management policy and procedure, undated, documented: The indications for initiating, withdrawing, or withholding medications, as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment .The following considerations will be included in the management of [MEDICAL CONDITION]/psychoactive medication (with initiation of a medication and also for continued use of a medication) .Were non-pharmacological interventions considered? .Residents do not receive [MEDICAL CONDITION]/psychoactive drugs pursuant to a PRN (as needed) order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record . Resident 1 had [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment, dated 08/28/20, documented Resident 1's Brief Interview for Mental Status score was 99, which indicated severe cognitive impairment. The assessment documented the resident had exhibited no behaviors during the seven days prior to the assessment date and had received an antidepressant medication on seven of seven days prior to the assessment date. The care plan revised 09/14/20, documented Resident 1's problems included the use of psychoactive medications related to depression, and behavioral and psychotic symptoms due to dementia. The care plan did not address Resident 1's behaviors of crying/tearful, yelling at others, agitation/anxiousness, and/or paranoia/delusions. Non-pharmacological interventions for the behaviors were a not addressed in the care plan. A physician's orders [REDACTED]. (The order was discontinued on 09/14/20.) A physician's orders [REDACTED]. The Medication Administration Record, [REDACTED]. The clinical record (nursing progress notes and/or the behavior monitoring flow sheet) contained no documentation non-pharmacological interventions had been attempted prior to the administration of [MEDICATION NAME] for Resident 1' on the following dates/times: 09/10/20 at 7:46 PM, 09/11/20 at 5:47 PM, 09/12/20 at 4:12 PM, and 09/15/20 at 8:01 PM. On 09/16/20 at 12:24 PM, Registered Nurse (RN)-D was asked where in the clinical record a resident's behaviors would be documented. RN-D stated behaviors would either be documented in a progress note or on the behavior monitoring sheet. On 09/16/20 at 12:59 PM, the Director of Nursing (DON) was asked if non-pharmacological interventions should be attempted prior to the administration of a PRN anxiolytic medication. The DON stated, Yes. When asked if a behavior, which required the administration of a PRN anxiolytic medication, should be documented in the clinical record, the DON stated, Either in a progress note or on the behavior sheet. When asked if a behavior which required the administration of a PRN anxiolytic medication should be care planned, the DON stated, If there are multiple occurrences, it should be care planned. The above listed dates/times of the administration of [MEDICATION NAME] for Resident 1' were provided to the DON. The DON was asked to find documentation of non-pharmacological interventions attempted prior to the administration of [MEDICATION NAME] and/or indications for the administration of the [MEDICATION NAME] on the four dates/times. On 09/16/20 at 1:40 PM, the DON returned with Registered Nurse (RN)-B, who provided documentation of behaviors documented in the clinical record for the administration of [MEDICATION NAME] for Resident 1 on 09/12/20 at 4:12 PM. RN-B stated there was no documentation of non-pharmacological interventions having been attempted on any of the four dates/times and no indication for use of [MEDICATION NAME] documented on 09/10/20 at 7:46 PM, 09/11/20 at 5:47 PM, or 09/15/20 at 8:01 PM.